DOCTOR-PATIENT RELATIONSHIP
AND
INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy, and Medicine, and for the patient to understand what to expect from chiropractic care. It is the chiropractic premise that proper spinal alignment allows normal nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. In this way, chiropractic health care seeks to restore health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of chiropractic procedures often depends on environment, underlying causes, and the physical and spinal conditions of each individual patient. It is important that the patient understands what to expect from your chiropractic care. Due to the complexities of nature, and the many variables (both known and unknown) that can affect a patient's response, no doctor can promise specific results. The Doctor of Chiropractic provides a specialized, unique, non-duplicating health service. The Doctor of Chiropractic is licensed in a special area of practice and is available to work with other types of providers in your health care regime.

ANALYSIS

Your doctor will conduct a clinical analysis for the express purpose of determining whether there is evidence that your situation may be the result of a vertebral subluxation and that you might respond satisfactorily to chiropractic care. If such is found, chiropractic care will be recommended in an attempt to restore spinal integrity.

RESULTS

The purpose of chiropractic care, is to promote natural health through the reduction of the vertebral subluxation. Since there are so many variables, it is difficult to predict the time schedule or the efficacy of the chiropractic adjustment on any given patient. Sometimes the response is phenomenal, however, in most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same type of care and actual response is not predictable. Many medical failures have found significant benefit through chiropractic care. In turn, many conditions which do not respond to chiropractic care may come under the control or be helped through medical treatment. Chiropractic and medicine may never be so exact as to provide definite answers to all problems, however, both have made great strides in patient care.

DIAGNOSIS

Although Doctors of Chiropractic are experts in the analysis of the structural alignment of the human spine, and its effects on the nerve system, they are not internal medical specialists. Every patient should be mindful of his/her own symptoms and should secure other opinions should he/she have any concerns as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

By signing below, the patient gives the doctor permission and authority to care for him/her in accordance with recognized and acceptable chiropractic analytical and corrective procedures. The chiropractic adjustment is usually beneficial and seldom causes any adverse reactions. In rare cases, undetected physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give an adjustment if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through other health care procedures whether he/she is suffering from: pathological conditions (latent of otherwise), illnesses, injuries, or deformities which would otherwise not come to the attention of the doctor.

TO THE PATIENT

Please discuss any questions or problems with the doctor **before** signing this statement of understanding and consent for care.

I have read and understand the foregoing. I give hereby give my consent for the doctor to render chiropractic care to me.

______________________________ ______________

Patient's Signature Date

PATIENT FINANCIAL OPTIONS

Our office provides two options for the handling of patient accounts. Please review the following choices and check the type of arrangement that best depicts the way that you would like us to handle your account. *Thank-you!*

☐ NON-INSURED / CASH OPTION

The following policy applies to those who do not have health insurance benefits or to those who prefer to pay for their services and handle their own insurance processing.

1. Our office will not bill patients for their care. Payment is expected at time of service.

2. We will accept cash, check, MasterCard, and VISA as payment for services rendered.

2. We will not deny care to anyone based upon their ability to pay for our services.

3. If necessary, we will work to make specific arrangements with patients experiencing substantiated financial difficulties.

5. We will provide forms, information and the guidance necessary to enable patients to process their own insurance claims if they so desire.

☐ APPROVED INSURANCE OPTION

The following will apply to those patient with approved health insurance coverage. (We do not accept assignment on personal injury cases.)

1. Our office will accept assignment on the estimated amount of insurance benefits available for care in our office.

2. Our office ***will estimate*** the total cost of care, and pro-rate ***the patient's portion*** into weekly payments.

3. Only patients undergoing active care will be eligible to assign their insurance benefits to this office.

4. If the patient discontinues care prior to doctor's release, all outstanding balances will immediately become due and payable.

Patient Signature:________________________________

Welcome to Natural Health Family Chiropractic. We are honored that you have chosen us to be a part of your health and wellness team. In order to initiate the process of becoming well, we must start by pinpointing the cause of what is keeping you from living to your maximum potential. A short but detailed history is contained on the following pages that will give us a picture of the accumulation of physical, chemical, and emotional stress from childhood until today. All of the following is confidential and we ask that you answer the following questions completely and leave no questions unanswered. Thank you and we look forward to serving you.

Your Personal Information

Name: _________________________________ Date of Birth: ______________ Age: _____ Sex: ❑ M ❑ F
Address: _______________________________ City: ________________ State: _________ Zip: ________________
Home Phone: ________________________ Cell Phone: _________________________ SS#: _________________________
E-Mail Address: ____
Employer: ______________________ Work Phone: _________________________
What is the best method to contact you? ❑ Home phone ❑ Cell phone ❑ Work Phone ❑ Email
Marital Status: ❑ M ❑ S ❑ W ❑ D Spouse's Name: ____
In Case of Emergency Notify: _______________________________________ Phone: _________________________
Who is your family physician? ____
By whom were you referred to this office? ____

Your Current Health Complaint

Please describe the specific complaints that bring you to the office today: ____
____
____
When did this start? ____
What do you believe may have caused it? ____
What other doctors have you seen for this condition? ____
Are you interested in Chiropractic Wellness Care? ❑ Yes ❑ No

Your Past Health Complaints

Early Years (Birth to age 17)

Did you have any severe or abnormal childhood illnesses? ❑ Yes ❑ No
*If yes, please describe: ____
Did you have any serious traumas as a child (serious falls, car accidents, emotional trauma, birth trauma, etc.)? ❑ Yes ❑ No
*If yes, please describe: ____
As a child, did you require frequent medication, antibiotics, or use of an inhaler? ❑ Yes ❑ No
Were you vaccinated as a child? ❑ Yes ❑ No
As a child, were you under regular chiropractic care? ❑ Yes ❑ No

Adult Years (Age 18 to present)

Have you ever or are you presently experiencing any serious health conditions? (Please check other and list if not listed)

❑ Allergies ❑ Arthritis ❑ Asthma ❑ Blood disorders ❑ Cancer ❑ Dementia ❑ Depression ❑ Diabetes
❑ Epilepsy ❑ Gall bladder disease ❑ Heart disease ❑ High blood pressure ❑ Major infection ❑ Kidney disease
❑ Liver disease ❑ Multiple sclerosis ❑ Stroke ❑ Thyroid disease ❑ Other ________________________________

Have you had any **major injuries** as an adult? (Sport injury, work injury, car accident, broken bone, head injury, falls, etc.)

❑ Yes ❑ No If yes, please describe these injuries: ____
____

Have you had any **surgeries** as a child or as an adult?

❑ Yes ❑ No If yes, please list surgical procedures: ____
____

Health Solutions for Life Through Chiropractic

Do you have any **allergies or sensitivities** that you are aware of? (Please check other and list if not listed)

❑ None ❑ Animals ❑ Corn ❑ Dairy ❑ Dust ❑ Eggs ❑ Fish ❑ Gluten ❑ Insect stings ❑ Latex
❑ Food additives ❑ Legumes ❑ Mold ❑ Nuts ❑ Penicillin ❑ Pollen ❑ Seafood ❑ Seasonal allergies
❑ Sesame ❑ Soy ❑ Sulfa drugs ❑ Wheat ❑ Other ____

Have you **recently or are you presently** taking any **prescription/over the counter medication OR nutritional supplements**?
*We can photocopy an existing list or you may attach a sheet of paper if you are taking many medications or supplements.

❑ Yes ❑ No If yes, please list them and reason for taking them: ____________________________________
____

Review of Systems:

Do you presently or have you in the last three (3) months experienced any of the following? Please check all that apply.

❑ Chills ❑ Hot flashes ❑ Fatigue ❑ Changes in hair, skin, or nail growth/texture
❑ Fever ❑ Sleeping problems ❑ Frequently sick ❑ Heartburn ❑ Stomach problems
❑ Constipation ❑ Diarrhea ❑ Changes in appetite ❑ Difficulty swallowing ❑ Nausea/Vomiting
❑ Numbness ❑ Tingling ❑ Fainting ❑ Weakness ❑ Tremors
❑ Memory loss ❑ Mood swings ❑ Psychiatric problems ❑ Irritability ❑ Difficult concentrating
❑ Difficulty breathing ❑ Frequent cough ❑ Chest pain ❑ Heart palpitations ❑ Leg pain
❑ Bruise or bleed easily ❑ Blood clots ❑ Cold hands/feet ❑ Lymph node enlarged ❑ Lymph node tender
❑ Dizziness ❑ Change in smell/taste ❑ Ringing/buzzing in ears ❑ Light sensitivity ❑ Changes in vision
❑ Sinus/nasal problems ❑ Hot/cold intolerance ❑ Difficulty urinating ❑ Sexual dysfunction ❑ Joint stiffness/pain
❑ Swelling ❑ Back pain/stiffness ❑ Neck pain/stiffness ❑ Headaches
❑ Unexplained weight changes ❑ Loss of balance/coordination

Females Only: Have you ever or are you presently experiencing any of the following?
❑ Breast lumps/pain ❑ Painful/irregular cycles ❑ Infertility ❑ Difficult pregnancy/delivery

Your Social Health Profile

How would you grade your overall health? ❑ Poor ❑ Adequate ❑ Good ❑ Excellent
How often do you use tobacco? ❑ Never ❑ Quit ❑ Daily ❑ Weekly ❑ Monthly
How often do you drink alcohol? ❑ Never ❑ Quit ❑ Socially ❑ Daily ❑ Weekly ❑ Monthly
How often do you use illicit drugs? ❑ Never ❑ Quit ❑ Daily ❑ Weekly ❑ Monthly
How often do you exercise? ❑ Never ❑ 1-2 days/week ❑ 3-4 days/week ❑ 5-7 days/week
How would you describe your diet? ❑ Poor ❑ Adequate ❑ Good ❑ Excellent
How would you describe your sleep quality? ❑ Poor ❑ Adequate ❑ Good ❑ Excellent
What position do you normally sleep in? ❑ Back ❑ Stomach ❑ Left side ❑ Right side
How many pillows do you sleep with under your neck? ________
What type of mattress do you sleep on? ❑ Innerspring ❑ Air ❑ Pillow top ❑ Foam ❑ Other ________________
What type of pillow do you sleep on? ❑ Down ❑ Feather ❑ Foam ❑ Contour ❑ Other __________________
How would you describe your daily stress levels? ❑ None ❑ Mild ❑ Moderate ❑ Excessive
What is your occupation? ____
Please describe your work activities: ____
Please list any athletic participation or hobbies: ____

Your Family Health Profile

We are interested in the health of your family not only because it is important to your own health history but because we are concerned about their health and well being as well. Do any members of your family (including parents, grandparents, siblings, spouse, and children) have a history of any of the following conditions?

❑ Allergies ❑ Arthritis ❑ Asthma ❑ Blood disorders ❑ Cancer ❑ Dementia ❑ Depression ❑ Diabetes
❑ Epilepsy ❑ Gall bladder disease ❑ Heart disease ❑ High blood pressure ❑ Major infection ❑ Kidney disease
❑ Liver disease ❑ Multiple sclerosis ❑ History of similar symptoms ❑ Sexually Transmitted Disease ❑ Stroke
❑ Thyroid disease ❑ Other ____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

______________________________ ____________________
Signature Date

Lindholm Chiropractic, P.C.
Dr. Mark Lindholm
Dr. Joshua Martens

PRIVACY NOTICE ACKNOWLEDGEMENT

EFFECTIVE DATE

This Notice is effective as of April 14, 2003.

ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Practice's Privacy Notice that has an effective date of April 14, 2003.

______________________________ ______________________________
Name of Individual (Printed) Signature of Individual

Date Signed _______/_______/_______