Appalachia
CHIROPRACTIC & WELLNESS

Patient Information

Name: _____ Date of Birth: _____ mm/dd/yyyy

Address:_____ City:_____ State:_____ Zip:_____

Email: _____ Preferred Contact Method: ○ Cell ○Home ○ Work

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Occupation: _____

Emergency Contact Name: _____Emergency Contact Phone Number: _____

Relationship to Patient: _____ (spouse, parent, guardian, other)

Primary Care Physician: _____ PCP Phone Number: _____

Who may we thank for referring you? _____

Chief Complaint

Describe the reason for your visit. Mark areas of concern on the body to the right.

_____

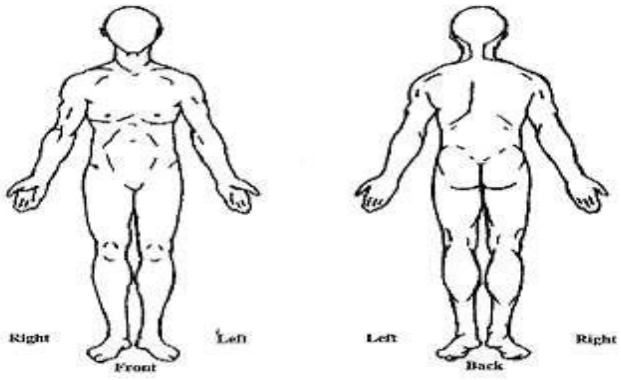
_____

_____

_____

_____

_____



When did your symptoms appear? _____ How often do you have this pain? _____

Is this condition getting progressively worse? ○ Yes ○ No Is it constant or does it come and go? _____

Rate the severity of your pain on a scale of 1 (least) to 10 (most) _____

Type of pain: ○ Sharp ○ Dull ○ Aching ○ Burning ○ Tingling ○ Shooting ○ Numbness ○ Other_____

Does it interfere with your: ○ Work ○ Sleep ○ Daily Routine ○ Workouts

Activities or movements that are painful to perform: ○ Standing ○ Sitting ○ Walking ○ Bending ○ Other_____

What helps relieve your discomfort? ○ Ice ○ Heat ○ Medication ○ Other (describe)_____

Who have you seen for your symptoms? ○ No One ○ Medical Doctor ○ Chiropractor ○ Massage ○ Other_____

Are you still receiving care from another provider? ○ Yes ○ No

Have you received any imaging? (X-Ray, MRI, CT) _____

Prior surgeries or implants _____

Do you have any spinal fusions? ○ Yes ○ No

Do you have a history of stroke or heart attack? ○ Yes ○ No

Do you have a pacemaker? ○ Yes ○ No

Accident Information

Is the condition due to an accident? ○ Yes ○ No Date of Accident _____

Type of Accident ○ Auto ○ Work ○ Home ○ Other

Insurance Information

Who is responsible for this account? _____

Policy Holder DOB _____

Relationship to Patient? _____

Insurance Co. _____ Secondary Insurance_____

Insurance ID # _____ Secondary ID #_____

I certify that I, and/or my dependent, have insurance coverage with _____

and assign directly to Dr. Travis Horne all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above- named insurance company and their agencies for the purpose of obtaining payment of service and determining insurance benefits. The consent will end when my current treatment plan is completed.

_____ _____ _____

Signature of Patient/Guardian Print Name Date

Cancelation/No Show Policy

Appalachia Chiropractic & Wellness, P.C. understands that unanticipated events occasionally do happen in everyone's life. Please inform us at least 24 hours prior to your appointment if you need to cancel or reschedule your appointment. This allows us to offer this appointment slot to other patients who may have an immediate need to our care. It is office policy that you are allowed 3 missed appointments or cancellations with no penalty. After the third cancellation or missed appointment, you will be charged a $25 fee.

_____ _____ _____

Signature of Patient/Guardian Print Name Date

Informed Consent

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. **Following are the known risks: Temporary soreness or increased symptoms or pain** It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.

Dizziness, nausea, flushing These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

Fractures When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

Disc herniation or prolapse Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

Stroke A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both Doctors of Chiropractic and primary care medical doctors before or during their stroke.

Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.

Bruising Instrument assisted soft tissue manipulation may result in temporary soreness or bruising.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor. I have made my decision voluntarily and freely.

_____	_____	_____
Signature of Patient/Guardian	Print Name	Date