File #: _____

Democko Chiropractic

Dr. Joseph Democko
Dr. James Stieglitz

☐ Military/1st Responder ☐ VA ☐ MC ☐ MD ☐ PI ☐ MM ☐ Cash

Today's Date: _____

ABOUT YOU

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ☐ Male ☐ Female

Birth Date: _____ SS# _____

Mailing Address: _____

_____
CITY STATE ZIP

Cell Phone: _____ Alternate Phone: _____

Email Address: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Emergency Contact: _____

Phone #: _____ Relation: _____

INSURANCE INFO

Primary Insurance	Secondary Insurance
_____ Name of insurance company:	_____ Name of insurance company:
_____ Subscriber name:	_____ Subscriber name:
_____ Subscriber DOB:	_____ Subscriber DOB:
_____ Relationship:	_____ Relationship:
_____ Insured's ID#:	_____ Insured's ID#:

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REASON FOR VISIT

Patient Name: _____

Reason for today's visit: ☐ Emergency ☐ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Wellness

Are you in pain? ☐ Yes ☐ No Rate your pain on the scale: Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Did your injury occur during: ☐ Work ☐ Sports/play ☐ Auto Accident ☐ Routine/Household activity

When did your condition/accident occur? _____ Where did your injury occur? _____

Please explain what happened: _____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is your condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine? If so, how: _____

_____

Has this or something similar happened in the past?

☐ Yes ☐ No Explain: _____

_____

Have you been treated by a medical physician for this condition?

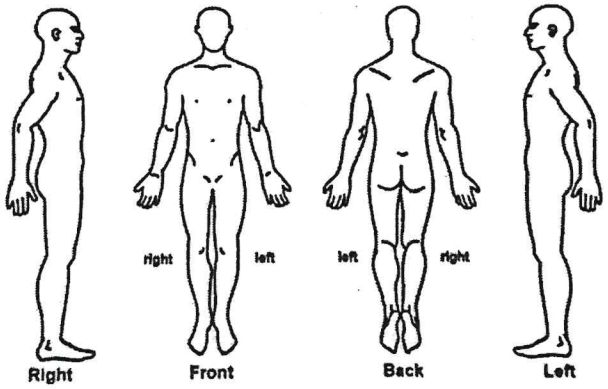
☐ Yes ☐ No If so, where? _____

_____

Have you ever been treated by a chiropractor?

☐ Yes ☐ No If so, where? _____

_____



Using the body chart above, please circle all affected areas.

NOTES: _____

_____

_____

_____

_____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service, and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information provided.

Patient's Signature: _____ Date: _____

File #: _____

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MEDICAL HISTORY

Patient Name: _____ Date of last physical exam: _____

DO YOU HAVE or HAVE YOU EVER HAD:

	Yes	No
Hospitalization for illness or injury?	☐	☐
Allergic to any medications?	☐	☐
Heart problems or cardiac stent within the last 6 months?	☐	☐
Artificial heart valve, repaired heart defect (PFO)?	☐	☐
Pacemaker or implantable defibrillator?	☐	☐
Artificial prosthesis (heart valve or joints)?	☐	☐
High or low blood pressure?	☐	☐
Head or neck injuries?	☐	☐
Stroke?	☐	☐
Digestive disorders (i.e., celiac disease, gastric reflux)?	☐	☐
Anemia or other blood disorders?	☐	☐
Emphysema, shortness of breath, sarcoidosis?	☐	☐
Tumor/abnormal growth?	☐	☐
Tuberculosis, Measles, Chicken Pox?	☐	☐
Chemotherapy, immunosuppressive?	☐	☐
Asthma?	☐	☐
Stomach or Duodenal Ulcer?	☐	☐
Breathing or sleep problems (i.e., sleep apnea, snoring, sinus)?	☐	☐
Kidney disease	☐	☐
Liver disease	☐	☐
Thyroid, parathyroid disease, or calcium deficiency?	☐	☐
Hormone deficiency?	☐	☐
High cholesterol or taking statin drugs?	☐	☐
Diabetes (HbA1c=_____)	☐	☐
Osteoporosis/Osteopenia (i.e. taking bisphosphonates)?	☐	☐
Arthritis, rheumatoid arthritis, lupus?	☐	☐
Epilepsy, convulsions (seizures)?	☐	☐
Neurological disorders (ADD, ADHD, Orion Disease)?	☐	☐
Hepatitis (Type _____)?	☐	☐
Antidepressant medications?	☐	☐
Alcohol/ street drug use?	☐	☐
Hives, skin rash, hay fever?	☐	☐
STI/STD?	☐	☐
HIV/Aids?	☐	☐

ARE YOU:

	Yes	No
Presently being treated for any other illness?	☐	☐
Aware of a change in your health in the last 24 hours (i.e., fever, chills, new cough, or diarrhea)?	☐	☐
Experiencing frequent headaches?	☐	☐
FEMALE - pregnant?	☐	☐

If so, what? _____

	Yes	No
Often exhausted or fatigued?	☐	☐
A smoker, smoked previously, or use smokeless tobacco?	☐	☐
MALE - prostate disorders?	☐	☐

LIST ANY SURGERIES YOU MAY HAVE HAD:

_____ _____ _____

_____ _____ _____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature: _____ Date: _____

INFORMED CONSENT FORM

PATIENT NAME: _____ **DATE:** _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment: The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to 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 a part of the analysis, examination, and treatment, you are consenting to the following procedures:

X Spinal Manipulative Therapy	X Palpation	X Vital Signs
X Range of Motion Testing	X Orthopedic Testing	X Basic Neurological Testing
X Muscle Strength Testing	X Postural Analysis	___ Ultrasound
X Hot/Cold Therapy	X Electrical Stim.	X Radiographic Studies
X Mechanical Traction	___ K Laser Therapy	___ Shockwave Therapy
___ Other (please explain)		

The material risks inherent in chiropractic adjustment: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, 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 serious complications including stroke. 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.

The probability of those risks occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. 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 analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated. Remaining untreated may allow the formation of adhesions and reduce 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.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [X] or had read to me [X] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *a provider* and have had my questions answered to my satisfaction. 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.

	Dr. Joseph Democko
Patient's Name (Print) **Date**	**Doctor's Name** **Date**
	Joseph Democko D.C.
Signature (or Parent/Guardian if minor)	**Signature**

DEMOCKO
CHIROPRACTIC

Democko Chiropractic Patient Consent Form
Patient Consent for Use/Disclosure of Health Care Information
Patient Acknowledgement form and understanding of our Privacy Practices.

Patient Name: _____ **DOB:** _____ **Chart #** _____

I understand that the patient's health information is private and confidential. I understand that Democko Chiropractic PLLC works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Democko Chiropractic PLLC may use and disclose the patient's personal information to help provide health care to the patient, t handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that in unusual situations the law may require the release of this information without my permission.

Democko Chiropractic PLLC has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement. Democko Chiropractic PLLC before signing this agreement. Democko Chiropractic PLLC may update this "Notice of Privacy Practices". If I ask, Democko Chiropractic PLLC will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Democko Chiropractic PLLC to limit how the patient's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Democko Chiropractic PLLC does not have to agree to my request. If Democko Chiropractic PLLC does agree to my request, I understand that Democko Chiropractic PLLC would follow the agreed limits.

I may cancel this consent in writing at any time by writing, signing, and dating a letter to Democko Chiropractic PLLC. The letter must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health for treatment, payment and health care operations. If I revoke this consent, Democko Chiropractic PLLC does not have to provide any further health care services to the patient.

Within this Notice of Privacy Practice is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to access my medical records; restrictions on certain users; receiving and accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Democko Chiropractic PLLC has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorization; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Democko Chiropractic PLLC by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I am responsible for any co-payment, payment or balance of payment not covered by an insurance company with which Democko Chiropractic PLLC participates. My signature indicates that I have been given the chance to review a current copy of Democko Chiropractic PLLC "Notice of Privacy Practices". My signature means that I agree to allow Democko Chiropractic PLLC to use and disclose that patient's personal health information to carry out treatment, payment and health care operations.

X_____ _____

Patient or Guardian signature **Date**

_____

Relationship to patient