MALAMA CHIROPRACTIC

Welcome to Malama Chiropractic. The purpose of this office to inform as many people as possible of the spinal condition called the **VERTEBRAL SUBLUXATION COMPLEX.** Vertebral Subluxations disrupt the normal innate functions of the nervous system and interferes with your opportunity for optimal health and healing. Your experience here should be one of healing as well as learning the TRUE meaning of HEALTH for you, your family, and your friends.

First Name: ______ Middle Initial: ______ Last Name: ______

Name you prefer to go by: ______ SSN: ______

Home Address: ______

City: ______ State: ______ Zip Code: ______

Date of Birth ____ / ____ / ____ Sex: ______ Age: ______

Height: ______ Weight: ______ Marital Status: ______

Home Phone: ______ Cell Phone: ______

Work Phone: ______ May we contact you at work? ______

Your Email Address: ______

Primary Health Insurance: ______ Primary Insured Name: ______

Insured's ID Number: ______ Insured's Date of Birth: ______

Spouse/Significant Other: ______ Spouse's Date of Birth: ______

Your Primary Care Physician: ______ Phone: ______

Your Occupation: ______

Your Employer: ______

Employer's Address: ______

City: ______ State: ______ Zip: ______

Number of Children: ______ Ages: ______

Emergency Contact: ______ Phone: ______

How did you hear about our office? ______

Please read carefully
Office Policies and Insurance Payment Information

Your Insurance Coverage is a contract between YOU and your Insurance Company. We will collect fees for our services up front, from you, and will bill your Insurance. If your Insurance denies payment for any of our services, you are responsible for any and all of those fees, up to the contracted rate your Insurance Company allows.

-All patients are required to fill out the necessary paperwork so as to serve you in your Health Care needs and to efficiently deal with the administrative demands that accompany your care.

-Children need to be supervised while in the office. There is equipment throughout the clinic that is potentially dangerous to the curious child. It is greatly appreciated if you make arrangements for your child's/children's care while you are being examined or treated.

-All New Patients will receive a thorough examination and most patients will require spinal Xrays. The X-Ray equipment used in this office is of the most up to date technology. **ANY WOMAN WHO THINKS SHE MAY BE PREGNANT, MUST NOTIFY THE DOCTOR.**

-Should you require additional time for your appointment for any reason, please notify the Receptionist when you schedule your appointment time.

-Failure to cancel an appointment 24 hours in advance will result in a "No-Show" charge of $25.00

With my signature, I give Malama Chiropractic permission to provide my Insurance Carrier with any needed records to facilitate payment for services rendered.

____

Patient Signature **Date**

PATIENT INFORMATION

Patient Name: ______________________________ Today's Date: ______________

What is your major complaint? ______________________________

When did your symptoms start? ______________________________

Is your condition the result of an AUTO ACCIDENT or a WORK INJURY? Y / N

Date of Injury: __________ Have you opened a Personal Injury or Work Comp Claim? Y / N

Is it getting: _________ Better ________Worse _______Staying the Same ________ Intermittent

What makes it worse? ______________________________

What makes it better? ______________________________

Rate the severity of your pain on a scale of O (No Pain) to 10 (Severe Pain) 0 1 2 3 4 5 6 7 8 9 10

Type of Pain: ___Sharp ___Aching ___Throbbing ___Swelling

___Dull ___Shooting ___Tingling ___Burning

___Cramping ___Numbness ___Stiffness ___OTHER:_________

What other treatments do you use for pain?

□ Medication □ Physical Therapy □ Chiropractic

□ Massage □ Surgery □ None □ Other: ____________

Have you experienced these symptoms before? Y / N When? ______________

What other Doctors or Physicians have you seen for this condition? ______________

Do you sleep on your side, back or stomach? ______________ Average hours of sleep per night? ______

How often do you exercise? ______________ What Type of Exercise? ______________

Do you smoke? ________ Packs/day? ________ Do you consume caffeine? ________ Cups/day? ______

Do you consume alcohol? ______________ How Often? ______________

Does your work include:

______Sitting ________Standing ________Light Labor ________Heavy Labor

Personal and Family History

Please tell us, whom, in your IMMEDIATE family, INCLUDING YOURSELF, suffers from the following conditions. (Living and Deceased)

Y / N Allergies ______________________
Y / N Angina ______________________
Y / N Anorexia ______________________
Y / N Aortic Aneurysm ______________________
Y / N Arthritis ______________________
Y / N Asthma ______________________
Y / N Blood Disorder ______________________
Y / N Breast Soreness ______________________
Y / N Bulimia ______________________
Y / N Cancer ______________________
Y / N Colitis ______________________
Y / N Convulsions ______________________
Y / N Diabetes ______________________
Y / N Dislocated Joints ______________________
Y / N Dizziness ______________________
Y / N Emphysema ______________________
Y / N Epilepsy ______________________
Y / N Fainting ______________________
Y / N Hay Fever ______________________
Y / N Headaches ______________________
Y / N Heart Disease ______________________
Y / N High Blood Pressure ______________________
Y / N HIV/Aids ______________________
Y / N Irritable Bowel ______________________
Y / N Kidney Disease ______________________
Y / N Kidney Stones ______________________
Y / N Liver Disease ______________________
Y / N Low Blood Pressure ______________________
Y / N Lung Disease ______________________
Y / N Multiple Sclerosis ______________________
Y / N Osteoporosis ______________________
Y / N Painful Urination ______________________
Y / N PMS ______________________
Y / N Polio ______________________
Y / N Prostate Disease/Cancer ______________________
Y / N Rapid Heart Rate ______________________
Y / N Rheumatic Fever ______________________
Y / N Scoliosis ______________________
Y / N STD ______________________
Y / N Sickle Cell Anemia ______________________
Y / N Spinal Disc Disorder ______________________
Y / N Sinus Trouble ______________________
Y / N Stroke ______________________
Y / N Thyroid Disorder ______________________
Y / N Tuberculosis ______________________
Y / N Ulcer ______________________
OTHER ______________________

MEDICATIONS YOU'RE TAKING	TAKING THEM FOR	VITAMINS/MINERALS/HERBS

Accidents/Injuries/Falls/Surgeries

Incident	Year
1.	
2.	
3.	
4.	

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Privacy Practices

In the course of your care as a patient at Malama Chiropractic, we may use or disclose personal and health related information about you in the following ways:

-To another Healthcare Provider or hospital if it is necessary to refer you for further diagnosis, and or assessment.
-To an insurance carrier, an HMO or a PPO, or your employer if they are; or may be responsible for the payment of your care.
-To contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your voicemail. You have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care. Under federal law, we are required to disclose your health information in the following circumstances:

-If we are providing health care services to you based on the orders of another health care provider.
-If we are providing care to you in an emergency.
-If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
-If there are substantial barriers to communicating with you, but in our professional judgment, we believe that you intend for us to provide care to you.
-If we are ordered by the courts or another appropriate agency.

If you would like to receive this information about your account elsewhere than your mailing address, please advise us in writing.

You have the right to inspect your information 7 years from the date that your record was created or for as long as the information remains in our files. Any requests to inspect, copy, or amend your health related information must be provided to us in writing.

We are required by State and Federal law to maintain the privacy of your patient file and information. In addition, we reserve the right to alter, change, and amend the terms of this notice. Any change will apply to all of your health information in our files. Should any alteration ensue, you will be notified in writing by this office.

By signing this notice, you are acknowledging that you have read and understand the statutes set forth, and agree that you have been given the opportunity to receive a copy of this notice.

______________________	______________________	______________________
Printed Name	Signature	Date
______________________	______________________	______________________
Personal Representative (If Patient is a Minor)	Personal Representative Signature	Date

Malama Chiropractic Clinic

Informed Consent to Chiropractic Treatment

Dear Patient,

Every type of health care is associated with some risk of potential problem. This includes Chiropractic Health Care. We wish you to be informed about the possibility of any potential problems associated with Chiropractic Health Care before consenting to treatment. This is called Informed Consent.

The Nature of Chiropractic Treatment: The Doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a 'click' or 'pop, such as the noise when a knuckle is 'cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of Risks occurring: The risks of complications due to chiropractic treatment have been described as 'rare', about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered 'rare'.

Other Treatment options which should be considered may include the following:

- ***Over the counter analgesics.*** **The risk of these medications include irritation to the stomach, liver and kidneys, and other side effects in a significant number of cases.**
- ***Medical Care,*** **typically anti-inflammatory drugs, tranquilizers, and analgesics. Risk of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.**
- ***Hospitalization*** **in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.**
- ***Surgery*** **in conjuction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.**

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probably that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual Risks: I have had the unusual risks of my case explained to me.

I have read the explanation of Chiropractic Treatment above. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Name: ______________________ **Signature:** ______________________ **Date:** __________

Witness: ______________________ **Signature:** ______________________ **Date:** __________