NORTH HILLS CHIROPRACTIC

PATIENT INFORMATION

Please complete the following forms to the best of your knowledge. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help you.

Patient's Full Name:_____ Today's Date:_____

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

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

Birth Date: _____ Gender: _____Male _____ Female

Are You: _____ Minor _____ Single _____ Married _____Separated _____ Divorced _____ Widowed

Email Address: _____ (Health tips, Updates, Schedule Changes)

May we contact you for appointment reminders via e-mail or text message? ☐ YES ☐ NO

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Whom may we thank for referring you to us?:_____

PATIENT HEALTH QUESTIONNAIRE

Describe your symptom(s): _____

_____

a. When did your symptom(s) start? _____

b. How did your symptom(s) begin? _____

How often do you experience your symptoms?

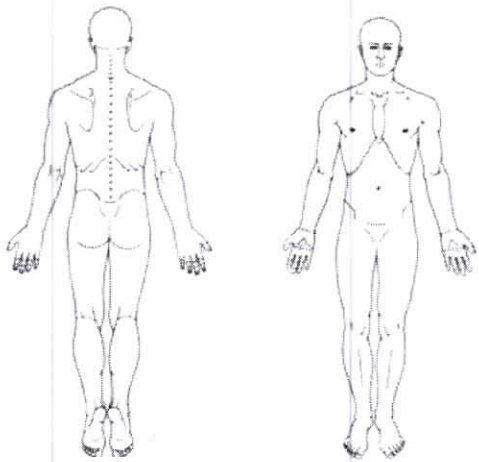
☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Which word best describes your symptoms?

☐ Sharp ☐ Radiating
☐ Numb ☐ Sore
☐ Shooting ☐ Stabbing
☐ Burning ☐ Stiff
☐ Dull ☐ Stinging
☐ Pinching ☐ Throbbing
☐ Pounding ☐ Tight
☐ Tingling ☐ Aching

Indicate where you have pain or other symptoms?



Aggravated by:

_____

_____

Relieved by:

_____

_____

Average pain intensity:

Last 24 hours: **no pain** ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **unbearable pain**

Past 4 weeks: **no pain** ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **unbearable pain**

DOCTOR USE ONLY

NORTH HILLS CHIROPRACTIC

During the *past 4 weeks* how much of the time has your condition interfered with your usual daily activities? (Including both work outside the home and housework, etc.)
☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little bit ☐ None

Who have you seen for your current symptoms?
☐ No One ☐ Chiropractor ☐ Medical Doctor
☐ Physical Therapist ☐ Other_____

What treatment did you receive and when:_____

What tests have you had for your symptoms and when:

_____

Have you had similar symptoms/episodes in the past? ☐ Yes ☐ No
If yes, who did you see for care? _____

What is your normal activity/exercise level? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

For each condition below, check if you have had it in the past and/or present:

Past / Present	Past / Present	Past / Present
☐ ☐ Headache	☐ ☐ Dizziness	☐ ☐ Diabetes
☐ ☐ Neck Pain	☐ ☐ Heart Attack	☐ ☐ Excessive Thirst
☐ ☐ Upper Back Pain	☐ ☐ Chest Pain	☐ ☐ Tobacco Use
☐ ☐ Mid Back Pain	☐ ☐ Stroke	☐ ☐ Allergies
☐ ☐ Low Back Pain	☐ ☐ Kidney Stones	☐ ☐ Drug Dependence
☐ ☐ Shoulder Pain	☐ ☐ Kidney Disorder	☐ ☐ Alcohol Dependence
☐ ☐ Elbow / Arm Pain	☐ ☐ Bladder Infection	
☐ ☐ Wrist Pain	☐ ☐ Painful Urination	☐ ☐ Allergies
☐ ☐ Hand Pain	☐ ☐ Abdominal Pain	☐ ☐ Depression
☐ ☐ Hip/Upper Leg Pain	☐ ☐ Ulcer	☐ ☐Epilepsy
☐ ☐ Knee / Lower Leg	☐ ☐ Hepatitis	☐ ☐ HIV/AIDS
☐ ☐ Ankle / Foot Pain	☐ ☐ General Fatigue	**Other Health Problems**
☐ ☐ Jaw Pain	☐ ☐ Cancer	☐ ☐_____
☐ ☐ Joint Pain	☐ ☐ Tumor	☐ ☐_____
☐ ☐ Frequent Urination	☐ ☐ Asthma	
☐ ☐ Rheumatoid Arthritis	☐ ☐ Chronic Sinusitis	**Females Only**
☐ ☐ Liver/Bladder Disorder	☐ ☐ Osteoporosis	☐ ☐ Birth Control
☐ ☐ Muscle Un-coordination	☐ ☐Dermatitis/Eczema	☐ ☐ Hormone Replacement
☐ ☐ Visual Disturbance	☐ ☐ Arthritis	
☐ ☐ High Blood Pressure	☐ ☐ Systemic Lupus	☐ ☐Pregnancy

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐Stroke
Family Member: Father Mother Siblings Grand Parents

List all prescriptions, over-the-counter medications, and nutritional/herbal supplements you are taking: _____

_____

_____

List all surgical procedures you have had and times you have been hospitalized:

_____

_____

Patient / Guardian Signature: _____ **Date**_____.

DOCTOR USE ONLY

_____

_____

_____

_____

_____

_____

_____

Review of Systems

Cardiovascular:

_____

Gastrointestinal:

_____

Neurological:

_____

Other:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

NORTH HILLS CHIROPRACTIC, INC.

208 Lemmon Drive
Reno, Nevada 89506
Phone: (775) 972-4488
Fax: (775) 972-1853

Financial Agreement

North Hills Chiropractic and the Doctors participate in many insurance plans, but not all of them. It is your responsibility to know whether the doctor you are seeing is a participant on your plan. Charges for services rendered by North Hills Chiropractic will be submitted directly to your insurance company for payment, as a courtesy to you. All copays and deductibles are due at the time of service. We will try our best to notify you of your financial obligations at the time of your visit, but it is ultimately your responsibility to know and pay your financial obligations. **Copays and/or deductibles collected upfront are an estimated amount. You will be responsible for any amount not paid by your insurance.**

Should you not have insurance coverage, you will be considered a self-pay patient. We offer discounted rates and you will be responsible for paying the total charges at the time of your visit.

*** Patients should note that not all Chiropractic procedures, exams and/or modalities are covered by insurance. Patients may be directly responsible for such fees. We will do our best to inform you of your benefits at the time of your visit.

*** It is your responsibility to notify our office if prior authorization/referrals are required.

*** **Please be aware that our office has a 24-hour cancellation policy.** You will be charged a fee of $20 for every appointment that is broken without giving 24 hour notice. 24 hour notice can be given when we are closed, such as on the weekends, by simply leaving a message on our voicemail 24 hours prior to your appointment time.

Authorization

I authorize North Hills Chiropractic, Dr. David D. Berg, DC., to release any information acquired during my exam and treatment for the purpose of claim payment. I further authorize payment directly to the doctor for benefits due to me for this service. I recognize and accept personal responsibility for any balance remaining after payment of such benefits.

Patient Name _____ Social Security # _____

Signature _____ Date _____

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Privacy Policy

Our office is fully committed to compliance with HIPAA guidelines by:

1. Providing appropriate security for our patients records
2. Protecting the privacy of our patients' medical information
3. Providing our patients with proper access to their medical records, one a signed release is obtained.
4. Appropriately maintaining our patients information and billing process in compliance with National HIPAA standards
5. NOT providing patients' data to marketers or pharmaceutical companies for the purpose of research

I acknowledge that I have read and understand the privacy policy of North Hills Chiropractic, Inc.

_____ _____

Patient/Legal Guardian Signature Date

_____ Please be advised that pursuant to Federal Law, your medical records will be kept for 5
Initials years, after which, they may be destroyed.

Yes____ No____ Can messages be left on your answering machine, voicemail, or with family members?

Please list the alternate phone number that you which to receive calls about appointments, billing issues, or any other information, if you do not wish to be contacted at home.
*Preferred Alternate Phone Number:*_____

*** If left blank, we will assume it is okay to call your home phone number and also leave messages for you ***

NORTH HILLS CHIROPRACTIC

Informed Consent for Diagnostic and Treatment Procedures

I have received my examination and the doctor explained to me what he/she found. Based on this, I give my permission to have diagnostic tests, procedures, and a treatment plan for my condition(s). I understand that the treatment I receive at this clinic is from a licensed Doctor of Chiropractic. Chiropractic scope of practice includes a wide range of services, but if the clinician determines the services I need cannot be provided by this office, then he/she will direct me to the appropriate health care provider.

Within the service provided by this office, treatment almost always includes either physical therapy procedures including exercise, manual therapy, and functional activities or the chiropractic adjustment, a specific type of joint manipulation. Spinal manipulation and physical therapy modality procedures are done to ease pain and/or help the body function better. Like most health care procedures, the spinal manipulation and physical therapy procedures carry with it some risks. Unlike many such procedures, the serious risks associated with the spinal manipulation and physical therapy procedures are extremely rare. **The following are the potential 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 doctor 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 doctor if you have been diagnosed with a bone weakening disease or condition. If your doctor 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 doctor if symptoms change or worsen.
- **Stroke** According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. Regarding neck pain and headache symptoms, there is an association between stroke and visits to all provider-types, including primary care medical visits, which may occur before or during the provider visit.
- **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.
- **Alternatives** to manipulation discussed through a shared decision-making process include: Medicines, Physical Therapy, Massage, Mobilization, Acupuncture, and/or Cognitive-behavioral therapy. You can do these whether or not you are doing spinal manipulation.
- **Refusing diagnostic and/or treatment procedures** may carry a risk to future capabilities in regard to performing activities of daily living or progression towards chronic pain.

_____ I am not pregnant to my knowledge (date of last menstrual cycle: _____). I have been advised that it may not be advisable to be exposed to x-rays if I believe that there is a possibility that I am pregnant.

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. The material risks have been disclosed to me, including a description of those material risks; and after consideration, I agree to the procedures understanding any material risks which are inherent to that procedure.

• PATIENT PLEASE REVIEW • PRINT & SIGN NAME •

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 and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

PATIENT'S NAME (Print)_____ **DATE OF BIRTH:** _____

PATIENT GUARDIAN/REPRESENTATIVE (PRINT) _____

_____ _____ _____ _____

(PATIENT GUARDIAN/REPRESENTATIVE SIGNATURE) **(DATE)** **(TRANSLATOR | INTERPRETER SIGNATURE)** **(DATE)**

CLINICIAN ONLY

Based on my personal observation, the patient's history and physical exam, I conclude that throughout the informed consent process the patient was:

□ OF LEGAL AGE □ APPEARS UNIMPAIRED □ CONSENT GIVEN THROUGH GUARDIAN/PATIENT REPRESENTATIVE

□ ORIENTED X3 □ FLUENT IN ENGLISH □ ASSISTED BY A TRANSLATOR OR INTERPRETER

_____, **D.C.** _____

(CLINICIAN SIGNATURE) **(DATE)**

STUDENT INTERN/EXTERN INITIALS AS WITNESS TO PATIENT DISCUSSION WITH CLINICIAN: _____

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New Patient Instructions

1. **Ice Pack** — *Ice is essential in the healing process.* Ice numbs the nerves which reduces pain, relaxes muscles and reduces inflammation and swelling. **When in doubt, use ice, not heat, for pain, unless prescribed by doctor.** Place a paper towel or t-shirt thin cloth between skin and ice. Never apply ice on bare skin. Apply to involved areas for 20 minutes. Max 20 minutes per hour for thicker body parts, less for thinner areas. If stretching is recommended, stretch before icing.

2. **Muscle Cream** — *Biofreeze is not a substitute for ice.* If you were given Biofreeze, apply a small amount 15 minutes *after* icing to the affected area. *Do not use Biofreeze if pregnant or nursing.*

3. **Soreness** — Some people experience stiffness or soreness following chiropractic manipulation. This is normal. Use the above guidelines of icing and muscle cream to decrease pain, inflammation and muscle spasms. *If your symptoms become worse or new symptoms occur, please notify the doctor as soon as possible.*

4. **Follow Up** — Follow up appointments are recommended by your doctor *only* if there is a strong benefit to further treatment. Please allow approximately 30 minutes for a follow up appointment. Our goal at North Hills Chiropractic is for you to get better as quickly as possible, while achieving long term benefits.

5. **Reschedule** — In the event you are unable to make your appointment, please contact us within 24 hours to prevent the $20 no show fee.

6. **Time to Heal** — Injuries require time to heal. Just because there is no immediate change in symptoms (pain) does not mean that there isn't any improvement. Soft tissue injuries require *at least* 3 weeks to heal. Injured tissues can be easily injured again, either directly or indirectly. Treatment, rest and time are best for full recovery. Factors that affect healing time are the severity of the injury, how long the problem has existed, and how quickly one's body heals.