NATURAL HEALING
OF TAMPA BAY

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. You may wait to ask questions of the doctor before you sign if there is anything that is unclear.

The Nature of Upper Cervical Chiropractic Therapy

One of the chiropractic treatment methods we use at Natural Healing of Tampa Bay is a percussion integument adjusting. We may use this procedure to treat you. We may use a table mounted mechanical instrument in such a way as to potentially move your joints using a percussive sound wave. This procedure is x-ray dependent and requires consenting to outpatient imaging.

The Nature of Traditional Chiropractic Therapy

One of the treatment methods used by most Chiropractic doctors is spine manipulative therapy. We may use this procedure to treat you. We may use a hand-held mechanical instrument or our hands upon your body in such a way as to potentially move your joints. That may cause an audible "pop" or "click", like the sound of "cracking" your knuckles.

Analysis/Examination/Treatment

As part of the analysis, examination and treatment, you are consenting to the following procedures:
manual palpation; range of motion testing; orthopedic testing; basic neurological testing; manual muscle strength testing; postural analysis testing; diagnostic x-ray; percussive instrument spinal adjusting; manual spinal manipulative therapy; soft tissue therapy; neuromuscular or rehabilitative exercise.

The Material Risks Inherent in Chiropractic Adjustment

As with any health care procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Some patients will feel some stiffness and soreness following the first few days of treatment. Rarer complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and friction burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading or contributing to serious complications including stroke, although these types of manipulation are never performed at Natural Healing of Tampa Bay. We 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 our attention, it is your responsibility to inform us.

The Probability of Those Risks Occurring

It is common for some patients to feel some stiffness and soreness following the first few days of treatment. Fractures are rare occurrences and generally result from some underlying weakness of the bone which will be checked for during the taking of your history and during examination and x-ray. 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 extremely rare.

The Availability of Other Treatment Options

Other treatment options for your condition may include (but are not limited to):

- Hospitalizations
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain killers
- Other styles of chiropractic therapy
- Physical Therapy
- Self-administered, over-the-counter analgesics and rest
- Surgery

If you choose to use 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 to Remaining Untreated

Remaining untreated may allow the degenerative process to continue complicating future treatment making it more difficult and less effective the longer it is postponed. Some conditions if left untreated for too long may require surgical interventions as conservative care is generally most effective.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE PREVIOUS INFORMATION. YOU MAY WAIT TO ASK THE DOCTOR QUESTIONS BEFORE SIGNING THIS FORM.

I have read the explanation of the chiropractic adjustment and related treatment. Any questions that I have were discussed with a doctor or staff member and have had my questions answered to my satisfaction. By signing below, I state 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 those treatments.**

Please check the boxes below if you **WOULD NOT** like to receive the following treatments. Leaving all the boxes blank states that you consent to all the following treatments.

- ❑ basic neurological testing
- ❑ diagnostic X-Ray
- ❑ manual muscle strength testing
- ❑ manual palpation
- ❑ manual spinal manipulative therapy
- ❑ neuromuscular or rehabilitative exercise
- ❑ percussive instrument
- ❑ postural analysis testing
- ❑ range of motion testing
- ❑ soft tissue therapy
- ❑ spinal adjusting

Date: _____ Date: _____

Patient's Name: _____ Doctor's Name: _____

Signature: _____ Signature: _____

IF UNDER 18

Patient's Name: _____

Parent or Guardian's Name: _____ Signature: _____

NATURAL HEALING OF TAMPA BAY

PATIENT INFORMATION RECORD

The following information is needed in order to better serve you. Please complete all questions.

Please Print

PERSONAL INFORMATION

Last Name:_____ First Name:_____ MI____

Birth Date:_____ Age:_____ Gender(circle): M F

Number of Children (if applicable):_____ Marital Status (circle): Married Single Widow

Home Phone:_____ Cell Phone:_____

Home Address:_____
Address City State Zip

Mailing Address (if different from above):_____
Address City State Zip

Email Address:_____

Place of Employment:_____ Occupation:_____

Employer Address:_____
Address City State Zip

EMERGENCY CONTACT INFORMATION

Last Name:_____ First Name:_____

Relationship to Patient:_____ Email:_____

Home Phone:_____ Cell Phone:_____

Referred by:_____

HEALTH HISTORY

Name:_____ Date:_____

Describe the major complaint(s) that brought you to our office:_____

List your current health problems:_____

List any other doctors seen, diagnoses, treatments and results obtained:_____

List your current Physician(s)/Therapist(s):_____

List all hospitalizations/surgeries and the dates:_____

List any traumas you have sustained and the dates:_____

List all medications and supplements that you are currently taking:_____

HEALTH HISTORY

List any food or medication allergies:_____

_____

_____

List any tobacco or prior drug abuse:_____

_____

Alcohol Use:_____

_____

Describe your exercise and activity habits:_____

_____

_____

_____

_____

Height:_____ Weight:_____ High Blood Pressure: Yes No

How many glasses of water do you drink per day?_____

FAMILY HISTORY

Father:	Age_____	Deceased:	Yes	No	Health:	Good	Fair	Poor
Mother:	Age_____	Deceased:	Yes	No	Health:	Good	Fair	Poor
Sister(s)	Age_____	Deceased:	Yes	No	Health:	Good	Fair	Poor
	Age_____	Deceased:	Yes	No	Health:	Good	Fair	Poor
Brother(s)	Age_____	Deceased:	Yes	No	Health:	Good	Fair	Poor
	Age_____	Deceased:	Yes	No	Health:	Good	Fair	Poor

Children:	Age_____	Health:	Good	Fair	Poor
	Age_____	Health:	Good	Fair	Poor
	Age_____	Health:	Good	Fair	Poor

HEALTH HISTORY

Please check all that apply

ARMS & HANDS
- ❑ Cold hands
- ❑ Pain in fingers
- ❑ Pain in forearm
- ❑ Pain in hands
- ❑ Pain in upper arm
- ❑ Swollen feet
- ❑ Swollen fingers
- ❑ Tingling in arms

HEAD
- ❑ Dizziness
- ❑ Frequent headaches
- ❑ Head feels heavy
- ❑ Injury/Concussion
- ❑ Light headedness
- ❑ Loss of balance
- ❑ Loss of grip strength
- ❑ Loss of hearing
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Severe headaches

NECK
- ❑ Grinding sounds in neck
- ❑ Mass in neck
- ❑ Muscle spasms in neck
- ❑ Neck feels out of place
- ❑ Pain in neck
- ❑ Pain w/movement
- ❑ Popping sounds in neck
- ❑ Previous neck injury
- ❑ Stiffness in neck
- ❑ Swelling in neck

SHOULDERS
- ❑ Can't raise arms
  - ○ Above head
  - ○ Above shoulder
- ❑ Muscle spasm
- ❑ Pain across shoulders
- ❑ Pain in shoulders

MID-BACK
- ❑ Dull ache
- ❑ Mid-back pain
- ❑ Pain between shoulders
- ❑ Pain from front to back
- ❑ Pain over kidney area
- ❑ Sharp stabbing pain

LOWER BACK
- ❑ Limited back movement
- ❑ Lower back feels out of place
- ❑ Lower back pain
- ❑ Muscle spasms
- ❑ Numbness/tingling down the legs
- ❑ Shooting pain down the legs

HIPS, LEGS, AND FEET
- ❑ Cold feet
- ❑ Knee pain
- ❑ Leg cramps
- ❑ Numbness in legs
- ❑ Numbness in toes
- ❑ Pain down leg
- ❑ Pain in buttocks
- ❑ Pain in hip
- ❑ Swollen ankles
- ❑ Tingling in legs

OTHER
- ❑ General body aches
- ❑ General weakness
- ❑ Osteoporosis
- ❑ Passing out

EARS
- ❑ Difficulty hearing
- ❑ Discharge from ear(s)
- ❑ Hearing Loss
- ❑ Pain in ear(s)
- ❑ Ringing in ear(s)
- ❑ Vertigo

EYES
- ❑ Blurred Vision
- ❑ Cataracts
- ❑ Double vision/vision changes
- ❑ Excessive itching
- ❑ Excessive tearing
- ❑ Eye fatigue
- ❑ Lack of tearing
- ❑ Light sensitivity
- ❑ Pain in eyeball

NOSE & SINUSES
- ❑ Allergies
- ❑ Frequent colds
- ❑ Loss of smell
- ❑ Nose bleeds
- ❑ Nose obstruction
- ❑ Pressure over eyes
- ❑ Sinusitis

MOUTH & THROAT
- ❑ Abscessed tooth
- ❑ Bleeding gums
- ❑ Difficulty swallowing
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Lesion in mouth
- ❑ Pain in throat

SKIN, HAIR, NAILS

- ❑ Baldness
- ❑ Bruise easily
- ❑ Dry skin
- ❑ Eczema
- ❑ Itchy skin
- ❑ Nail biting
- ❑ Oily skin
- ❑ Paper thin nails
- ❑ Rough, scaly skin
- ❑ Yellow skin

ENDOCRINE/HORMONAL

- ❑ Craving for sweets
- ❑ Diabetes
- ❑ Dry skin
- ❑ Easy bruising
- ❑ Fatigue (not alleviated by sleep)
- ❑ Hair thinning
- ❑ Hot or cold intolerance
- ❑ Increased susceptibility to infection
- ❑ Thyroid problems
- ❑ Weight gain
- ❑ Weight loss

RESPIRATORY

- ❑ Asthma
- ❑ Bronchitis
- ❑ Chronic cough
- ❑ COPD
- ❑ Coughing up blood
- ❑ Dry cough
- ❑ Productive cough
- ❑ Shortness of breath
- ❑ Sleep Apnea
- ❑ Tuberculosis
- ❑ Wheezing

CARDIOVASCULAR

- ❑ Angina/MI
- ❑ Area of numbness
- ❑ Blindness
- ❑ Blood vessel disease
- ❑ Blue or purple nail beds
- ❑ Blue or purple skin
- ❑ Blurred vision
- ❑ Burning sensations
- ❑ Chest pain
- ❑ Cold hands/feet
- ❑ Congestive heart failure
- ❑ Dizziness
- ❑ Double vision
- ❑ Fainting
- ❑ Family history of stroke
- ❑ General swelling
- ❑ Heart attack
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypertension
- ❑ Inability to form words
- ❑ Irregular heartbeat
- ❑ Loss of coordination
- ❑ Loss of memory
- ❑ Muscle weakness
- ❑ Pounding heartbeat
- ❑ Previous head injury
- ❑ Previous neck injury
- ❑ Rapid heartbeat and/or palpitations
- ❑ Stroke
- ❑ Swelling around eyes
- ❑ Swelling in face
- ❑ Swelling in legs
- ❑ Taking birth control pills
- ❑ TIA (mini stroke)

GASTROINTESTINAL

- ❑ Abdominal pain
- ❑ Blood in stool
- ❑ Change in bowel habits
- ❑ Constant nibbling
- ❑ Constipation
- ❑ Diarrhea
- ❑ Difficulty swallowing
- ❑ Gallbladder disease
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Indigestion
- ❑ Nausea & vomiting
- ❑ Pancreatitis
- ❑ Poor appetite
- ❑ Ulcers
- ❑ Vomiting blood

GENITOURINARY

- ❑ Bloody urine
- ❑ Chronic UTI's
- ❑ Cloudy urine
- ❑ Difficulty urinating
- ❑ Dribbling/Leaking
- ❑ Erectile dysfunction
- ❑ Frequent urination at night
- ❑ Intense desire to urinate
- ❑ Kidney failure
- ❑ Lack of control
- ❑ Pain in urination
- ❑ Prostatitis

Urination is:

- ❑ Frequent
- ❑ Not sufficient

The amount is:

- ❑ High
- ❑ Moderate
- ❑ Low

STD's

- ❑ Gonorrhea
- ❑ Syphillis
- ❑ Other

OB/GYN (Women)

- ❑ Breast discharge
- ❑ Breast Enlargement
- ❑ Breast Pain
- ❑ Hot flashes
- ❑ Irregular periods/menses
- ❑ Lumps in breast
- ❑ Painful periods
- ❑ Polycystic ovarian syndrome
- ❑ Premenstrual symptoms
- ❑ Prior breast biopsy
- ❑ Spotting
- ❑ Uterine fibroids

_____Age at menses
_____Age at menopause
_____# of pregnancies
_____# of deliveries

SYSTEMIC CONDITIONS

- ❑ AIDS/HIV
- ❑ Anemia
- ❑ Arthritis
- ❑ Cancer
- ❑ Chronic Fatigue
- ❑ Depression
- ❑ Diabetes
- ❑ Epilepsy/seizures
- ❑ Fibromyalgia
- ❑ Hypoglycemia
- ❑ Multiple sclerosis
- ❑ Parkinson's disease
- ❑ Polio
- ❑ Rheumatic arthritis
- ❑ Rheumatic fever
- ❑ Tuberculosis

SOCIAL/PSYCHOSOCIAL

- ❑ Alcohol use
- ❑ Anxiety
- ❑ Depression
- ❑ Drink coffee or tea
- ❑ Fatigue
- ❑ Generally, feel run down
- ❑ Insomnia/problems sleeping
- ❑ Irritability/mood swings
- ❑ Low sex drive
- ❑ Nervousness
- ❑ Other tobacco use
- ❑ Panic attacks
- ❑ Reduced tolerance for stress
- ❑ Smoking

My diet is:
- ❑ Balanced
- ❑ Not balanced

My family stress is:
- ❑ Severe
- ❑ High
- ❑ Moderate
- ❑ Minimal
- ❑ None

My job stress is:
- ❑ Severe
- ❑ High
- ❑ Moderate
- ❑ Minimal
- ❑ None

My sleep is:
- ❑ Sufficient
- ❑ Insufficient

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it CAREFULLY.

USES AND DISCLOSURES

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and/or providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health professionals who may provide treatment to you.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health care information may be used as necessary to support the day-to-day activities and management of Natural Healing of Tampa Bay. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement investigations and to comply with government-mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Require Your Authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo and use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information:

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders.

Information About your Treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Institute Duties. We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information. You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office at. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints. If you would like to submit a comment or complaint about our privacy practices or you believe that your privacy rights have been violated, you can send a letter outlining your concerns to:

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