

# **Albanese Chiropractic**

## **Terms of Acceptance and Consent for Care**

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When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

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Print Name

Signature

Date

### **Consent to evaluate and adjust a minor child:**

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above Consent for Care and hereby grant permission for my child to receive chiropractic care.

# Albanese Chiropractic

## Confidential Patient Information

Full Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status M S W D

Email \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Position \_\_\_\_\_

Business Phone \_\_\_\_\_

Spouses Name \_\_\_\_\_ Spouses Employer \_\_\_\_\_

Name and Age of Children \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

## Health Assessment

Have you ever seen a Chiropractor? Y N For what reason? \_\_\_\_\_

Purpose of this visit: \_\_\_\_\_ Wellness Check-up \_\_\_\_\_ Accident \_\_\_\_\_ Other (please explain) \_\_\_\_\_

If you are experiencing symptoms, when did they first appear? \_\_\_\_\_

Type of accident, describe in detail (if applies): \_\_\_\_\_

What are your health goals? \_\_\_\_\_

Do you have a plan to reach your health goals? \_\_\_\_\_

What areas of your health would you like to change or improve? \_\_\_\_\_

Rate the quality of the following on a scale from 1-10 (10 being the best, 1 being the lowest)

Overall Health \_\_\_\_\_ Diet \_\_\_\_\_ Rest/Sleep \_\_\_\_\_ Stress \_\_\_\_\_, major stress is: \_\_\_\_\_

Exercise hours/week \_\_\_\_\_ Hours of sitting/driving per week \_\_\_\_\_ Caffeinated drinks/day \_\_\_\_\_

Family Health History (Diseases, Chronic Conditions, etc.) \_\_\_\_\_

Please list hobbies and activities you participate in: \_\_\_\_\_

List medications currently taking (prescription and non-prescription): \_\_\_\_\_

Please list year and type of surgeries: \_\_\_\_\_

Please check any of the following you are experiencing or have experienced in the past:

- |  |  |  |   |                                       |
|--|--|--|---|---------------------------------------|
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Hip Pain      | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Gas          |
| <input type="checkbox"/> Headaches       | <input type="checkbox"/> Arm Pain      | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Allergies      | <input type="checkbox"/> Nausea       |
| <input type="checkbox"/> Chest Pain      | <input type="checkbox"/> Neck Pain     | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Hay Fever      | <input type="checkbox"/> Diarrhea     |
| <input type="checkbox"/> Nervousness     | <input type="checkbox"/> Wrist Pain    | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Sore Throats   | <input type="checkbox"/> Indigestion  |
| <input type="checkbox"/> Ankle Swelling  | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Liver Problem       | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Heart Condition     | <input type="checkbox"/> Sinus Problem  | <input type="checkbox"/> Stomach      |
| <input type="checkbox"/> Skin Conditions | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Kidney Problem      |   |                                       |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/>               | <input type="checkbox"/> Bladder Problem     |   |                                       |
| <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/>               | <input type="checkbox"/> Thyroid Condition   |   |                                       |
| <input type="checkbox"/>                 | <input type="checkbox"/>               | <input type="checkbox"/> High Blood Pressure |   |                                       |

**Males:**

- Painful Urination  
 Frequent Urination  
 Hesitancy upon Urinating

**Females:**

- PMS  
 Hot Flashes  
 Excessive Flow  
 Painful Menses  
 Irregular Cycle  
 Date of Last Period \_\_\_\_\_  
 Are you pregnant? \_\_\_\_ Y \_\_\_\_ N

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Complete only if patient is not the primary insured:**

Name of Insured \_\_\_\_\_  
\_\_\_\_ Male \_\_\_\_ Female Insured's Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_  
Address (if different) \_\_\_\_\_  
Patient's relationship to primary insured \_\_\_\_\_  
Insured's Social Security Number \_\_\_\_\_  
Primary Insured's Employer \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

*I authorize Albanese Chiropractic to accept assignment and direct payment for insurance reimbursement. Payment is expected at the time service is rendered, unless other arrangements have been made. I agree to pay a Finance Charge of 1.5% per month on balances over thirty (30) days past due, which is an Annual Percentage Rate of 18%. I understand a \$35 fee will be charged to my account for any returned bank checks per each occurrence. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Albanese Chiropractic for all costs of such collection efforts, including, but not limited to, all court costs, all attorney fees in the amount of thirty- three and one- third percent (33 1/3%) and any interest accrued at 1.5% per month.*

**Consent For Chiropractic Care of a Minor:** I hereby authorize the Doctor to administer an Examination, X-Rays, and Chiropractic care as deemed necessary.

Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_