Corridor Chiropractic of Iowa
2771 Oakdale Blvd Suite 2 Coralville, IA 52241
(319) 853-8592 drariannejohnsonc@iowacorridorchiropractic.com www.CoralvilleChiropracticHealth.com

Patient Information

First Name _____ MI __ Last Name _____Date_____
Street Address _____
City _____ State _____ Zip _____
Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( )_____
Best time to reach you _____ On what Phone: Home Work Cell
E-mail: _____ How did you hear about us?_____

Gender (as registered on insurance): Male Female
Preferred Pronouns: He/Him She/Her They/Them
Marital Status: Single Married Widowed Divorced Legally separated Partnered
Birth date _____ Age_____ # of Children/ages _____ Deliveries/Pregnancies_____
Patient Employer/School_____ Occupation_____

Emergency Contact

Emergency Contact _____ Relationship_____
Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( )_____

Chief Health Concerns and Symptoms Please circle: Neck Mid-Back Low Back Extremities
Main reason for visit_____
What was the cause?_____
When did your symptoms first appear?_____
Did it begin: Suddenly Gradually Worsened over time
Have you had this problem before: Yes No
Describe the pain: Achy Burning Dull Sharp Stiff Throbbing
Describe the frequency: Constant Frequent Intermittent Occasional
Does the pain travel?: Yes No If Yes, to where? _____
When does the pain feel **worse**? Morning Evening With Activity No change, hurts constantly
What makes the pain **worse**? Sleeping Walking Bending Working Sitting Movement in general
When does the pain **improve**? Morning Evening Sleep With Activity
What makes the pain **improve**? Sleeping Walking Bending Working Sitting Movement in general
Describe any location of numbness: _____
Describe any location of spasm: _____
Describe any location of weakness: _____
Do you notice any swelling/bruising? Yes No If Yes, where?_____

Patient's Name:_____ **Date:**_____

Secondary reason for Visit:_____

What was the cause?_____

When did your symptoms first appear?_____

Did it begin: Suddenly Gradually Worsened over time

Have you had this problem before: Yes No

Describe the pain: Achy Burning Dull Sharp Stiff Throbbing

Describe the frequency: Constant Frequent Intermittent Occasional

Does the pain travel?: Yes No If Yes, to where? _____

When does the pain feel **worse**? Morning Evening With Activity No change, hurts constantly

What makes the pain **worse**? Sleeping Walking Bending Working Sitting Movement in general

When does the pain **improve**? Morning Evening Sleep With Activity

What makes the pain **improve**? Sleeping Walking Bending Working Sitting Movement in general

Describe any location of numbness: _____

Describe any location of spasm: _____

Describe any location of weakness: _____

Do you notice any swelling/bruising? Yes No If Yes, where?_____

Headaches

Do you suffer from headaches or migraines? Yes No **Pain Intensity** 0 (least) - 10 (worst) _____

If so, where are they typically located? Forehead Temples Back below skull bone Behind eyes

When are the headaches **worse**? Morning Evening With Activity Constant

How frequent are the headaches? _____times per Week Month Year

Activities of Daily Living

Does your pain keep you from dressing/grooming without assistance? Yes No

Does it hurt to:	Walk	Yes No	Do housework	Yes	No
	Sit	Yes No	Drive	Yes	No
	Stand	Yes No	Exercise	Yes	No
	Lift	Yes No	Sleep	Yes	No
	Climb Stairs	Yes No	Take care of dependant's	Yes	No
	Get in & out of bed	Yes No	Work	Yes	No

Social History

Exercise	Work Activity	Habits	
__ None	__ Sitting	__ Smoking	Packs/Day_____
__ Moderate	__ Standing	__ Alcohol	Drinks/Week_____
__ Daily	__ Light Labor	__ Coffee/Caffeine	Cups/Day_____
		__ Recreational Drugs	Type & Amount_____

Patient's Name:_____ Date:_____

List Surgeries	Dates	**List Accidents/Falls/Sports Injuries**	Dates

Medications or Supplements (Use back if more space is needed)

Rx or Supplement	Date Started	Frequency & Dose	Prescribed By

Allergies

Type (Meds or food)	Allergen	Adverse Event Date	Prescription?

Health History

Circle any treatment you have already received for your condition?

Medication Surgery Physical Therapy Chiropractic None Other_____

Name and address of other doctor(s) who had treated you for your condition:_____

_____

Date of last: Physical Exam_____ Spinal X-Ray_____ Spinal Exam_____

MRI/CT/Bone Scan_____ Chest X-Ray_____ Urine Test_____

Are you pregnant? Yes No If Yes, what is the Date of your last menstrual period_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes No	COPD	Yes No	Liver Disease	Yes No	Rheumatoid Arthritis	Yes No
Alcoholism	Yes No	Diabetes	Yes No	Measles	Yes No	Rheumatic Fever	Yes No
Allergy Shots	Yes No	Emphysema	Yes No	Other	Yes No_____	Scarlet Fever	Yes No
Anemia	Yes No	Epilepsy	Yes No	Migraine Headaches	Yes No	STI	Yes No
Appendicitis	Yes No	Fractures	Yes No	Miscarriage	Yes No	Stroke	Yes No
Arthritis	Yes No	Glaucoma	Yes No	Mononucleosis	Yes No	Suicide Attempt	Yes No
Asthma	Yes No	Goiter	Yes No	Multiple Sclerosis	Yes No	Thyroid Problems	Yes No
Bleeding Disorders	Yes No	Gonorrhea	Yes No	Mumps	Yes No	Tonsillitis	Yes No
Breast Lump	Yes No	Gout	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Bronchitis	Yes No	Heart Disease	Yes No	Pacemaker	Yes No	Tumors	Yes No
Bulimia	Yes No	Hepatitis	Yes No	Parkinson's Disease	Yes No	Typhoid Fever	Yes No
Cancer	Yes No	Hernia	Yes No	Pinched Nerve	Yes No	Ulcers	Yes No
Cataracts	Yes No	Herniated Disc	Yes No	Pneumonia	Yes No	Whooping Cough	Yes No
Chemical Dependency	Yes No	Herpes	Yes No	Polio	Yes No		
Chicken Pox	Yes No	High Blood Press	Yes No	Prostate Problem	Yes No		
CAD	Yes No	High Cholesterol	Yes No	Prosthesis	Yes No		
CHF	Yes No	Kidney Disease	Yes No	Psychiatric Care	Yes No		

Patient's Name:_____ Date:_____

Is there a family history of:

Maternal/ Paternal	Relationship	Heart Disease	Arthritis	Cancer (Type)	Diabetes	Other	Deceased	Cause of Death

Attestation

I have reviewed the information on this questionnaire an it is accurate to the best of my knowledge. i understand that this information will be used by the chiropractor to hl determine appropriate and healthful chiropractic treatment. if there is any change in my medical status, I will inform the chiropractor.

_____ Date_____

Signature of Patient, Guardian or Personal Representative

_____ Relationship to Patient_____

Please print name of Patient, Guardian or Personal Representative

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Visual Pain Rating Scale

Please rate your pain/discomfort intensity in EACH category

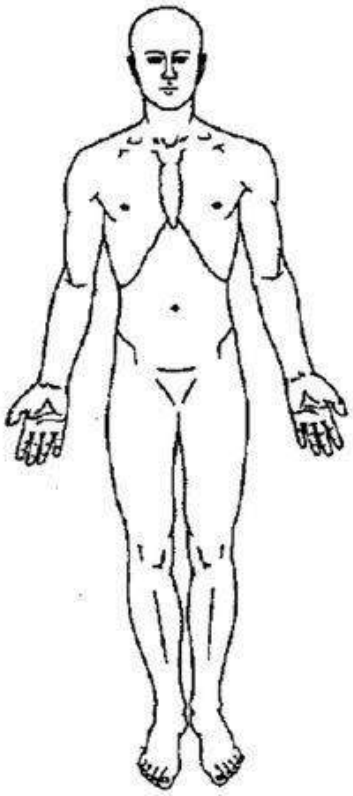
No Pain										Worst Pain	
0	1	2	3	4	5	6	7	8	9	10	Neck
0	1	2	3	4	5	6	7	8	9	10	Mid Back
0	1	2	3	4	5	6	7	8	9	10	Low Back

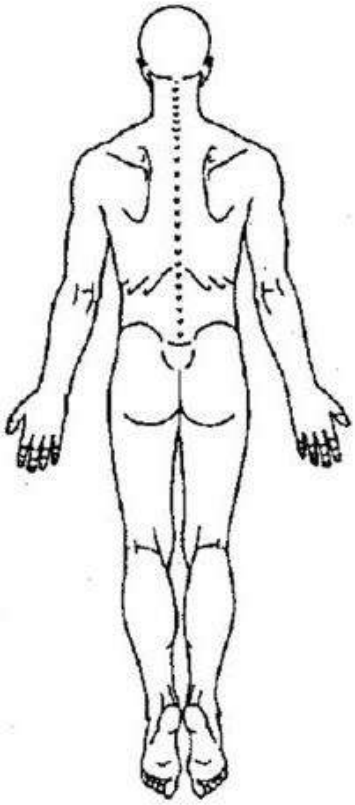
Pain Diagram

On the following diagram, indicate areas of pain/discomfort using these symbols:

Aching	Stabbing	Burning	Stiffness/Tightness	Pins & Needles	Numbness
xxxx	--------	^^^^^	///////	oooooo	******

Front





Back

Patient Name: _____ Today's Date: _____

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Informed Consent

Patient Name: _____

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

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 part of the analysis, examination and treatment, you are consenting to the following procedures:

__spinal manipulative therapy	__palpation	__vital signs
__range of motion testing	__orthopedics testing	__basic neurological testing
__muscle strength testing	__postural analysis	__EMS
__ultrasound	__hot/cold therapy	__radiological studies

__Other (please explain)_____

***Please initial each procedure you are consenting to**

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, discs 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 during 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 treatments 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 pain-killers
- Hospitalization
- Surgery

If you choose 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 doctor 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 APPROPIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Arianne and have had my questions answered to my satisfaction. By signing below I state that i have weighted 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.

Dated_____ **Dated**_____

_____ _____

Patient's Name **Doctor's Name**

_____ _____

Signature of Patient/Parent or Guardian (if minor) **Signature**

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Consent for Use and Disclosure of Health Information

Date of Consent: _____ Date of Birth: _____

Patient Name: _____ _____

By signing this form, I give this clinic, consent to use and/or disclose my protected health information (PHI) to carry out treatment, payment or health care operations.

I have the right not to sign this consent. If I refuse to sign this consent, this clinic may refuse to provide me with treatment until I consent.

This clinic has provided me with a copy of its Notice of Privacy Practices, which describes how this clinic may use and disclose my health information. I have the right to review this Notice before signing this consent.

This clinic may change the Notice of Privacy Practices as needed. I may obtain a current copy of this clinic's Notice of Privacy Practices by contacting this clinic's Privacy Officer.

I have the right to withdraw this consent at any time. I must do this in writing to this clinic. Note that my withdrawal of this consent will **NOT** be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then this clinic, by law, is unable to provide to me further treatment or follow-up, other than required emergency services.

This consent is good unless and until I withdraw it in writing.

_____

Signature of Patient or Legal Representative *Date*

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Notice of Privacy Practices - Abbreviated

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

How medical information about you may be used and disclosed and how you can access this information.

We may use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization. We are required to obtain your authorization for the sale of your protected health information (PHI) and marketing that results in direct or indirect payment from a third party for the communication.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we restrict certain uses and communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, notification of a breach of unsecured protected health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices, which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the bottom of this page indicated the date of the most current Notice in effect.

You have the right to receive a copy of our current Notice in effect. If you have not received a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your health information, please contact: Dr. Arianne Johnson-Calvopina of our office at 319-853-8592.

8/1/2020

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Acknowledgment of Privacy Practices

I acknowledge that a copy of this clinic's Notice of Privacy Practice's has been made available to me. I also understand that this Notice is available by request.

_____

Signature of Patient or Legal Representative *Date*

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READ THIS NOTICE, so you can make an informed decision about your care.

Due to the many changes in insurance, it is no longer an easy task to interpret individual policies therefore we urge you, the patient, to please check with your insurance company regarding your coverage. It is your responsibility to know your individual coverage and limitations. Failure to comply with this suggestion could result in you being responsible for all non-covered costs incurred. Please remember that your insurance policy is between you and your insurance company.

It you have a co payment or out-of-pocket expenses, deductible, etc, it must be paid at the time of the service.

Insurance may also be denied due to reaching maximum benefits due to number of visits or dollar maximums. Please call your insurance company and learn about your coverage. It may save you a lot of confusion and out of pocket expense. We will continue to assist you as we can.

BE AWARE, that **Medicare** and other **Health Care insurance** may not pay for everything, even care that you or your health care provider have good reason to think you need. Medicare and other Health Care insurance may deny payments for chiropractic services if it believes these services are for maintenance purposes. Some examples:

EXAM Medicare does not pay for this service $72-$111
THERAPY Medicare does not pay for this service $10-$40
MAINTENANCE ADJUSTMENT Medicare does not pay for this service $39-$55
REPORT OF FINDINGS Medicare does not pay for this service $20
VITAMINS/SUPPLEMENTS Medicare does not pay for this service $10-$100
PILLOWS, ICE PACKS Medicare does not pay for this service $8-$100
ORTHOTICS Medicare does not pay for this service $150-$250
ELECTRODES Medicare does not pay for this service $11
EXERCISES Medicare does not pay for this service $40

I understand that Medicare and other insurance companies may deny payment for chiropractic services depending on my insurance policy benefits. I am financially responsible for all charges whether or not paid by insurance.

Our office accepts **personal injury** accounts with the provision that you, the patient, have complete contact information available in order for us to bill **your** insurance company, through **your** personal injury protection/medical payments. OUR OFFICE DOES NOT ACCEPT “THIRD-PARTY” INSURANCE OR “LIENS”.

Signing below means that you have received and understand this notice.

_____ _____
Patients signature/Guardian Date