Date______________________

Name _____________________________________ Birthdate ____________ Age________

Address ____________________________________

City _______________________State ______ Zip ___________

Home Phone ____________________ Cell Phone ____________________

Married/Single/Divorce/ Widow Spouse Name _____________________# Children____

Type of Work _______________
e-Mail Address ____
Have you been to a chiropractor before? □ No □ Yes / If yes how long ago ___________
Emergency Contact ____________________ph# __________________________________
Medical Doctor(s)____

- I authorize the Dr. Storey/ChiroDen or his staff to render care as deemed appropriate for me and / or my child. ______________initial
- I authorize Dr. Storey/ChiroDen to release and / or request records to or from other providers as may be necessary. I understand I am responsible for all bills incurred in this office. _________initial

AGREEMENTS FOR TOP RESULTS:

- Remember it takes time and effort to improve your health. *No time + No effort = No results*
- Please keep your appointments and make-up any missed or rescheduled visits within a day whenever possible. Any No Show without a 24 hour Call and No-Show appointment for any provided care scheduled will count against your treatment plan or a $35 Charge

Privacy Practice

At ChiroDen, I understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Application For Care) on my first visit, whenever that may have occurred. _________initial

I understand that this office will properly maintain my records and will use all due means to protect my privacy as outlined in this privacy practices statement. _______initial

______________________________________ ____________________

Patient / Parent Signature Date

General Health History

Patient Name_______________________________________ *Mark the conditions that only apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other			

Past History

List any past auto collisions:_______________________________________ Was any care received?_________________

Please describe any past conditions and treatment received:

____

Do you view your health as an investment or expense? ________________

How committed are you to living a healthier life on a scale 1-10 with 10 being the healthiest life possible? ________

How would your life change if you didn't have the health conditions you indicated above?______________________

Describe your Chief Complaint: ____
How long has this been an issue? _____________________

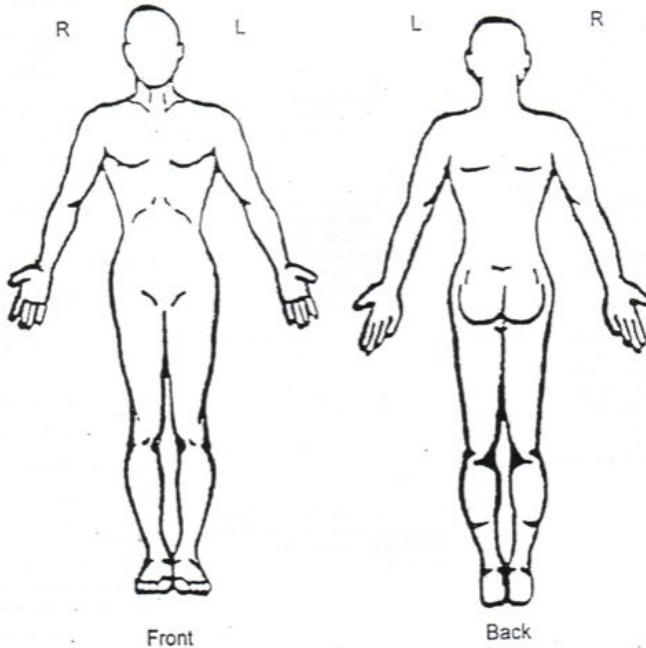
• Dull • Sharp • Ache • Numb / Tingle • Stabbing • Constant • Occasional • Staying the same • Getting worse • Mild • Moderate • Severe • Worse in the morning • Worse in evening • Pain radiates to_________________________

What makes this better? ______________________________

What makes this worse? ______________________________

On a scale of 0-10 what are your discomfort levels? (0 no pain and 10 being extremely painful). Circle. 1- 2- 3- 4- 5- 6- 7- 8- 9- 10

Is the Pain; Constant 100%, Frequent 75-50%, Intermitten 50-25%, or 25%- or less.



Medical History: Surgeries ____ yes _____no What surgeries if any? _______________________

History of Broken bones/Fractures or spinal surgery______________________

Are you taking any Medications: ____ yes ______no
List any medications you are taking:
____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well.

When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure.

As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache.

Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: ___________________________ Signature: ________________________Date:___________

Intramuscular Manual Therapy (IMT) aka
Functional Dry Needling (FDN) Consent Form

IMT / FDN involves placing a small needle into the muscle at the trigger point which is typically in an area which the muscle is tight and may be tender with the intent of causing the muscle to contract and then release,improving the flexibility of the muscle and therefore decreasing the symptoms. The performing therapist will not stimulate any distal or auricular points during the dry needling treatment.IMT / FDN is a valuable treatment for musculoskeletal related pain such as soft tissue and joint pain, as well as to increase muscle performance. Like ant treatment, there are possible complications. While these complications are rare in occurrence, it is recommended you read through the possible risks prior to giving consent to treatment.

Risks of the procedure:
Though unlikely there are risks associated with this treatment. The most serious risk associated with FDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment as it can resolve on its own. The symptoms of pain and shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern. If you feel any related symptoms, immediately contact your IMT / FDN provider. If a pneumo is suspected, you should seek medical attention from your physician or, if necessary, go to the emergency room. Other risks may including bruising, infection and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood, require blood anticoagulants or any other conditions that may have an adverse effect to needle punctures. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from IMT / FDN is unlikely.

Please consult with your practitioner if you have any questions regarding the treatment above.
Do you have any known disease or infection that can be transmitted through bodily fluids?
[ ] Yes [ ] No
*If you marked yes, please discuss with your practitioner.

____
Please print your name
____ ______________________
Signature Date

NOTE: Dry Needling is not covered by commercial insurance companies or Medicare.

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DIRECT ASSIGNMENT OF BENEFITS & RIGHTS

PROVIDER: Spencer W. Storey, DC PATIENT:____________ ____________ Date:___________________

In consideration of your undertaking to render care, I agree to the following:

1. RELEASE OF INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any Insurance company, attorney or adjuster In order to process any claim for reimbursement of charges incurred by me at your treatment facility.
2. RIGHT TO RECEIVE INFORMATION: I authorize my chiropractic provider the authority to affix my necessary signature as noted below to obtain medical information from any hospital, medical provider, etc. as It relates to the care being provided by my chiropractic doctor.
3. RIGHT TO RECEIVE PAYMENT: I irrevocably authorize and assign to you, the chiropractic provider, the right to receive direct payment from my attorney or any Insurance company which may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled.
4. ASSIGNMENT OF RIGHT TO SUE: In the event any insurance company or attorney obligated by contractual agreement to make payment to me for your service charges refuses to make such payment upon demand by you, I irrevocably hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me.
5. RIGHT TO LIEN: I also irrevocably assign to you, the chiropractic provider, and grant the right of lien against any and all claims against any third party whose negligence may have caused my Injury, Including their insurance, up to the amount of the bill for treatment, as it relates to my healthcare as provided by you.
6. RIGHT FOR INFORMATION: I irrevocably authorize my attorney, legal representative, insurer or any other party regarding my care or case to release financial information about proposed settlement, settlement/verdict payments or amounts owed included, but not limited to other providers or legal representatives, liens, billing amounts, and balances. I also instruct all representatives to include all financial information from all facets of my case including, but not limited to third party, uninsured motorist and underinsured motorists.
7. I irrevocably waive the Statute of Limitations regarding my doctor's right to recover from me directly.
8. I hereby acknowledge that I am receiving (or about to receive) health care services and I am advised that they are willing to wait for payment for these services, provided there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined either (a) there Is no insurance company obligated to pay for the services, or if the insurance company Involved refuses to acknowledge an assignment to the Doctor(s) or make other provisions for the protection of the interest of the Doctor(s); or (b) if a liability claim exists and my attorney refuses to agree to protect the interest of the Doctor(s) or If I have not engaged the services of an attorney, payment for services rendered by the above-named Doctor(s) will be made on a current basis and my account paid In full immediately. In any event, I hereby promise to pay my bill in full within (10) days from the date my liability claim Is settled or after the passage of three (3) months from the date of my last treatment, whichever comes first. 9. If any payment for any services rendered under this agreement becomes delinquent, the patient or patient's guardian shall be responsible for payment of any and all court costs, attorney's fees, service of process fees and any additional reasonable costs incurred in order to collect or that are associated with collecting monies due on the patient's· account. **Dated: Signature________day of ___________2021_____**

Patient Signature:_______________________________________

Witness Signaure:_______________________________________