Jillaine St.Michel, D.C.
Mobile Chiropractic and Wellness
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208-570-9388

Patient Information

Patient Full Name _________________________

Home Phone Number_____________________

Date of Birth _____________________________

Cell Phone Number________________________

Current Age______________________________

Employer________________________________

Street Address____________________________

Occupation______________________________

City______________________________________

How were you referred? __________________

State_____________________________________

Name of emergency contact/phone number__

____

Zip Code__________________________________

Have you previously had any chiropractic care? __________ **Date of last visit**____________________

Have you previously had any massage therapy? __________ **Date of last massage**________________

Primary care physician_______________________________________

Primary care physician contact information____

List any major surgeries with dates of treatment____

____

List any major trauma/injuries (ex- whiplash injuries, lifting injuries, falls, etc) with dates of incident

____

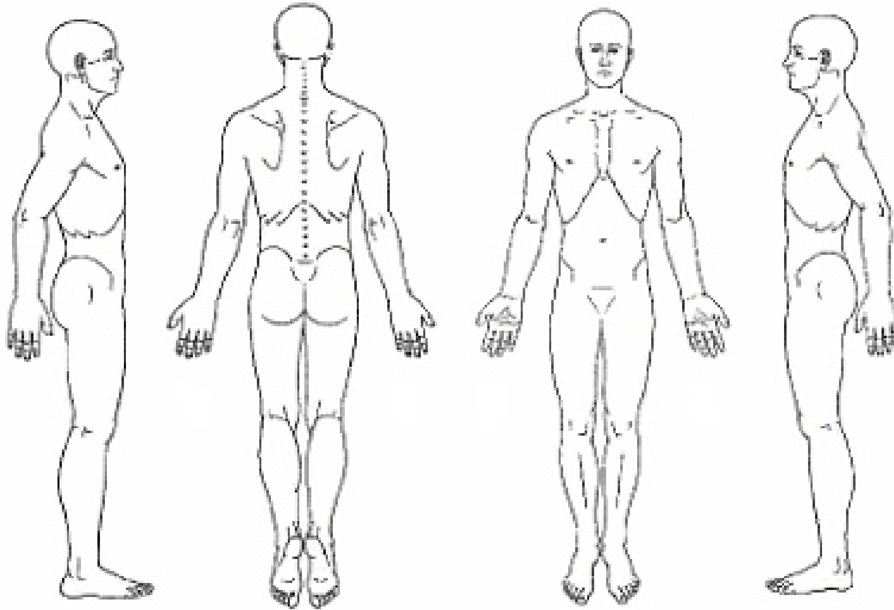
____

How would you rate your current health? Great/good/fair/needs improvement/poor (circle one)

What portion of your day is spent sitting? 0-25% 25-50% 50-75% 75-100% (circle one

Please keep MCW informed of any changes to personal information or health issues as they arise

Please mark any areas of complaint with an “X”:



Describe your areas of complaint:

1)____

2)____

3)____

4)____

5)____

How often do your symptoms bother you? (Please circle response)

0-25% of the time 25-50% of the time 50-75% of the time 75-100% of the time

Do any of the following help your symptoms? Circle all that apply

ice/heat/stretching/pain reliever/rest/activity/massage/chiropractic/none/other:

____

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Do any of the following make your symptoms worse? Circle all that apply

Coughing/sneezing/deep breaths/standing/sitting/lying/walking/exercise/none/other:

____

Circle any activities which are affected by your pain or symptoms:

Bending

Getting in and out of car

Climbing stairs

Sitting

Dressing

Standing

Walking

Exercising

Hoursework

Lifting

Lying in bed/sleeping

Changing positions

Turning or bending neck

Driving a vehicle

Taking a deep breath

Dressing

Other ________________

Circle any conditions you currenly have, or have had in the past:

Headaches

Migraines

Numbness or tingling into arms/hands

Numbness or tingling into legs/feet

Numbness or tingling into face

Neck pain

Back pain

Ankle pain

Stroke

Digestive issues

Blood clotting disorder

High blood pressure

Low blood pressure

Knee pain

Shoulder pain

Hip pain

Chest pain

Shortness of breath

Diabetes

Bowel or bladder incontinence

Heart attack

Seasonal allergies

Skin rash

Osteopenia/osteporosis

Dizziness or vertigo

Cancer

Other ________________

What are your goals for treatment? Circle all that apply

Wellness/preventative care

Decrease pain

Increase range of motion

Stress management

Return to normal activities

Recover more quickly from training

Other ____________

Please list anything else that may be of importance ____
____

____
Date

____
Patient printed name

____
Patient signature

____
Printed Name of Parent or Guardian of above named minor

____
Signature of Parent or Guardian of above named minor

____
MCW Representative

Please keep MCW informed of any changes to personal information or health issues as they arise

INFORMED CONSENT

PATIENT NAME: ________________________________ **DATE: ________________________**

Mobile Chiropractic & Wellness (hereinafter MCW) requires all patients initial each informed consent as outlined below, as well as a completed signature at the end of this consent.
Please read this document in its entirety; questions or concerns should be addressed prior to initials and final signature.

The nature of the chiropractic adjustment:
A common treatment used by Doctors of Chiropractic's is spinal manipulative therapy: MCW may use that procedure to treat you the patient in conjunction with manual muscle work/trigger point therapy. MCW may use hands on adjustments or a mechanical instruments to move specific joints. You may hear audible "clicks" or "pops", much as you would when you "crack" your knuckles. You may also feel a sense of movement.

______________ Patient Initials

Analysis/Exam/Treatment:
As part of the analysis, exam, and treatment, you the patient are consenting to the following procedures: spinal manipulative therapy, gentle traction, palpation, range of motion testing, orthopedic testing, basic neurological testing, vital signs, postural analysis testing, muscle strength testing, manual muscle work, instrument-assisted soft tissue mobilization, trigger point therapy, rehab/strengthening activities.

______________ Patient Initials

The material risks inherent in chiropractic adjustments:
As with any healthcare procedure, there are certain complications which may arise during spinal manipulation and therapy. The most common complaints are of stiffness/soreness after adjustment. Other complications may include, but are not limited to fractures, disc injury, dislocations, muscle strain, cervical myelopathy, costovertebral strain or separation. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. MCW will make every reasonable effort during the exam to screen for contraindications to care; however if you have a condition which would otherwise not come to MCW's attention, it is your responsibility to inform MCW.

______________ Patient Initials

The probability of those risks occurring:
Fractures are rare occurrences and generally result from some underlying weakness of the bone which MCW will check for during the taking of your history and during exam. 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 a 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.

______________ Patient Initials

The availability and nature of other treatment options:
Other treatment options may include: self-administered over-the-counter analgesics and rest; medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain-killers; hospitalization; surgery. If you choose to use one of the above noted "other treatments", you should be aware that there are risks and benefits of such options; It is up to you the patient, to discuss these with your primary medical physician.

______________ Patient Initials

The risk and dangers attendant to remaining untreated:
Remaining untreated may allow the formation of adhesions and reduced 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. It is up to you, the patient, to schedule any future treatments with MCW.

______________ Patient Initials

FINAL CONSENT AND AUTHORIZED SIGNATURES

CONSENT TO TREAMENT (MINOR)

I hereby request and authorize Jillaine St.Michel, D.C. of MCW to perform diagnostic tests and to render chiropractic adjustments and other treatment to my minor son/daughter: _______________________.

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.

____
Printed Name of Parent or Guardian of above named minor

____
Signature of Parent or Guardian of above named minor

____
Date

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE CONSENT IN ITS ENTIRETY

I have read (or have had read to me) the above explanation of the chiropractic adjustment and related treatment. Any questions I have were discussed with Jillaine St. Michel, D.C. of MCW and have had my questions answered to my satisfaction. By signing below 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.

____
Date

____
Patient printed name

____
Patient signature

____
Printed Name of Parent or Guardian of above named minor

____
Signature of Parent or Guardian of above named minor

Please keep MCW informed of any changes to personal information or health issues as they arise

FINANCIAL AGREEMENT

Review and sign the following Financial Agreement in its entirety prior to your first appointment. This financial agreement will remain in place, unless given notice by the office Mobile Chiropractic and Wellness of any payment changes.

Services provided by Mobile Chiropractic and Wellness (hereinafter MCW) are not billable through your insurance provider; meaning MCW will not accept your insurance information and bill any patient charges for you through them. By eliminating this third party, it allows MCW to administer the treatment that that is felt necessary for the patient's best interest. It is MCW's policy that payment is collected same day of service or prior to service if a pre-payment option has been elected. MCW accepts cash, personal checks, and credit cards for payment on your account.

I __________________________ (printed patient name) agree to pay for services <u>at the time of service, or prior to service rendered</u>. If responsible financial party is not the above named patient, they are signing this document stating that as of this date, they have the legal right to select and authorize health care services for the printed patient named above and that they are also accepting financial responsibility for the treatment of the above named patient for MCW services. It is the responsibility of the authorized signature below to inform the office of MCW of any financial or legal changes.

___________________________ _______________

Printed name of above named patient or responsible party Date

___________________________ _______________

Signature of above named patient or responsible party Date

PATIENT CONSENT FORM (HIPAA COMPLIANCE)

I understand that some of my information may be used and/or disclosed by Mobile Chiropractic and Wellness to carry out treatment, payment, or healthcare operations. I understand that I may request restrictions on how my information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that I can revoke this consent, but only in writing.

Mobile Chiropractic and Wellness keeps a record of the healthcare services provide to you. You may ask to see and copy that record. You may also request to correct that record. We will not disclose your record to others, unless you direct us to do so, or unless the law compels us to do so. You may see your record by contacting Mobile Chiropractic and Wellness.

____

Patient signature and date

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures listed above, I hereby specifically authorize disclosure of my protected healthcare information to the person(s) indicated below.

____
Name and Relation

____
Designated Primary Care Physician name

____
Patient signature and date

_____________________________ _______________
MCW Representative Date

Please keep MCW informed of any changes to personal information or health issues as they arise