Chance Chiropractic Rehab & Wellness
3013 Aloma Avenue
Winter Park, FL 32792
Tel: 407-960-2103
Fax: 407-960-6798
www.winterparkchiro.com

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Chance Chiropractic Rehab & Wellness and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with **Dr. Brett Chance** and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

1. Thiel HW, Bolton JE, Docherty S, Portlock JC. Safety of chiropractic manipulation of the cervical spine: a prospective national survey. *Spine.* Oct 1 2007;32(21):2375-2378; discussion 2379.
2. Rubinstein SM, Leboeuf-Yde C, Knol DL, de Koekkoek TE, Pfeifle CE, van Tulder MW. The benefits outweigh the risks for patients undergoing chiropractic care for neck pain: a prospective, multicenter, cohort study. *J Manipulative Physiol Ther.* Jul-Aug 2007;30(6):408-418.
3. Cassidy JD, Boyle E, Cote P, et al. Risk of vertebrobasilar stroke and chiropractic care: results of a population-based case-control and case-crossover study. *Spine.* Feb 15 2008;33(4 Suppl):S176-183.
4. Boyle E, Cote P, Grier AR, Cassidy JD. Examining vertebrobasilar artery stroke in two Canadian provinces. *Spine.* Feb 15 2008;33(4 Suppl):S170-175.
5. Carragee EJ, Hurwitz EL, Cheng I, et al. Treatment of neck pain: injections and surgical interventions: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine.* Feb 15 2008;33(4 Suppl):S153-169.
6. Carroll LJ, Hogg-Johnson S, van der Velde G, et al. Course and prognostic factors for neck pain in the general population: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine.* Feb 15 2008;33(4 Suppl):S75-82.

HIPAA

The undersigned does hereby acknowledge that he/she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

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PHOTO CONSENT

We are PROUD of our patients and the progress they make while under our care! There's nothing we enjoy more than CELEBRATING our patients' successes along with them. And when something good is happening in our lives, we feel inclined to share it with others, right?

If the moment arises, we would love to share your photo, story, or progress on our Social Media page(s) or website in the interest of showing others that "real people" visit our office and are smiling while they're here – and most importantly, getting results!

Please check the box that applies to you:

☐ Sure! You can use my picture on the Straight-ahead Website and Social Media (i.e. Facebook, Instagram, etc.) pages, if I look good in it!

☐ No thanks! I'll pass for now.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

_____
Print Patient's Name

_____
Signature of Patient

_____/_____/_____
Date

To be completed by the patient's representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated)

_____
Print Name of Representative

_____
Signature of Representative

_____/_____/_____
Date

Physician Signature _____ Date _____/_____/_____

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Authorization to Release Medical Records to Dr. Chance, D.C. For:

Patient :_____ Date(s) of Service_____

Date of Birth_____ Social Security Number_____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

__INFORMATION TO BE RELEASED OR ACCESSED:

__Complete records __Progress notes
__Labs/ Path reports __Imaging Reports and Images (X-Rays, MRI, CT etc.)
__Clinical summaries
__Consultation notes __other_____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and at the appropriate address):

FROM: _____
(Doctor, Hospital, Clinic, Imaging center etc.) Phone number

_____
Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drugs or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.
The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Signature:_____
Patient or Legally Authorized Representative
_____ Print Name: _____
Relationship to Patient Patient or Legally Authorized Representative

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New Patient Intake Form

PATIENT INFORMATION

First Name _____**Middle**_____ **Last** _____

Date of Birth_____/_____/_____ **Sex** M F **Married** ◊ **Single** ◊ **Other** ◊

Address_____ **Email** _____

City_____ **State**_____ **Zip**_____

Home Phone (_____)_____-_____ **Cell Phone** (_____)_____-_____ **Work Phone** (_____)_____-_____

Occupation_____ **Employer's Name**_____

Emergency Contact_____ **Phone** (_____)_____-_____

ACCIDENT/ILLNESS INFORMATION

Is this condition related to:	Employment	YES	NO
	Auto Accident	YES	NO
	Other Accident	YES	NO

Date of Accident _____/_____/_____ Dates missed from work_____

How did you hear about Chance Chiropractic Rehab & Wellness?

_____

Physician Signature _____ Date _____/_____/_____

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Past/ Present Medical History

Patient Name_____ Date_____/_____/_____

List any **past diseases** including those from childhood_____

_____

List any **surgeries**, major **traumas** (including concussions and broken bones), illnesses, recent immunizations, or other hospitalizations_____

_____

_____

Have you ever been diagnosed with a splondylolisthesis, compression fracture, or other spinal fracture?

_____

List any medical **allergies** _____

_____

List all **medications** you are currently on or have recently taken_____

_____

List all **vitamins** or other supplements you currently take_____

_____

Have you **family** members suffered from any diseases such as heart disease, diabetes, cancer, or any other inherited disease? If so, please list_____

_____

What is your occupation? _____

What are your hobbies/recreational interests? _____

YES NO Are you currently taking NSAIDS (Ibuprofen, Acetaminophen, etc) How often? _____

YES NO Do you drink alcohol? If yes how many drinks and how often? _____

YES NO Do you smoke? How many packs a day? _____ How many years? _____

YES NO Do you exercise on a regular basis? How? _____

YES NO Do you eat fast food more than 3 times a week? How often? _____

YES NO Do you drink water on a regular basis? How many glasses a day? _____

YES NO Do you have difficulties sleeping soundly through the night? _____

YES NO Do you feel fatigued on a regular basis?

YES NO Do you eat healthy? Briefly explain your diet _____

_____

HIGH MED LOW What is your level of stress? Explain_____

YES NO Have you been to a chiropractor before? If so, why and when? _____

_____

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Please check all boxes that apply

CONDITION	DATE(s)	CONDITION	DATE(s)
Musculoskeletal:		**Blood/Immune System**	
☐ Neck pain		☐ High cholesterol/triglycerides	
☐ Mid back pain		☐ High glucose	
☐ Low back pain		☐ Hypothyroidism	
☐ Headaches ___Mild____ Mod._____Severe_____ Daily ___ Weekly____ Monthly____		☐ Diabetes ☐ Allergies	
☐ Numbness/Tingling Arm___ Hand____ Thighs ___ Leg ___ Foot___		☐ Sinus Infections ☐ Ear Infections	
☐ Foot/Ankle Pain		**Digestive System:**	
☐ Hip Pain		☐ Acid Reflux/GERD	
☐ Knee Pain		☐ Peptic ulcer *(gastric/duodenal)*	
☐ Elbow Pain		☐ Constipation	
☐ Carpal Tunnel		☐ Irritable bowel syndrome	
☐ Dizziness		☐ Nausea	
☐ Arthritis		☐ Vomiting	
☐ Rheumatoid Arthritis			
☐ Sciatica		**Vasculature:**	
☐ Herniated/Degenerative Disc Condition		☐ Varicose veins	
☐ Fibromyalgia		☐ Blood clots	
☐ Ear Aches		☐ Stroke/TIA	
☐ Abnormal X-Ray or MRI findings		☐ Peripheral Artery Disease (PAD)	
☐ Shoulder Pain		☐ Hardening of the arteries	
☐ Wrist Pain			
Heart:		**Lungs:**	
☐ High blood pressure		☐ Pneumonia	
☐ Heart Attack		☐ Asthma	

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☐ Angina		☐ Bronchitis	
☐ Congestive heart failure		☐ COPD	
Nervous system:		☐ Emphysema	
☐ Neuralgia			
☐ Migraines		**Other Conditions:**	
☐ Cluster Headaches		☐ Chest pressure/tightness with exertion	
☐ Pinched nerves		☐ Chest pressure/tightness with rest	
☐ Depression		☐ Generalized weakness	
☐ Panic Attacks/Anxiety		☐ Cancer: Type:	
		☐ Night Sweats	
Organ System:		☐ Trouble breathing	
☐ Kidney Stones		☐ Feeling faint or passing out	
☐ Gallstones		☐ Pain in legs while walking	
☐ Hepatitis		☐ Recent Weight loss: # pounds lost	
☐ Bladder infections		☐ Recent weight gain: # pounds gained	
☐ Enlarged Prostate		☐ Swollen feet or ankles	

Physician: _____ Date: _____/_____/_____