PATHWAYS CHIROPRACTIC

120 Boardman Avenue Suite A., Traverse City, MI 49684

Name _____ Today's Date _____ Birthdate _____ Age _____

Street _____

City _____ State _____ Zip _____

Primary Phone _____ Gender ☐ M ☐ F

Significant Other's Name _____ Kid's Name & Ages _____

Your Employer _____ Type of Work _____

E-Mail _____ When was your last chiropractic visit _____

Emergency Contact _____ Phone number _____

Name of Medical Doctor(s) _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Dr. Larabee and his staff to request records from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.

_____ _____

Patient or Parent/Legal Guardian Signature Date

REASON FOR SEEKING CARE

CURRENT HEALTH COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse

☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to: _____

2. _____ How long has this been an issue? _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse

☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to: _____

3. _____ How long has this been an issue? _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse

☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to: _____

Does your health condition affect: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving ☐ Other (*describe below*)

_____

What makes it better? _____

What makes it worse? _____

What doctor(s) have you seen for this? _____

Type of treatment: _____

Results: _____ Are you pregnant? ☐ Yes ☐ No

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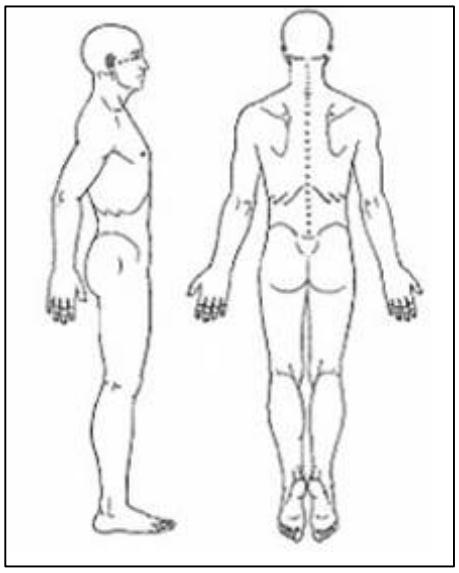
HEALTH COMPLAINTS CONT'D

Please mark ALL areas of concern



GENERAL HEALTH HISTORY

Mark the conditions that apply to you.

Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Urinary Problems
☐	☐	Migraines	☐	☐	Easy Bruising
☐	☐	Shortness of Breath	☐	☐	Tobacco Use
☐	☐	Allergies / Asthma	☐	☐	Dental Problems
☐	☐	Medication Side Effects	☐	☐	Fibromyalgia
☐	☐	Diabetes	☐	☐	Blood Thinner Use
☐	☐	Hands or Feet cold	☐	☐	HIV Positive
☐	☐	Muscle aches	☐	☐	Cancer
☐	☐	Trouble Walking	☐	☐	Depression
☐	☐	Leg / Foot Numbness	☐	☐	Alcohol Use
☐	☐	Fainting	☐	☐	High Blood Pressure
☐	☐	Gall Bladder Trouble	☐	☐	Stroke History
☐	☐	Ringing in Ears	☐	☐	High Cholesterol
☐	☐	Ear Problems	☐	☐	TMJ
☐	☐	Sleeping Problems	☐	☐	Digestive Problems
☐	☐	Vision Problems	☐	☐	Pain All Over
☐	☐	Thyroid Problems	☐	☐	Tension / Irritability
☐	☐	Liver Disease	☐	☐	Chest Pains
☐	☐	Kidney Problems	☐	☐	Heart Pacemaker
☐	☐	Light Bothers Eyes	☐	☐	Heart Problems
☐	☐	Other _____			

1. List any medications you are taking: _____

2. List all doctors you are currently seeing: _____

3. Has any doctor or other professional advised you to "Go to a Chiropractor"? ☐ Yes ☐ No
Name: _____

PAST HISTORY

4. List any past auto collisions: _____ Was any care received? ☐ Yes ☐ No

5. List any past work injuries: _____ Was any care received? ☐ Yes ☐ No

6. List any past sport, recreational, or home injuries: _____

Was any care received? ☐ Yes ☐ No

7. Describe any past conditions and treatment received: _____

8. List any past hospitalizations and/or surgeries: _____

FAMILY HISTORY

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication Use ☐ Arthritis ☐ Other: _____

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication Use ☐ Arthritis ☐ Other: _____

Is there any other family history you want us to know? _____

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HIPPA Compliance Form

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this information carefully, if you have any questions, please ask our Office Manager for clarification.

Uses & Disclosures

Disclosure of your protected health information without authorization is strictly limited to defined situations. We may use or disclose your protected health information without your written consent, written authorization or oral agreement for the following purposes; emergency care, quality assurance activities, public health, research, and any law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining consent. You may request restrictions on disclosure.

With the exception of the above circumstances, any use or disclosure of your health information will be made only with your written authorization. Your written authorization may be revoked, in writing, at anytime except to the extent that we have provided services or taken action in reliance on your authorization.

Your Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Your request to limit the use and/or disclosure of your health information must be made in writing to our Office Manager.

You have the right to inspect and receive copies of your records within 30 days of request. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You have the right to request changes to your records. Our practice has the right to accept or deny your request.

You have the right to receive a copy of this Notice, upon request.

Our Duties

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We maintain a history of protected health information disclosures that are accessible to you. In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

We must abide by the terms of the Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

Complaints

You may complain to us and to the Secretary of Health and Human Services if you believe you privacy rights have been violated. We will not take any action against you for filing a complaint.
You may file a complaint with us by writing our Office Manager at the address that follows:
Pathways Chiropractic, 120 Boardman Avenue Suite A., Traverse City, MI 49684

Print _____ Signature _____ Date _____

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Informed Consent to Chiropractic Care

Please discuss any questions or concerns with the doctor before signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me (or the said minor for whom I am legally responsible) by Dr. Brandon Larabee, his staff, and/or his associates.

The Nature Of The Chiropractic Adjustment

The chiropractor will use his/her hands or a mechanical device upon your body in such a way as to move your joints. Doing so may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

The Material Risks Inherent In The Chiropractic Adjustment

Although extremely rare, there are potential complications that may arise during a chiropractic adjustment. Such complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strains, and stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The Risks And Dangers Attendant To Remaining Untreated

Remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective as care is continually postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had all my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. I acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given.

Date: _____

_____
Printed Name of Patient or Parent/Legal Guardian

_____
Signature of Patient or Parent/Legal Guardian

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Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective.

Care in this office is limited to a single goal. It is important that each patient understands the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

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

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes disturbance to the nervous system and discoordination between the body systems. This results in a less than optimal expression of health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal 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.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate disturbance to the body's natural coordinated function. Our only method is through specific adjusting to correct vertebral subluxation.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

_____ _____

Signature Date