Welcome to Arizona Chiropractic Neurology Center
Patient and Contact Information History and Review of Systems

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Please fill out the following form in as much detail as possible. All your health information is kept confidential.

Name_____

Today's Date _____ Age _____ Address_____

City _____ State _____ ZIP _____

Gender: Male Female Height _____ Weight _____ DOB _____

Home Phone (_____) _____ Cell (_____) _____ Work (_____) _____

Email_____

Occupation_____

Emergency Contact name _____ Emergency Number (_____) _____

List of current/previous doctors:

Primary Care Physician _____

Other (please specify)_____

How did you hear about our office? _____

Medication List: *Please list the name of each current prescribed and over the counter medications, prescribed use and any side effects/reactions*

Medication	Purpose of Taking Medication	Any Side-Effects

NEUROLOGICAL & METABOLIC CASE HISTORY

What is the main problem/symptom that you are having? (Be as specific as possible)

_____

_____

List other symptoms you are currently experiencing even if not related to complaint listed above:

_____

_____

Describe what you are feeling (diffuse, dull, achey, sharp, burning, cramping)?

_____

_____

When did this begin?_____

How did this begin?_____

Have you had this or similar conditions in the past? Yes No If yes, when?_____

What makes your condition worse?_____

_____

What makes your condition better? _____

Do you experience Numbness or Tingling? Yes No If yes, where? _____

Does it radiate down the arm(s), leg(s), back or other? _____

SYMPTOM INTENSITY: Please circle the number describing the intensity of symptoms.

None/0 1 2 3 4 5 6 7 8 9 10/Unbearable

When you are awake, how often are you feeling these symptoms? (0-100%) _____

Does this affect you at night? Yes No

When do you experience this throughout the day (AM/PM/All Day)? _____

How many days per week do you experience your main complaint? _____

Is this progressively getting worse? Yes No

Is your condition: Constant Comes & goes

Have you had any treatment for this problem in the past? Yes No If yes, when/by whom? _____

How did the previous method(s) work for you? _____

Are there any conditions that run in your family? Yes No If yes, what condition(s) and what family member?

_____

_____

When was your last: Physical _____ Blood/lab work _____ X-ray _____ MRI _____

Have you been treated for your current condition before? Yes No If yes, when/by whom? _____

_____

Surgical History: Please list the type and reason of surgery, and year performed (e.g. left breast for cancer in 2004)

_____

_____

REVIEW OF SYSTEMS

Changes in or loss of smell? Normal, Loss, increased or decreased? _____ Yes No

Monovision correction? _____ Yes No

Visual changes or loss of vision? _____ Yes No

Difficulty with visual focus or acuity? _____ Yes No

Double vision? If yes, in which direction? _____ Yes No

Dry eyes, dry mouth or excessive tearing or saliva? _____ Yes No

Weakness or numbness of the face? _____ Yes No

Difficulty hearing or ringing in your ears? _____ Yes No

Maintaining balance with or without head movements? _____ Yes No

Light headedness/dizziness when rising from a lying or seated position? _____ Yes No

Sensations of spinning? If yes, which direction? _____ Yes No

Difficulty swallowing foods? _____ Yes No

Poor digestion, constipation, diarrhea, or abnormal bowel movements? (circle) _____ Yes No

Bladder control issues? _____ Yes No

Changes in sexual function or ability? _____ Yes No

Increasing food sensitivities? Gluten / Dairy Other: _____ Yes No

Excessive Bloating? _____ Yes No

Difficulty shrugging or raising your shoulders or arms? _____ Yes No

Slurring your words or your tongue feeling thick? _____ Yes No

Sweaty hands or feet? _____ Yes No

Cold hands or feet? _____ Yes No

Noticeable sweating difference on the right or the left? _____ Yes No

Please Circle any of the following conditions or complaints that you have or are experiencing

AD/HD	Adrenal Disorder	Anxiety	Arthritis	Asthma
Atypical Facial Pain	Arm or Leg Pain	Autoimmune Condition	Balance Problems	Bleeding Disorder
Blood Sugar Issues	Blurred Vision	Buzzing in Ear (s)	Carpal Tunnel	Cancer _____
Celiac Disease	Chest Pains	Chronic Fatigue	Colitis/Diverticulitis	Compression Fractures
Concussion	Connective Tissue	COPD	Depression	Diabetes (Type 1 or 2
Digestive Issues	Dizziness (sitting up/standing up)	Double Vision	Dyslexia	Ear Infections
Fibromyalgia	Food Sensitivity	Fusions (spinal)	Gout	Gall Bladder Issue
Headache	Heart Disease	Hepatitis A, B, C	Herpes	High Blood Pressure
Hip Replacement	HIV/AIDS	Immune Deficiency	Insomnia	Joint Pain
Kidney Disease	Liver Disease	Low Back Pain	Migraine	Multiple Sclerosis
Neck Pain	Osteoporosis/Penia	Regional Pain Syndrome (CRPS)	Rotator Cuff Issues	Shoulder Pain
Stroke/TIA	STI/STD	Tremors	Trigeminal Neuralgia	TMJ
Thyroid Issues	Tuberculosis	Tingling, Burning, Numbness in Hands or Feet		Vertigo

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Informed Consent Document

To the patient: Please read this entire document prior to signing it. 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 we use as a Doctor of Chiropractic is spinal manipulative therapy (SMT, CMT). We will use this procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as you 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/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

--Spinal manipulative therapy --Palpation --Vital Signs
--Range of motion testing --Orthopedic testing --Neurological testing
--Postural analysis --EMS/TENS/Galvanic --Imaging and Lab studies as indicated
--hot/cold therapy --Stretching --massage therapy --exercise rehabilitation
--Microcurrent --low level laser therapy --SSEP --Functional medicine/supplements --Other_____

The material risks inherent in chiropractic care

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and physiotherapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strains, ligament sprains, cervical myelopathy, 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 complications including stroke (CVA). Some patients will feel some stiffness and soreness following the first few days of treatment. I 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 my attention, it is your responsibility to inform me. Cauda Equina Syndrome has been reported in rare cases which requires immediate medical care.

The probability of those risks occurring

Statistically, Chiropractic Care has been demonstrated to be one of the safest of all healthcare practices. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the raking of your history and examination. CVA has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur one in five million cervical adjustments. Two major studies (2008, 2015) showed there was not causation between CMT and CVA but rather the patient was already presenting with arterial dissection. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

-Self-administered, over-the-counter (OTC) analgesics, ice, head or rest.
-Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and pain killers.
-Hospitalization/Surgery

If you choose to use on of the above noted "other treatment" options, you should be aware that there are severe risks associated with these treatments. Many patients taking OTC NSAID's such as Ibuprofen and Acetaminophen are not aware that every year there are thousands of deaths associated with their use. No medicine should ever be taken without discussing their side effects and inherent statistical danger with their primary care physician or pharmacist. The PDR is also a good reference regarding pharmaceutical use.

The risks and dangers attendant to remaining untreated

Remaining untreated may create adhesions or scar tissue that can weaken the area and reduce mobility. Further joint degeneration may occur as well as the development of chronic pain syndromes. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. 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 treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

DATED:_____PATIENTS NAME:_____SIGNATURE_____

SIGNATURE OF PARENT OR GUARDIAN (if minor)_____

DATED:_____DOCTOR'S NAME:_____SIGNATURE_____

PATIENT FINANCIAL RESPONSIBILITY PATIENT RECORD OF DISCLOSURES/HIPAA ACKNOWLEDGEMENT

Thank you for choosing Arizona Chiropractic Neurology Center. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our Patient Financial Responsibility Policies and HIPPA Acknowledgement.

INSURANCE: The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you; however, it is the patient's responsibility to know the details of their insurance in addition to any lapses in insurance coverage. If you do not inform us of special requirements required by your plan, and we provide medically necessary services that are not covered by your plan, we may bill you directly for those charges.

COPAYS, DEDUCTIBLES & CO-INSURANCE: All patients are responsible for their copayments, deductibles, and past due balances at the time of service.

CANCELLATION/NO SHOW OF APPOINTMENTS: When an appointment is not kept, it creates an unused appointment slot that could have been used for another patient. It is very important that you call to cancel your appointment. If for any reason you need to cancel or reschedule an appointment, please notify our office within 24 hours to avoid a fee of $30.00.

RETURNED CHECKS: There will be a $25 service fee for any check returned for insufficient funds.

PLEASE NOTE THAT ANY BENEFIT INFORMATION FURNISHED IS NOT A GUARANTEE OF PAYMENT NOR A DETERMINATION OF MEDICAL NECESSITY AND FINAL CLAIM DETERMINATION WILL BE MADE UPON RECEIPT AND REVIEW OF THE CLAIM. THE PATIENT IS RESPONSIBLE FOR ALL BALANCES OUTSTANDING.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Phone: _____

☐ Cell Phone:_____

I authorize Dr. Berry, Dr. Teames and Dr. Santo to discuss my protected health information with the following family members or healthcare providers that are caring for me. I authorize the release of my medical health records from/to other healthcare providers that are caring for me.

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone: _____ Phone: _____

I understand that I may revoke this authorization at any time, which will then apply to any future disclosures of my protected health information. I have been given the opportunity to review the Notice of Privacy Practices available in the office.

Signature of Patient/Guardian: _____ Date: _____