VIVICARE
CHIROPRACTIC
AND WELLNESS CENTER

Informed Consent to Chiropractic Treatment and Massage Therapy

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

_____ _____

Patient Signature (Legal Guardian) **Witness Signature**

_____ _____

Name (Please Print) **Name (Please Print)**

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent For Use of Health Information

Name:_____ Date:_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Dated this _____ day of _____, 20_____

By: _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State Law:

By: _____
Signature of Parent/Guardian (circle one)

<Authorization to Release Records >

To: _____
_____
_____
_____

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by him/her/them, all records and reports, including x-rays and photostatic copies, abstracts or excerpts of all records and any other information he/she/they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past or now have.

Please forward the reports and information requested to:

Dr. Nicole Kamau
4920 Roswell Road
Unit 39
Atlanta, GA 30342

_____ _____

Signature (Witness)
(Patient or Legal Representative)

_____
Printed Name

_____
Address

_____
City, State, Zip

Date: _____

Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST.

PATIENT INFORMATION

Today's Date:_____

Name:_____ DOB:_____ Age:_____
Address:_____City:_____State:_____Zip:_____
Email Address:_____
Home Phone #:_____ Work Phone #:_____ Cell Phone #:_____
Gender: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐Other: _____
Name of Spouse or Nearest Relative:_____
Occupation:_____ Employer:_____
Referred to this Office By: ☐ Friend/Family Member – Name:_____
☐ Yellow Pages ☐Mail ☐Clinic Location ☐Other:_____
Payment for Services will be by: ☐ Cash ☐ Check ☐ Credit Card ☐ Health Insurance
☐ Auto Insurance ☐Worker's Compensation
Name of Insurance Co.: _____ Insured's Employer:_____
Employer's Phone #: _____
Are you covered by more than one insurance company? ☐ Yes ☐No Name:_____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	Dislocated Joints	☐	☐	☐	Neck Pain
☐	☐	☐	Anemia	☐	☐	☐	Epilepsy	☐	☐	☐	Nervousness
☐	☐	☐	Arthritis	☐	☐	☐	German Measles	☐	☐	☐	Numbness
☐	☐	☐	Asthma	☐	☐	☐	Headaches	☐	☐	☐	Polio
☐	☐	☐	Back Pain	☐	☐	☐	Heart Trouble	☐	☐	☐	Poor Circulation
☐	☐	☐	Bladder Trouble	☐	☐	☐	Reproductive Trouble	☐	☐	☐	Hepatitis
☐	☐	☐	Bone Fracture	☐	☐	☐	High Blood Pressure	☐	☐	☐	Rheumatic Fever
☐	☐	☐	Cancer	☐	☐	☐	HIV/ARC	☐	☐	☐	Rheumatism
☐	☐	☐	Chest Pain	☐	☐	☐	Kidney Disorder	☐	☐	☐	Scarlet Fever
☐	☐	☐	Concussion	☐	☐	☐	Bowel Control Loss	☐	☐	☐	Serious Injury
☐	☐	☐	Convulsions	☐	☐	☐	Menstrual Cramps	☐	☐	☐	Sinus Trouble
☐	☐	☐	Diabetes	☐	☐	☐	Multiple Sclerosis	☐	☐	☐	Tuberculosis
☐	☐	☐	Indigestion	☐	☐	☐	Muscular Dystrophy	☐	☐	☐	Venereal Disease

Have you been treated by a physician for any health condition in the last year? ☐ Yes ☐ No

Describe Condition:_____ Date of Last Physical Exam:_____

Surgical History:

1._____ Date:_____
2._____ Date:_____
3._____ Date:_____

ACCIDENT HISTORY: ☐ Job ☐ Auto ☐ Other 1._____ Date:_____
☐ Job ☐ Auto ☐ Other 2._____ Date:_____
☐ Job ☐ Auto ☐ Other 3._____ Date:_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

(Please Rate your symptoms (1-10 with 1 being the least serious)

1._____ Rate:_____

2._____ Rate:_____

3._____ Rate:_____

4._____ Rate:_____

5._____ Rate:_____

6._____ Rate:_____

Symptoms are worse in: ☐ MORNING ☐ AFTERNOON ☐ NIGHT

When and How Occurred?_____

_____

Symptoms Developed from: ☐ Job Related Injury ☐ Auto Accident ☐ Unknown Cause
☐ Illness ☐Gradual Onset ☐Other:_____

Symptoms Have Persisted For #: _____Hour(s) _____Day(s) _____Week(s) _____Month(s) _____Year(s)
Symptoms/Complaints: ☐ Come & Go ☐ Are Constant
Have You ever had this before?: ☐ No ☐ Yes When?:_____
If you were to Guess, what do you think is causing your complaints?_____
_____

_____

Name and location of doctors previously seen for present condition(s):

_____

_____

Are you allergic to any medications?: ☐ No ☐ Yes What Kind?:_____
Are you taking any medications?: ☐ No ☐ Yes What Kind?:_____
Are you pregnant?: ☐No ☐Yes Date of Last Menstrual Period:_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT ***AGGRAVATE*** YOUR CONDITION:
☐Bending ☐Reaching ☐Straining at Stool ☐Coughing ☐Sitting ☐Turning Head
☐Lifting ☐Sneezing ☐Walking ☐Lying Down ☐Standing

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT ***RELIEVE*** YOUR CONDITION:
☐Bending ☐Sitting ☐Lifting ☐Standing ☐Lying Down ☐Reaching ☐Walking

Please Check any ***ADDITIONAL SYMPTOMS*** You may be experiencing:
☐Blurred Vision ☐Buzzing in Ears ☐Cold Feet ☐Cold Hands ☐Cold Sweats ☐Constipation
☐Concentration loss/Confusion ☐Depression/Weeping Spells ☐Diarrhea ☐Dizziness ☐Face Flushed
☐Fainting ☐Fever ☐head seems too heavy ☐Headaches ☐Insomnia ☐Light Bothers Eyes
☐Loss of Balance ☐Loss of Smell ☐Loss of Taste ☐Low Resistance to Colds ☐Muscle Jerking
☐Numbness in Fingers ☐Numbness in Toes ☐Pins and Needles in Arms ☐Pins and Needles in Legs
☐Ringing in Ears ☐Shortness of Breath ☐Stiff Neck ☐Upset Stomach

Patient's Signature:_____ Date:_____

VIVICARE
CHIROPRACTIC
AND WELLNESS CENTER

Credit/Debit Information

Name as it appears on card:_____

Card No.:_____

Expiration Date:_____

CVV code:_____

Billing Address:_____

_____

- 4920 Roswell Road, Unit 39, Atlanta, GA 30342 • Ph: (404) 963-1913 • Fax: (404) 963-1947

Email : info@vivicarechiropractic.com