FREITAG
FAMILY CHIROPRACTIC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

Freitag Family Chiropractic LLC is committed to patient privacy and the confidentiality of personal health information entrusted to us.

The ways in which we may use or disclose your health information are detailed in the Notice of Privacy Practices. You may request a copy of this form in our office or via email drgreg@freitagfamilychiropractic.com or on the Online Forms Page on our website www.freitagfamilychiropractic.com

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, we will provide you with a Limitation of Use and Disclosure of Protected Health Information Request form.

Your Right to Request that Your Patient Record be Amended: You have the right to request that we amend the information in your patient record. If you would like to amend any information in your record we will provide you with a Request to Amend Protected Health Information form.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, FREITAG FAMILY CHIROPRACTIC LLC WILL NOT BE ABLE TO DISCLOSE IMPORTANT INFORMATION TO OUTSIDE HEALTH CARE PROVIDERS IN THE EVENT OF AN EMERGENCY OR COORDINATION OF CARE.

Initial here [ ] I acknowledge receipt/review of the Freitag Family Chiropractic - Notice of Privacy Practices.

By signing below, I give consent to Freitag Family Chiropractic clinicians or staff to use or disclose my personal health information as noted in the Notice of Privacy Practices.

Patient Printed Name _____ Date ____ / _____ /_____

Patient Signature _____

Guardian Name & Relationship _____ Date ____ / _____ / _____

Guardian Signature_____

Legal Name _____

Preferred Name _____

Address _____

_____

City _____ State _____ Zip _____

Cell # _____

Home # _____

Names of Parents/Guardians _____

Current Medications/Vitamins:

☐ Antibiotics
During past 6 months: _____ Total in lifetime: _____

☐ Prescription Medications
Type/Purpose: _____

☐ Other(s): _____

How did you hear about our office?

☐ Google ☐ Social Media ☐ Referral: ☐ Other:

Referral/Other_____

FREITAG FAMILY CHIROPRACTIC

Birth Date ___/____/____ Appt. Date___/____/____

☐ Male ☐ Female Height _____

Weight_____

Pediatrician _____

Date of last visit _____

Reason_____

Has your child been treated by a chiropractor before?

☐ No ☐ Yes, Approx. date of last visit _____

PRIMARY COMPLAINT/CONCERN: _____

_____

When did this begin _____

What caused this _____

Since onset this has: ☐ Stayed the same ☐ Gotten worse
☐ Gotten better ☐ Comes and goes

What makes this better?

_____

What makes this worse?

_____

Has this occurred before? ☐ No ☐ Yes; explain:

_____

Have you had any past treatment for this concern?

☐ No. ☐ Yes, treatment: _____

Results: _____

Average Pain Intensity on a Scale of 0-10:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Does this discomfort travel/radiate anywhere?

☐ No. ☐ Yes; where? _____

Has this happened before? ☐ No. ☐ Yes; when _____

Describe this discomfort (mark all that apply):

☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Burning
☐ Sharp ☐ Throbbing ☐ Stabbing Needles ☐ Dull ☐ Achy
☐ Pins and Needles ☐ Tension

How often does this discomfort occur?

☐ Constant (76-100% of the time) ☐ Frequent (51-75%)
☐ Occasional (26-50%). ☐ Intermittent (0-25%)

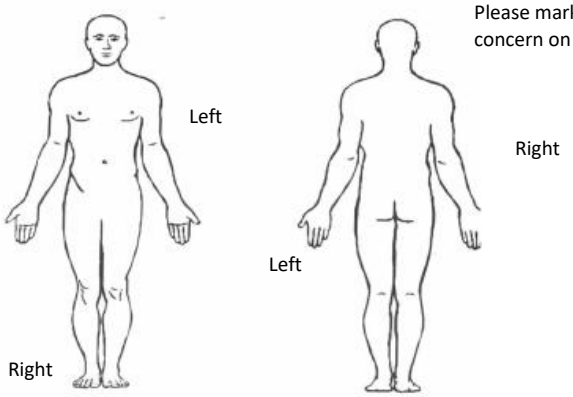
Does this interfere with:

☐ Daily routine ☐ School ☐ Sleep ☐ Other activities
Please explain: _____

How do these symptoms impact your daily activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Please mark areas of concern on diagram



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GENERAL HEALTH HISTORY

Please indicate if your child has had or currently have any of the following

Past	Present		Past	Present		Past	Present	
☐	☐	Ear infections	☐	☐	ADD/ADHD	☐	☐	Cancer _____
☐	☐	Chronic colds	☐	☐	Temper Tantrums	☐	☐	Vision Problems
☐	☐	Recurring fevers	☐	☐	Headaches	☐	☐	Dental or Jaw Problems
☐	☐	Asthma	☐	☐	Genetic Disorders	☐	☐	Chronic Constipation
☐	☐	Scoliosis	☐	☐	Accidents/Trauma	☐	☐	Chronic Diarrhea
☐	☐	Allergies			(falls, auto accidents, etc.)	☐	☐	Feeding/Eating Problems
☐	☐	Colic	☐	☐	Hearing Problems	☐	☐	Hospitalizations
☐	☐	Digestive problems	☐	☐	Trouble Sleeping	☐	☐	Major Illnesses
☐	☐	Bed wetting	☐	☐	Depression	☐	☐	Recurring Illnesses
☐	☐	Seizures	☐	☐	Anxiety	☐	☐	Surgeries
☐	☐	Diabetes	☐	☐	Fainting	☐	☐	Other _____

Additional Information to any checked boxes: _____

_____

_____

Newborn History:

Weight at birth: _____ Delivery Method: ☐ Vaginal ☐ C-section Forceps of vacuum used? ☐ Yes ☐ No

Born more than 2 weeks early? ☐ Yes ☐ No Born more than 2 weeks late? ☐ Yes ☐ No

Was/Is the child breast fed? ☐ Yes ☐ No. Age breastfeeding discontinued: _____

FAMILY HEALTH HISTORY

Please check each of the health conditions that a family member has now or has had in the past

Mother	☐ Headaches	☐ Diabetes	☐ Asthma	☐ Heart Disease	☐ Stroke	☐ Cancer	☐ Drug/Alcohol abuse	☐Depression	☐ Arthritis
Father	☐ Headaches	☐ Diabetes	☐ Asthma	☐ Heart Disease	☐ Stroke	☐ Cancer	☐ Drug/Alcohol abuse	☐Depression	☐ Arthritis
Grandmother	☐ Headaches	☐ Diabetes	☐ Asthma	☐ Heart Disease	☐ Stroke	☐ Cancer	☐ Drug/Alcohol abuse	☐Depression	☐ Arthritis
Grandfather	☐ Headaches	☐ Diabetes	☐ Asthma	☐ Heart Disease	☐ Stroke	☐ Cancer	☐ Drug/Alcohol abuse	☐Depression	☐ Arthritis
Sibling(s)	☐ Headaches	☐ Diabetes	☐ Asthma	☐ Heart Disease	☐ Stroke	☐ Cancer	☐ Drug/Alcohol abuse	☐Depression	☐ Arthritis

Any other family history? _____

PATIENT AUTHORIZATION

The statements made on this form are accurate to the best of my knowledge, and I hereby authorize this office and its Doctor to administer care to my son/daughter as deemed necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. I understand that health and accident insurance policies are an arrangement between myself and my insurance provider. The office does not work with insurance companies directly. If requested, documentation will be provided to me in order to submit the claims directly to my insurance company for reimbursement. In the event that an account become delinquent and a collection agency and/or law office is needed to collect on the account, the patient is responsible for all collection costs and/or attorney fees.

Parent/Guardian Signature: _____ Date: _____

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INFORMED CONSENT TO CHIROPRACTIC CARE

The nature of chiropractic treatment: We provide adjustments or manual manipulations through the gentle application of a targeted movement, applied by hand or with an adjusting instrument, where and when indicated by a licensed Doctor of Chiropractic to restore and improve motion of the body's spinal column and extremities.

Chiropractic treatment, including spinal and extremity adjustment, has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Routine chiropractic treatment can result in improved musculoskeletal function, improved joint motion, and a healthier, more active lifestyle.

Common alternatives to adjustments and manipulations include medications, physical therapy, other medical treatments and surgery provided by physicians and surgeons. The risk of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and surgical procedures given for the same conditions.

However, there are some risks associated with chiropractic adjustments including, but not limited to the following:

1. Temporary soreness or increased symptoms or pain. While chiropractic treatment usually results in pain relief, it is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.

2. Bruising. While chiropractic manipulation or adjustment is usually well tolerated by most patients, there is a risk of mild bruising at the contact point between the doctor's hand or adjusting instrument and the patient's body. Please inform the doctor if you are on a blood thinner or if you bleed or bruise easily and modifications will be made to prevent bruising.

3. Dizziness, nausea, flushing. These symptoms are relatively rare and usually subside within a few minutes. It is important to notify the chiropractor if you experience these symptoms during or after your care.

4. Strains, sprains, dislocations or fractures. When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with such a condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risks of fracture.

5. Disc herniation or prolapse. Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

6. Stroke. A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before or during their stroke.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

----------● PATIENT PLEASE REVIEW ● PRINT & SIGN NAME ●----------

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

Patient Printed Name: _____

Patient (or Guardian) **Signature**: _____ **Date:** _____

Description of Guardian's relationship/authority: _____

Doctor of Chiropractic (DC): _____

Signature of DC: _____ **Date:** _____

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