PRACTICE MEMBER INFORMATION

Date:_____

Name: _____ **Contact Phone**: _____

Cell Other

Age: _____ **Date of Birth**: _____ **Status**: S M D W **E-mail** _____

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

Occupation: _____ Employer: _____ Spouses Name: _____

Children Name/Age: _____

Have you ever received chiropractic care? Y N How long ago? _____ Are you aware of your alignment? Y N

WHAT BRINGS YOU HERE

Describe the health problem you want addressed the most: _____

This is a (circle) New problem Old Problem **I feel it (circle)** Constantly/Daily Off and On

What happened recently to cause it? _____

What happened originally? (if an old problem) _____

What have you tried to correct it? Ice/Heat Stretching/Exercise Vitamins Medications Other: _____

Who have you seen? Chiropractor Medical Doctor Physical Therapist Acupuncture Other**: _____**

Since it started, is it Getting worse About the same Getting better **Severity:** 1 2 3 4 5 6 7 8 9 10

What makes it worse? _____ Better? _____

What does it keep you from doing (partially or fully) that you would like to start doing again? _____

_____

If it is not addressed properly, what do you feel will happen? _____

YOUR LIFESTYLE

Do you exercise? Y N What and How often? _____

Do you drink water? Y N How much do you drink? _____ Stress Level: 1 2 3 4 5 6 7 8 9 10

Typical Breakfast?_____ Lunch?_____ Dinner?_____

Do you take vitamins or supplements? Y N What? _____

_____

REVIEW OF TRAUMA AND STRESSORS

Throughout life, events occur which damage the expression of health causing alterations of alignment, performance, and neurological health. This case history will uncover layers of damage that has resulted in poor health.

Have you had any surgeries? **Y** **N** _____

Were you involved in any car accidents? **Y** **N** _____

Have you had prolonged use of medicine? **Y** **N** _____

Have you suffered any traumas or fractures? **Y** **N** _____

Do you drink coffee? How much? **Y** **N** _____

Do you smoke? Packs a day? **Y** **N** _____

Do you drink alcohol? How much/week? **Y** **N** _____

List any medications you are taking, what it is for, and dosage: _____

_____

HEALTH CONDITIONS

Abnormal alignment and function can result in stress to the body. This stress can have an adverse effect on your overall health. Different areas of poor mechanics and stress can effect various conditions.

Neck Area:
Poor alignment can affect surrounding areas associated with this part of the body. Have you experienced…?

Neck Pain	Allergies	TMJ Pain	Visual Problems	Sinusitis
Colds/Flu	Weak Grip	Thyroid Conditions	Cold Hands	Dizziness
Low Energy	Arm Pain	Headaches	Hearing Problems	Arm Numbness

Upper Middle back:
Poor alignment in the mid back can affect these areas on the body. Do you experience…?

Heart Palpitations	Heart murmurs	Heart attacks	High Cholesterol	Lung infections
Breathing Pain	Shortness of breath	Tired between meals	Mid Back Pain	Asthma/wheezing
Indigestion	Heartburn	Ulcers	Chest pain	Hypoglycemia
Reflux	Nausea			

Low Back:
Poor alignment in the low back are associated with conditions of this part of the body. Do you experience…?

Leg/Hip pain	Difficulty urinating	Sexual dysfunction	Leg cramps	Leg numbness
Foot coldness	Constipation	Diarrhea	Menstrual cramps	Bladder infections

TERMS OF ACCEPTANCE

When a patient seeks care and we accept a patient for such care, it is essential for both to be working toward 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 and disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care to be provided so that you may make the decision whether or not to undergo care after being advised of the known benefits and risks. **Chiropractic** is the science and art, which concerns itself with the relationship between structure and function as that relationship may affect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of infirmity. A **Vertebral Subluxation** (misalignment) is a disturbance to the nervous system caused by improper position or restriction of one or more of the 24 vertebrae in the spinal column. This alteration of nerve function and interference to the transmission of mental impulses results in a lessening of the body's innate ability to express its maximum health potential and inefficiency in proper responses to environmental stress. An **Adjustment** is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our method of correction is by specific adjustments to the body and spine, which can be performed by hand or by handheld instruments. This is done to lessen the nerve disturbance centrally in its relationship to the spine. The other method of correction is done to lessen nerve disturbance peripherally with its relationship to the muscle. This approach is done to improve **Muscle Activation**. I during the course of an examination or care we encounter non-CAM or unusual findings, e will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider. All health care procedures carry some natural reaction to a change, which is similar to lifting weights for the first time. Other risks include, but are not limited to, muscle or ligament injuries, nerve injuries, vascular injuries, and fractures. Severe risks occur to 1/1,000,000 to 1/15,000,000 depending on the source utilized. Any valuable testing that can be performed in your case will be utilized to evaluate you.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. The benefits and risks of care have been explained to me to ty satisfaction. I understand that if I do not follow the Doctor's recommendations that I will not receive the full benefit from care, and that if I terminate my care for any reason, my balance or credit will be brought current in a timely way. I understand that I am responsible for all fees for services rendered and that all fees are paid in advance as a savings or at the time of each visit for a full fee investment. I have read and fully understand the above statements and therefore accept care on this basis.

_____	_____	_____
Print Name	Signature	Date

Consent to evaluate and adjust a minor child

I _____, being a parent or legal guardian of _____
Have read and fully understand the above Informed Consent and hereby grant permission for my child to receive care.

NOTICE OF PRIVACY PRACTICES. THIS NOTICE DESCRIBES HOW HEALHT INFORMAITON ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMAITON IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, or legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 10/9/2016 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, which changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information, we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATON

We use and disclose health information about you for care, payment, and healthcare operations. For example: **Care**: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may adjust you in the presence of others and discuss with them your condition and possible solutions. **Payment:** We may use and disclose your health information to obtain payment for services we provide to you. **Healthcare Operations**: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. **Your Authorization**: In addition to our use of health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for many purposes. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. **To Your Family and Friends**: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare, but only if you agree that we may do so. **Persons Involved in Care**: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your car, of your location, you general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object o such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up chiropractic supplies, x-rays, or other similar forms of health information. **Marketing Health-Related Services**: We will not use your health information for marketing communications without your written authorization. **Required by Law**: We may use to disclose your health information when we are required to do so by law. **Abuse or Neglect**: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others. **National Security**: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to correctional institution or law enforcement officials having lawful custody or protected health information of inmate or patient under certain circumstances. **Appointment Reminders**: We may use your health information to provide you with appointment reminders (such as voicemail messages, texts, email, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information). You may obtain a form to request access by using the contact information listed at the end of the Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, there will be a charge per item**. Disclosure Accounting**: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before 10-9-2016. If you request this accounting more than once in a 12 months period, we may charge you a reasonable, cost based fee in response to these additional requests. **Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (you must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. **Amendment**: You have the right to request that we amend your health information (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances. **Electronic Notice**: If you receive this Notice by e-mail, you are entitled to receive this Notice in written form.

QUESTONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated our privacy rights, or you disagree with the decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Gary Arbuckle, D.C. Phone: 610-952-2172 Address: 3119 N. Sage Loop, Lehi, UT 84043

I hereby certify that I have received a copy of this Notice of Privacy Practices.

_____ _____

Signature Date

Informed Consent Document

PATIENT NAME: _____

To the Patient: Please read this entire document prior to signing. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment. The primary treatment used by doctors of chiropractic is spinal manipulative therapy I will use that procedure to adjust you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack' your knuckles. You may feel a sense of movement.

Analysis/Examination/Care. As a part of the analysis, examination, and care given, you are consenting to the following procedures:

____adjustments ____ palpation ____vital signs ____range of motion testing ____ orthopedic testing ____ basic neurological testing ____ hot/cold therapy ____ manual therapy ____ muscle strength testing ____ postural analysis testing

The material risks inherent in chiropractic adjustment. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: Fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications of care; however if you have a condition that would otherwise not come to the Doctor's attention, it is our responsibility to inform the Doctor.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and/or during examination and X-ray. Stroke and/or arterial dissection cause by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The more current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a casual relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options. Other options for your condition may include:

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

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT OF A MINOR

I hereby request and authorize Dr. Gary Arbuckle to perform diagnostic tests and render chiropractic adjustments and other therapies to my minor son/daughter: _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. Under the terms oand conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify the doctor.

Please check the appropriate block and sign

I have read [ ] have had read to me [ ] the above explanation of the chiropractic adjustment and related care. I have discussed it with Dr. Arbuckle and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the care recommended. Having been informed of the risks, I hereby give my consent to that care.

Patient's Name:_____ Doctor's Name:_____

Patient/Guardian Signature:_____ Signature:_____

Dated:_____ Dated:_____