Welcome

DICKERSON CHIROPRACTIC, P.C.

We are pleased to welcome you to our practice. To save time and allow us to better serve you, please complete all the information required. If you have any questions, we'll be happy to help.

TODAYS DATE:				
1. Name (Last, First, Middle Initial)	2. Sex ☐ M ☐ F	3. Social Security #	4. Age	5. Date of Birth
6. Address City State Zip		7. E-mail Address		
8. Home Telephone	9. Cell Phone	10. Work Phone	11. Which phone would you like to be contact on? ☐ Home ☐ Cell ☐ Work	
12. Occupation	13. Employer	14. Employer's Address		
15. Marital Status ☐ Single ☐ Married	16. Name of Spouse	17. Does spouse have any health problems?		
18. # of Children	19. Name(s) & Age(s) of Children	20. Do your children have any health problems?		
21. Name and telephone # of Emergency Contact	22. Do you have health insurance? ☐ YES ☐ NO Company's Name:			
23. Referred by:	24. Have you had chiropractic care before? ☐ YES ☐ NO Where? When?	25. Are you possibly Pregnant? ☐ YES ☐ MAYBE ☐ NO		
26. Have you ever had any accidents, injuries, or major falls? ☐ YES ☐ NO	Month, Year	Type	Describe Injury	
27. Have you ever had any surgery? ☐ YES ☐ NO	Month, Year	Type	Describe Injury	
28. Are you currently taking any medication? ☐ YES ☐ NO	Name	Dosage	Reason for taking it	
29. Are you currently taking any Nutritional Supplements? ☐ YES ☐ NO	Name	Dosage	Reason for taking it	

Health History

Check any of the following conditions which you have had within the last year.

MUSCULO-SKELETAL
- ☐ Arthritis
- ☐ Arms/Hands Pain
- ☐ Hip Pain
- ☐ Jaw Problems
- ☐ Joints Pain
- ☐ Legs/Feet Pain
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Osteoporosis
- ☐ Shoulder Pain/Tightness
- ☐ Stiffness

NERVOUS
- ☐ Face Twitching
- ☐ Fainting
- ☐ Nervousness
- ☐ Numbness/Tingling
- ☐ Pinched Nerve
- ☐ Seizures/Convulsions
- ☐ Tremors

FEMALE (ONLY)
- ☐ Breast Pain/Lumps
- ☐ Menstrual Cramps
- ☐ Menstrual Irregularity
- ☐ Vaginal Pain/Infections

C-V-R
- ☐ Ankle Swelling
- ☐ Asthma
- ☐ Blood Pressure Problems
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ High Cholesterol
- ☐ Shortness of Breath

GASTRO-INTESTINAL
- ☐ Abdominal Pain/Cramps
- ☐ Black/Bloody Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Thirst
- ☐ Frequent Nausea/Vomiting
- ☐ Heartburns
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Poor Appetite
- ☐ Ulcers

GENITO-URINARY
- ☐ Bed Wetting
- ☐ Bladder Problems
- ☐ Discolored Urine
- ☐ Excessive Urination
- ☐ Painful/Burning urination

EENT
- ☐ Ear/Hearing Problems
- ☐ Ear Infections
- ☐ Eye/Vision Problems
- ☐ Nose/Smelling Problems
- ☐ Sinus Problems
- ☐ Throat Problems

SKIN
- ☐ Itching/Rash
- ☐ Skin Problems
- ☐ Tumors/Cysts/Lumps

GENERAL
- ☐ Allergies
- ☐ Cold Sweats
- ☐ Depression
- ☐ Dizziness
- ☐ Difficulty Sleeping
- ☐ Fatigue
- ☐ Headaches
- ☐ Memory Problems
- ☐ Sudden Loss of Weight
- ☐ Swelling

MALE (ONLY)
- ☐ Genital Problems
- ☐ Prostate Problems

Check any of the following diseases which you have had in your life.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Bulimia
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Disc Herniation
- ☐ Gout
- ☐ Hayfever
- ☐ Heart Problems
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Measles
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Polio
- ☐ Shingles
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Whooping Cough

Family History

Check the following family members that had any of the diseases mentioned above.

- ☐ Father: _____
- ☐ Mother: _____
- ☐ Brother: _____
- ☐ Sister: _____
- ☐ Spouse: _____
- ☐ Child: _____
- ☐ Uncles/Aunts: _____
- ☐ Grandparents: _____

Patient Name: _____ Date: _____

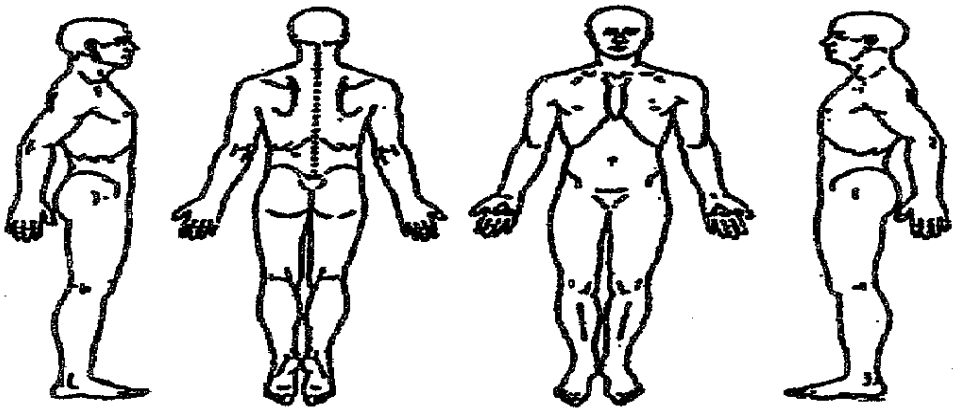
Your Current Condition

Patient Name: _____ Date: _____

1. Chief complaint? _____

2. Is today's problem caused by: ◻ Auto Accident ◻ Workman's Compensation ◻ Other

3. Indicate on the drawings below where you have pain/symptoms



4. How often do you experience your symptoms?

◻ Constantly (76-100% of the time) ◻ Occasionally (26-50% of the time)
◻ Frequently (51-75% of the time) ◻ Intermittently (1-25% of the time)

5. How would you describe the type of pain?

◻ Sharp ◻ Numb
◻ Dull ◻ Tingly
◻ Diffuse ◻ Sharp with motion
◻ Achy ◻ Shooting with motion
◻ Burning ◻ Stabbing with motion
◻ Shooting ◻ Electric like with motion
◻ Stiff ◻ Other:_____

6. How are your symptoms changing with time?

◻ Getting Worse ◻ Staying the Same ◻ Getting Better

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

8. How much has the problem interfered with your work?

◻ Not at all ◻ A little bit ◻ Moderately ◻ Quite a bit ◻ Extremely

9. How much has the problem interfered with your social activities?

◻ Not at all ◻ A little bit ◻ Moderately Quite a bit ◻ Extremely

10. Who else have you seen for your problem?

◻ Chiropractor ◻ Neurologist ◻ Primary Care Physician
◻ ER physician ◻ Orthopedist ◻ Other:_____
◻ Massage Therapist ◻ Physical Therapist ◻ No one

11. How long have you had this problem? _____

12. How do you think your problem began?_____

13. Do you consider this problem to be severe? ◻ Yes ◻ Yes, at times ◻ No

14. What aggravates your problem?_____

15. What concerns you the most about your problem; what does it prevent you from doing? _____

_____

16. What is your: Height_____ Weight _____ Occupation _____

17. How would you rate your overall Health? ◻ Excellent ◻ Very Good ◻ Good ◻ Fair ◻ Poor

18. What type of exercise do you do? ◻ Strenuous ◻ Moderate ◻ Light ◻ None

19. What activities do you do at work?

◻ Sit:	◻ Most of the day	◻ Half the day	◻ A little of the day
◻ Stand:	◻ Most of the day	◻ Half the day	◻ A little of the day
◻ Computer work:	◻ Most of the day	◻ Half the day	◻ A little of the day
◻ On the phone:	◻ Most of the day	◻ Half of the day	◻ A little of the day

20. What activities do you do outside of work? _____

_____

21. Have you ever been hospitalized? ◻ No ◻ Yes

If yes, why _____

22. Anything else pertinent to your visit today?_____

I certify that I have read, understood, and answered the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

_____ Date

Signature of Patient (or parent if minor)

Authorization

I authorize Dickerson Chiropractic, P.C. to release any information concerning my condition to any insurance company, attorney, or health practitioners. I authorize direct payment to Dickerson Chiropractic, P.C. for any sum that I owe now or in the future, from any insurance company that is obligated to reimburse me for charges incurred in your office, or my attorney out of the proceeds of my settlement. A photocopy of this form is acceptable for payment. I hereby assign and give to Dickerson Chiropractic, P.C. the right to take action against any insurance company that is obligated by contract to make payment to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents, and pay it within a 90 day period. I understand that in the event my account is past due, I will be charged and I will be responsible for an additional $20.00 fee.

_____ Date

Signature of Patient (or parent if minor)

_____ Date

Signature of Witness

Consent for Treatment & X-ray Policy

It is understood and agreed upon that the amount paid at Dickerson Chiropractic, P.C. for x-rays is for examination only. X-ray negatives will remain the property of this office, and could be seen at any time while the person is still a patient at this office. A copy of the x-rays may be provided for a fee. I hereby authorize Dr. John H. Dickerson III, and whomever he may designate as his assistant, to administer treatment to me or my dependents as he so deems necessary.

Could it be possible that you are pregnant? **YES** **NO**

_____ Date

Signature of Patient (or parent if minor)

_____ Date

Signature of Witness

DICKERSON CHIROPRACTIC, P.C.
TERMS OF ACCEPTANCE

In the course of chiropractic health care, it is essential for the physician and patient to work toward the same objective. As a patient, you should understand the goal and methods of chiropractic that will be used in order to avoid confusion or disappointment.

Health:
A state of optimal physical, mental and social well-being, not just the absence of illness/symptoms.

Vertebral Subluxation:
A misalignment of one or more of the 24 vertebra in the spinal column (causing alteration of nerve function and interference to the transmission of mental impulses), which can impair the body's ability to achieve maximum health potential.

Adjustment:
An adjustment is the specific application of forces to facilitate the body's collection of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

We do not offer advice regarding treatment prescribed by others. Our only objective/method is adjusting to correct vertebral subluxations, allowing the body to freely communicate with the brain, providing the opportunity for a higher level of health.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

DR. JOHN H. DICKERSON III
DICKERSON CHIROPRACTIC, P.C.

830 E. Fourth St., Suite 5
Royal Oak, MI 48067-2869
248.584.4222

Effective 04/14/2003, per federal HIPAA regulations, Dickerson Chiropractic, P.C. will no longer be able to leave any "Protected Health Informaiton" (PHI) on answering machines, i.e.: exam results, radiographic (x-ray) study results/findings, etc.

If you would like us to leave PHI on your answering machine you must authorize Dickerson Chiropractic, P.C. to do so by signing where indicated below.

Also, by signing this form, Dickerson Chiropractic, P.C. is exempt from damages that may be caused by PHI being heard by anyone other than the patient.

Date:_____ Signature:_____

Medical Records Authorization

I authorize the following individuals to be able to receive my medical information, including, but not limited to exam/radiographic results, appointment confirmation, financial status and copies of medical records:

Name: _____

Relationship to Patient: _____ Phone #: _____

Name: _____

Relationship to Patient: _____ Phone #: _____

I understand that this authorization will be valid until I provide Dickerson Chiropractic, P.C. with written confirmation that I no longer would like these individuals to receive my medical information.

Date: _____ Signature: _____
(patient)

DICKERSON CHIROPRACTIC, P.C.

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

*Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or 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 answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also 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 also permitted or required to use or disclose your health information without your consent or authorization involving the following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.
*If we provide health care services 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 judgement we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:
Dr. John H. Dickerson III

If you would like further information about our privacy policies and practices please contact:
Dr. John H. Dickerson III

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed please) _____ Signature _____ Date _____

If you are a minor, or if you are being represented by another party

Personal Representative Printed _____ Personal Representative Signature _____ Date _____

Description of the authority to act on behalf of the patient _____