AROLA
Chiropractic & Acupuncture

Today's Date: _____

Name: _____ Age: _____ DOB: _____
SSN: _____ Drivers License #: _____
Address: _____ City: _____ State: ____ Zip: _____
Home Telephone: _____ Cell Phone: _____
Work Phone: _____
Email Address: _____

Please check which contact method you prefer:
Home Phone: ___ Cell Phone ___ Email: ___ Work Phone: ____

Occupation: _____
Single ___ Married ___ Divorced ____ Widowed ____ No. of children: _____
Reason for consulting our office: _____
Whom may we thank for referring you to our office? _____

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential

Your Childhood Years (under 18 yrs old)

Childhood illnesses (if any) _____
Were you vaccinated: _____ Did you play youth sports: _____
Was there any prolonged use of medicine such as antibiotics? _____
List any serious falls you had as a child: _____
Have you fallen / jumped from a height over three feet? (i.e. crib, bunk bed, trees) _____
Were you involved in any car accidents as a child? _____
As a child, were you under regular Chiropractic care? _____

Adult Years- 18 yrs to present

Do/Did you smoke? _____ Do/did you play any adult sports? _____
Do/did you drink alcohol? _____ Do / did you participate in extreme sports? _____
Have you been in any accidents? _____ Have you had any surgery? _____
On a scare of 1 - 10 describe your stress level: (1 = none / 10 = extreme)
Occupational stress: _____ Personal stress: _____

On a scale of Poor, Good, Excellent describe your:

Diet: _____ Exercise: _____ Sleep: _____ General Health: _____

If you have no symptoms or complaints, and are here for wellness services, please check here _____.

Briefly describe the chief area of complaint, including the effect it has had on your life:

_____

_____

If you are experiencing pain, is it...

Sharp ___ Dull ___ Comes & goes ___ Travels ___ Constant ____

Since the problem started, it is... About the same ___ Getting better ___ Getting worse ___
What makes it worse? _____
Yes, it interferes with: Work ___ Sleep ___ Walking ___ Sitting ___ Hobbies ___ Leisure ___

Other Doctors seen for this problem (Please List)
Chiropractor: _____
Medical Doctor: _____
Other: _____

Please check all symptoms you have EVER had:

___ Headaches	___ Pins and needles in legs	___ Fainting	___ Neck pain
___ Pins and needles in arms	___ Loss of smell	___ Back Pain	___ Loss of balance
___ Ringing in ears	___ Buzzing in ears	___ Dizziness	___ Nervousness
___ Numbness in fingers	___ Numbness in toes	___ Loss of taste	___ Stomach upset
___ Fatigue	___ Depression	___ Irritability	___ Tension
___ Sleeping problems	___ Neck stiff	___ Cold hands	___ Cold feet
___ Diarrhea	___ Constipation	___ Fever	___ Hot Flashes
___ Cold sweats	___ Lights bother eyes	___ Heartburn	___ Mood swings
___ Problem Urinating	___ Menstrual Pain	___Ulcers	

List any Medications you are taking: _____
_____

Family Health Profile (list any health conditions or concerns)

Children: _____ Spouse:_____
Mother: _____ Father: _____
Siblings: _____ 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

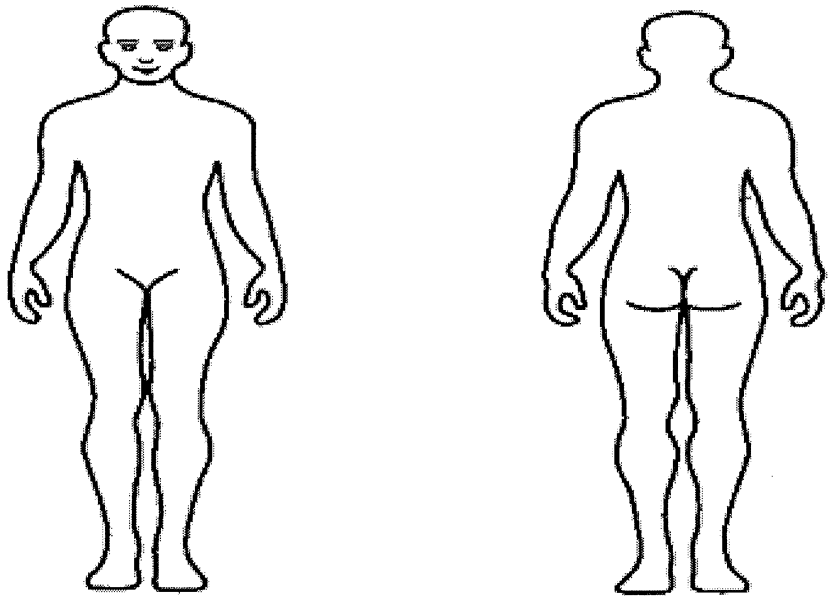
Please list any surgeries you have had including the date: _____

_____

_____

_____

Mark an X on the image below in areas that you have pain, numbness or tingling:



Female Patients:

Is there any chance you are pregnant? _____

Your Health is Our Goal!

AROLA

Chiropractic & Acupuncture

Insurance Services

Arola Chiropractic & Acupuncture participates with many health plans. As a courtesy to our patients, we will file claims with these companies. It is ultimately your responsibility for the full and timely payment of your account.

Please also provide the clinic with up to date contact information including your home address, telephone number, and emergency contact information. If you have any changes to your insurance **you are responsible** for letting us know so that we may file with the correct insurance information.

The Clinic will attempt to verify coverage and benefits prior to your visit with the physician. If we are unable to obtain a verification of coverage you may be asked to pay in full.

This verification will be used to **estimate your financial responsibility**; however, this verification is not a guarantee by your health plan of coverage or payment. Payment of your estimated patient liability is expected at the time services are rendered. This payment will include known deductibles, co-pays, and coinsurance due for each visit.

While we may estimate your financial responsibility, it is your insurance company that makes the final determination regarding your eligibility and benefits. Please be aware that certain office procedures or services may not be covered, or may be considered "not medically necessary "by your health plan. **You are responsible** for payment of these services.

Please also be aware that many health plans limit chiropractic annual and/or combine it with physical therapy coverage. In the event your care exceeds a plan limitation, **you will be responsible for the balance. It is your responsibility to know the benefits and limitations of your current health care coverage.** Arola Chiropractic & Acupuncture, PLLC will provide medically necessary care based on patients' medical needs, **not a patient's insurance coverage**.

The Physician & staff are not responsible for knowing your plan's specific benefit and coverage limitations.

Patient signature: _____

INFORMED CONSENT
DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialists of chiropractic, osteopath and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. it is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustment and ancillary procedure may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and give the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise your specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medicine specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other options if he/she has any concerns as to the nature of his/her total conditions. 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 OF CHIROPRACTIC CARE

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

RESULTS

Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally the results the less than expected. Two or more similar conditions may respond differently to the same chiropractic care.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy.

I have read and understand the foregoing.

Signature: _____ Date: _____

Patient Acupuncture Information and Consent Form

Please read this information carefully, and ask your practitioner if there is anything that you do not understand.

What is acupuncture?

Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body.

Is acupuncture safe?

Acupuncture is generally very safe. Serious side effects are very rare – less than one per 10,000 treatments.

Does acupuncture have side effects?

You need to be aware that:

drowsiness occurs after treatment in a small number of patients, and, if affected, you are advised not to drive;

minor bleeding or bruising occurs after acupuncture in about 3% of treatments;

pain during treatment occurs in about 1% of treatments;

symptoms can get worse after treatment (less than 3% of patients). You should tell your acupuncturist about this, but it is usually a good sign;

fainting can occur in certain patients, particularly at the first treatment.

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

if you have ever experienced a fit, faint or funny turn;

if you have a pacemaker or any other electrical implants;

if you have a bleeding disorder;

if you are taking anti-coagulants or any other medication;

if you have damaged heart valves or have any other particular risk of infection.

Single-use, sterile, disposable needles are used in the clinic.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having acupuncture treatment. I understand that I can refuse treatment at any time.

_____

Signature

_____

Print name in full

_____

Date

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices provided by Arola Chiropractic & Acupuncture and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.
I understand that this form will be placed in my patient chart and maintained for six years.

_____
Patient Name (please print)

_____
Date

_____
Parent, Guardian or Patient's legal representative's name (please print)

_____
Signature of Patient or Guardian (if under 18 yrs of age)