O' Fallon Crossing Chiropractic
Information For Care

The following information is needed in order to better serve you. Please complete all questions. Thank you.

Patient Information:

Name_____ Home # (__)_____ Cell # (____)_____

Address_____ City_____ State_____ Zip_____

Social Security #_____ Marital Status S M W D Number of Children_____

Age_____ Birth date_____ (If patient is a minor please be sure to complete Guardian section)

Email _____

Employer Information:

Employer Name_____ Occupation_____ Years Emp_____

Address_____ City_____ State_____ Zip_____

Work # (____)_____

Parent/Guardian/Spouse:

Name_____ Home # (__)_____ Cell # (____)_____

Address_____ City_____ State_____ Zip_____

Social Security #_____ Birth date_____ Relationship_____

Pain Diagram & Description:

Please write a brief description of your pain and then place an X on the corresponding area of pain to the right.

_____

_____

_____

_____

_____

_____

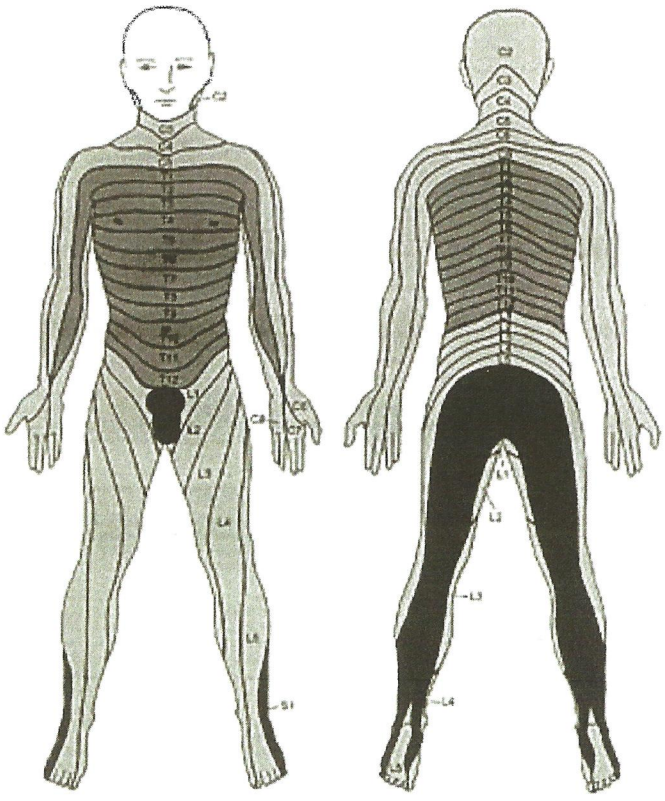
_____

_____

_____

_____

_____



Please complete back side of page

Is your condition due to an accident or work related injury? Yes or No _____

If so, please complete the appropriate accident / injury paperwork to insure payment from the responsible party involved. Please ask the receptionist for the mentioned paperwork if you have not already received them.

How did you hear about Dr. Hadden? (Please check one option)

____Referred by another patient (other patient's name)_____
____Yellow pages
____Internet
____ Google
____ Yellowbook.com
____ Other
____Other_____

May we have permission to send a letter to your Primary Care Physician, to keep him/her informed of your treatment at O'Fallon Crossing Chiropractic? YES or NO (circle one)

If Yes, Who is your Primary Care Physician? _____

By signing I agree to pay for services rendered to the above patient. I also agree that insurance policies are an arrangement between patient and the insurance carrier and that I am personally responsible for knowing my Chiropractic benefits per my plan. Therefore I am responsible for payment of any applicable deductibles, co-payment or services not covered by my plan. If my treatment is suspended all services rendered will be immediately due and payable. Also, by signing, I give O'Fallon Crossing Chiropractic and its representatives permission to communicate to me via the contact information above.

Patient Signature:_____ **Date:**_____

Guardian Signature:_____ **Date:**_____

Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name _____ Date _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL F – FREQUENT
C – CONSTANT

O	F	C	
			GENERAL
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
			MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
			Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tail bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal Curvature
☐	☐	☐	Swollen joints

O	F	C	
			GASTRO-INTESTINAL
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood
			EYES, EARS, NOSE &THROAT
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental Decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

O	F	C	
			CARDIO-VASCULAR
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles
			RESPIRATORY
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing
			SKIN
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins
			GENITO-URINARY
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine
			FOR WOMEN ONLY
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Miscarriage	☐ Scarlet fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Appendicitis	☐ Diphtheria	☐ Heart disease	☐ Mumps	☐ Tuberculosis
☐ Arteriosclerosis	☐ Eczema	☐ Influenza	☐ Pleurisy	☐ Typhoid fever
☐ Arthritis	☐ Emphysema	☐ Lumbago	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Polio	☐ Venereal disease
☐ Chorea	☐ Fever blisters	☐ Measles	☐ Rheumatic fever	☐ Whooping cough

Basic Nutrition Questionnaire

Have you ever been told you have High Cholesterol or Triglycerides? YES / NO

Have you ever been diagnosed with High Blood Pressure? YES / NO

Have your been Diagnosed as Diabetic? YES / NO

Have you been diagnosed as Pre-Diabetic or Metabolic Syndrome? YES / NO

How many days a week do you skip a meal? (3/meals/day) _____

How many "fast food', "refined food", or "pre-prepared" meals to you eat per week?

(0) (1-3) (4-6) (7+)

How many servings of fruit do you eat per day?

(0-1) (2-3) (4-5)

How many servings of vegetables to you eat per day?

(0-1) (2-3) (4-5)

Do you regularly drink 1 or more per day of the following: (circle all that apply)

Soda Diet Soda Coffee Juice Milk Alcohol

How many servings of refined sugar do you eat per day? (Candy, Cookies, Cake, etc)

(0-1) (2-3) (4-5)

Please list all nutritional supplements/vitamins you take regularly:

(Staff can photocopy a list if you have one)

Supplement Name/Type	Frequency	Brand or Where Purchased

O'FALLON CROSSING CHIROPRACTIC

Consent to Chiropractic Examination

Dear Patient,

Please read this entire document prior to signing. It is vital that you understand the information contained in this document. Please ask your doctor, or our staff, if there is anything that is unclear.

Thank you,

O'Fallon Crossing Chiropractic

PATIENT'S RIGHTS

Our team at O'Fallon Crossing Chiropractic respects each and every patient. To ensure quality care is maintained for all patients, the following rights will be exercised on the patient's behalf.

1. The patient has the right to respectful care.
2. The patient has the right to understandable information concerning diagnosis, treatments, and prognosis.
3. The patient has the right to know the identity of all staff that may be involved in their care.
4. The patient has the right to make decisions about their treatment plan at any given time during the course of treatment. Which includes the right to refuse recommended treatment or plan of care to the extent permitted by law, and to be informed of the consequences of this action.
5. The patient has the right to privacy.
6. The patient has the right to expect all records pertaining to the patient's care will be kept confidential, except in cases required by law or consent has been given by the patient, or patient guardian.
7. The patient has the right to expect reasonable continuity of care when appropriate and be informed by the staff at O'Fallon Crossing Chiropractic of available and realistic patient options.
8. The patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts.

THE CHIROPRACTIC EXAMINATION

Prior to establishing a treatment plan your doctor must perform a Chiropractic examination in order to determine the exact cause of discomfort. During the examination, the chiropractor will perform some procedures, or maneuvers, intended to reproduce your symptoms. This will allow for the physician to have a better understanding of the patient's condition and will contribute to the creation of a unique treatment regimen specifically for the patient. There is a slight possibility that these maneuvers may temporarily aggravate your symptoms.

INFORMATION ABOUT CHIROPRACTIC MANIPULATION

O'Fallon Crossing Chiropractic's primary treatment is spinal manipulation therapy. Spinal manipulation therapy involves the use of your doctor's hands and mechanical instruments upon your body in such a way to mobilize your joints. This movement may cause an audible "pop" or "click". You may also feel a sense of movement. All patient care, including chiropractic care, has the potential for negative effects. The risks associated with chiropractic treatment include, but are not limited to, dislocations and sprains, disc injuries, fractures, and strokes. Fractures are rare occurrences and generally result from some underlying weakness in the bone, which your doctor looks for during your initial consultation, your examination, and while reviewing your x-rays. The incidence of stroke is exceedingly rare and is estimated to occur one in one million and one in five million adjustments of the neck. The other complications are also generally described as rare.

Your doctor will formulate a treatment plan and will recommend what they feel is in your best interest.

Other treatment options for your condition may include:

- Self-administered, over the counter analgesics, and rest
- Medical care & prescription drugs such as anti-inflammatory, muscle relaxants, & pain killers
- Physiotherapy
- Hospitalization
- Surgery

You may wish to speak with your primary care physician if you choose to use one of the above noted "other treatment" options, and be aware that there are risks and benefits of such options.

FINANCIAL RESPONSIBILITY

I understand and agree that the health and accident insurance policies are an arrangement between the insurance carrier and me. This office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me are charges directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Notice of HIPAA Privacy Practice

This notice describes how personal health information about you may be used and disclosed and how you can receive access to this information. PLEASE REVIEW THIS CAREFULLY.

This notice of HIPAA Privacy Practice describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access control of your personal medication information. "Protected Health Information" (PHI) includes demographic information and is information about you that may identify you and relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by law to:

- Make sure that medical information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to your protected health information
  and
- Follow the terms of the notices that are currently in effect

Who will follow this notice: This notice applies to the faculty at O'Fallon Crossing Chiropractic for which patient information is shared. This notice also applies to other healthcare providers that provide services, such as billing and marketing. As a condition to providing services at O'Fallon Crossing Chiropractic, such providers must agree to comply with all HIPAA laws regarding said activity.

How we may use and disclose your protected health information: Your protected health information may be used and disclosed by your physician, office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of O'Fallon Crossing Chiropractic, to support the education of chiropractic interns, and any other use required by law.

As required by law: We will disclose your protected health information when required to do so by federal, state, or local law.

Public Health Risks: We may disclose your protected health information for public health activities. We may use and disclose this information to agencies when necessary to prevent a serious threat to your health and safety or health and safety of the public or another person. These activities generally include the follow:

- To prevent or control disease, injury, or disability
- To report child abuse or neglect
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure when required or authorized by law.
- To notify people of recalls of products they may be using.
- To notify persons who may have been exposed to disease or may be at risk for contracting or spreading a disease or condition.

Health oversight activities: We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with other laws.

Lawsuits & Disputes: If you are involved in a lawsuit or dispute, we may disclose your protected health information in response to a court order, subpoena, warrant, summons, or similar process.

Other uses of your Protected Health Information: With your written permission and direction, other uses and disclose of protected health information not covered by this notice of the laws that apply to use will be made. If you provide us permission to use or disclose your protected health information you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose this information for the reasons covered by your written authorization. You understand that we are unable to take back any disclosure we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Changes to this Notice: O'Fallon Crossing Chiropractic reserves the right to change this notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the office.

Questions or Complaints: If you believe your privacy rights have been violated you may file a complaint with us or with the Secretary of the United States Department of Health and Human Services.

- **DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE**

By signing below, I state that I want to investigate how chiropractic care can help me, or the patient listed below to whom I am the legal guardian, and consent to chiropractic examination. Once a treatment plan is established I will have the opportunity to discuss the treatment plan with my doctor and to consent to the proposed care. I intend to consent to cover any examinations for my present condition and for any future condition for which I seek treatment.

_____ _____

Patient's Signature/Legal guardian for minor Date

O'FALLON CROSSING CHIROPRACTIC

Cancellation Policy

The treatment plan prescribed for you, is based upon your body's need for therapy. We strive to give the best care possible, and hope to get you and your family back to good health. In order to offer our patients the opportunity to receive exceptional care in our office, we ask that all patients give us at least 24 hours' notice for all cancellations. However, we do understand that even with the best intentions, we can all make miscalculations. That is why we have created the following structure for cancellations.

Number of Cancelled Visits	Cost to Patient
1	$0
2	$0
3 or MORE	$25 per appointment

We require a 24 hour advance notice if you are unable to visit the office for treatment. In the event you are unable to cancel prior to the 24 hour deadline, O'Fallon Crossing Chiropractic will waive the cancellation fee for the first 2 missed appointments. After 3, or more, missed appointments without a 24 hour notice, you are responsible for the missed appointment fees for each visit missed thereafter. Please be advised, our reminders via text and e-mail are a courtesy. In the event our courtesy reminders are not functioning, it is the patient's responsibility to be aware of their appointment time.

___Opt in for TEXT reminders:

Cell phone number_____

___Opt OUT of text/email reminders

I UNDERSTAND AND AGREE TO THE ABOVE TERMS PERTAINING TO THE CANCELLATION POLICY

_____ _____

Patient Print Date

_____

Patient Signature