

A R C A D E
C H I R O P R A C T I C

Dr. Andy Ingram
401 Euclid Ave. STE 140
Cleveland, OH 44114
(216) 522-0300
www.arcdechiro.com

CHIROPRACTIC NEW PATIENT INFORMATION

Patient Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Birthdate _____ Age _____ Sex Female Male

Phone Number(s) _____

Email _____

Occupation _____

Employer's Name _____

Marital Status: Single Married Minor Widowed

Divorced Separated Partnered for ____ years

Spouse/Partner's Name _____

Emergency Contact

Emergency Contact's Name _____

Relationship to Patient _____

Phone Number _____

Accident Information

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

Type of accident: Auto Work Home Other _____

To whom have you made a report of your accident?

Auto Insurance Employer Workers Comp Other _____

Attorney's Name _____

How did you hear about us?

Google Social Media Reference _____ Other _____

Patient Condition

Reason for visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? yes no unknown

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

Type(s) of pain: sharp dull throbbing numbness aching swelling
 shooting burning tingling cramps stiffness other _____

How often do you have this pain? _____ Is it: constant intermittent

Does it interfere with your: work sleep daily routine recreation

Which activities are painful to perform?

sitting standing walking bending lying down other _____

What treatment(s) have you already received for your condition? medication surgery

physical therapy chiropractic services none other _____

Name and phone of previous doctor(s) _____

Health History

Medications	Supplements	Known Allergies

Date of last:

Physical Exam _____ Spinal Exam _____

Chest X-ray _____ Spinal X-ray _____

Dental X-ray _____ Blood Test _____

Urine Test _____ MRI _____

CT Scan _____ Bone Scan _____

Are you pregnant? yes (Due Date _____) no breastfeeding

Health History

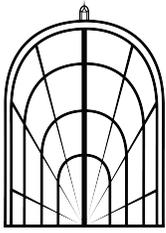
Place a check to indicate if you have had any of the following:

<input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Alcoholism <input type="checkbox"/> Allergy Shots <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fractures <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herniated Disk <input type="checkbox"/> Herpes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pacemaker <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Pinched Nerve <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Prostate Problem <input type="checkbox"/> Prosthesis <input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Sexually Transmitted Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Tumors/Growths <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Whooping Cough <input type="checkbox"/> Other(s) _____ _____
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Injuries/Surgeries	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
	_____	_____
	_____	_____

Habits

Exercise:	<input type="checkbox"/> None	<input type="checkbox"/> Moderate	<input type="checkbox"/> Daily	<input type="checkbox"/> Heavy		
Work Activity:	<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Heavy Labor		
Smoking:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Tobacco	<input type="checkbox"/> Vaping	<input type="checkbox"/> Marijuana	Amount per day _____
Alcohol:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Number of alcoholic drinks per week _____			
Coffee/Caffeine Drinks:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Number of caffeinated drinks per week _____			
High Stress Level:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Reason _____			



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CONSENT TO TREATMENT

AUTHORIZATION FOR TREATMENT AT ARCADE CHIROPRACTIC

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. This is the preferred method of treatment at Arcade Chiropractic. Our practitioners may use their 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” similar to what you may have experienced when cracking your own knuckles. You may also feel a sense of movement.

ANALYSIS, EXAMINATION, TREATMENT

As part of the analysis, examination, and treatment performed at Arcade Chiropractic, you are consenting to one or more of the following procedures: spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, hot/cold therapy, and intersegmental traction.

RISKS

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, 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 to care; however, if you have a condition that would otherwise not come to the doctor’s attention, it is your responsibility to inform the doctor.

PROBABILITY OF RISKS

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 during examination. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to the specific incident of this complication occurring. If there is a causal 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.

ALTERNATIVE TREATMENT OPTIONS

Other treatment options for your condition may include, self-administered over-the-counter analgesics, rest, medical care, prescription drugs, hospitalization, or surgery. If you chose to use one or more of these alternatives, you should be aware that there are risks and benefits to each that should be discussed with your primary care physician.

RISK AND DANGER TO REMAINING UNTREATED

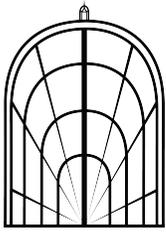
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read the above explanation of chiropractic adjustments and related treatments. I hereby give my consent to treatment at Arcade Chiropractic.

Signature: _____

Printed Name: _____

Date: _____ Relationship if not patient: _____



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HIPAA RELEASE

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996 and required by April 14, 2003, Arcade Chiropractic may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the use of and/or disclosure of protected health information described below.

I hereby consent to this practice to use and disclose my protected health information for the purpose of treatment, payment, and operations of my healthcare and this practice. This consent includes contact of and discussion with other healthcare professionals for my care and treatment.

I hereby authorize the use and/or disclosure(s) of the following protected health information that pertains to me: my medical records and diagnoses, including but not limited to all lab/x-ray reports, progress reports, and other information.

I understand that I have the right to:

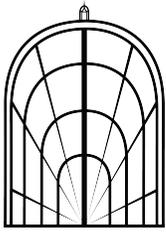
- Refuse to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.
- To inspect and obtain a copy of any protected health information disclosed relating to this authorization.
- Receive a signed copy of this authorization.

Signature: _____

Printed Name: _____

Relationship if not patient: _____

Date: _____



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CONSENT TO TREATMENT OF A MINOR

I hereby request and authorize Dr. Andy Ingram to perform diagnostic tests and render chiropractic adjustments, NAET treatments, and/or other treatment to my child _____.

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.

IF APPLICABLE: Under the terms and 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 this office.

Signature: _____

Printed Name: _____

Relationship to Patient: _____

Date: _____