Haggard Chiropractic
9675 W Camelback Rd
Phoenix, AZ 85037
623-849-8000

Patient Intake Form

Welcome to our office of chiropractic. Thank you for taking a moment to fill in our ***Patient Intake Form***. Please fill this form completely and to the best of your knowledge. Let our staff know if you have any questions. When complete return it to our office with the bottom authorization checked and appropriate signatures filled in.

Patient Information

Personal Information

*First Name: _____
Middle Name: _____
*Last Name: _____
*Gender: ○ Female ○ Male
*Date of Birth: _____
Social Security #: ___ ___ ____
Height: Feet Inches
Weight: _____
Marital Status: [ ]
Spouse's Name: _____
Number of Children: [ ]

Emergency Contact: _____
Relationship: _____
Phone: _____

Contact Information

*Email: _____

(We will NOT share your email with any third party. We will only use your email to contact you in relation to your care with our practice.)

*Home Phone: _____
Cell Phone: _____
Work Phone: _____

Country: United States
Address Line 1: _____
Address Line 2: _____
City: _____
State/Province/Region: [ ]
*Zip/Postal Code: _____

How did you find out about our office?

Referring Physician: _____
Referring Patient: _____
Referred by: _____

Did you hear about our office from an advertisement?

○ No ○ Yes

If Yes, Where:

Did you hear about our office from a phone or professional directory?

○ No ○ Yes

If Yes, Where:

Employment Information

Regular Work Status:
Employer Name:
Employer Address:
Employer City:
Employer State:
Employer Zip:
Occupation:
Supervisor Name:
Supervisor Phone/Extension:
Physical Work Duties:

What is the purpose of your visit?

○ Wellness ○ Complaint ○ Injury ○ Other

Insurance & Payment for Care

How do you plan to pay for care?

○ Personal Insurance ○ Third-Party Insurance ○ No Insurance, Self-Pay

Name of Party Responsible for Payment:
Responsible Party Phone:

Primary Insurance

Insurance Name:
Phone:
Address:
City:
State:
Zip:
ID/Policy #:
Group #:
Insured's Name:

Secondary Insurance

Insurance Name:
Phone:
Address:
City:
State:
Zip:
ID/Policy #:
Group #:
Insured's Name:

Insured's Date of Birth: _____

Insured's Date of Birth: _____

If an auto accident, please provide:

Claim #: _____

Insurance Contact Person: _____

Insurance Phone: _____

Attorney's Full Name: _____

Attorney's Phone: _____

Authorization

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

* ☐ **I agree with this statement of authorization**

Name of the Insured: _____
(Please Print)

Patient's/Guardian's signature: _____ **Date:** _____

Signature

Clear Signature

Haggard Chiropractic

Informed Consent for Care

TO THE PATIENT: *We want you to be informed about your condition and the recommended chiropractic manipulations and other possible therapeutic procedures utilized in this practice in order for you to make an educated decision whether or not to undergo the procedure after knowing the alternatives and potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the therapeutic procedures.*

Safety of Manipulation

"Chiropractic care in general is safe when employed skillfully and appropriately. Manipulation is regarded as relatively safe, but as with all therapeutic interventions, complications can arise, and it has known adverse effects, risks and contraindications."

"Spinal manipulation is associated with frequent, mild and temporary adverse effects, including new or worsening pain or stiffness in the affected region. They have been estimated to occur in 33% to 61% of patients, and frequently occur within an hour of treatment and disappear within 24 to 48 hours; adverse reactions appear to be more common following manipulation than mobilization."

"Rarely, spinal manipulation, particularly on the upper spine, can also result in complications that can lead to permanent disability or death; these can occur in adults and children. Estimates vary widely for the incidence of these complications, and the actual incidence is unknown, due to high levels of underreporting and to the difficulty of linking manipulation to adverse effects such as stroke, which is a particular concern. Estimates for serious adverse events vary from 5 strokes in 100,000 manipulations to 1.46 serious adverse events in 10,000,000 manipulations and 2.68 deaths in 10,000,000 manipulations. Several case reports show temporal associations between interventions and potentially serious complications."[1]

K-Laser

The K-Laser is a high-powered therapy laser approved by the FDA for the temporary relief of pain and reduction of symptoms associated with mild arthritis and muscle pain. Adverse effects of laser therapy may occur from multiple causes including hypersensitivity, pre-existing health conditions, thermal effects, excessive pressure from the probe and laser over-stimulation. The most common adverse effects are temporary increase in pain during application of laser, temporary increase in pain the following day after laser therapy, mild bruising from vasodilation or direct pressure of laser tip, temporary dizziness and reactions when photosensitizing drugs are used with laser therapy. In addition, laser light can damage the retina in the eye. Safety glasses are provided during these treatments to specifically block the wavelengths of light

[1] Chiropractic. (n.d.). In *Wikipedia*. Retrieved May 8, 2011, from http://en.wikipedia.org/wiki/Chiropractic

produced by the K-Laser. Pain relief from laser therapy varies from insignificant to substantial and improvements may last hours, days or weeks.

Massage Therapy

Massage therapy is generally safe although it can dangerously aggravate certain health conditions. People with pre-existing cardiovascular diseases, such as swollen blood vessels, blood clots and heart disease, may be at high risk for blood clots to move during massage. Common adverse effects are temporary increase in pain during the massage, bruising, soreness and skin irritation.

Mechanical Traction

Mechanical traction may be utilized to stimulate a therapeutic change in range of motion, flexibility, kinesthetic sense, posture, pain and proprioception. Thus, it is common for mechanical traction to result in a temporary increase of soreness in the area being treated. Other adverse effects include temporary increase in pain during traction and skin irritation or bruising at harness or strap contact areas. Although this clinic may utilize mechanical traction, we make no claims that powered traction devices are more effective than other forms of traction, other conservative treatments or surgery. The incorporation of mechanical traction into a comprehensive treatment program simply reflects the doctor's preference and style of clinical practice.

Consent

I hereby request and consent to the performance of chiropractic manipulation and other therapeutic procedures, on me by Haggard Chiropractic including other licensed Doctors of Chiropractic, chiropractic assistants or massage therapists working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for Haggard Chiropractic.

I have had the opportunity to discuss with a Doctor of Chiropractic, my diagnosis, the nature and purpose of chiropractic manipulation and other procedures as well as alternatives to chiropractic care.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

Haggard Chiropractic

Privacy Practices

As required by the Privacy Regulations, I hereby acknowledge that I have had the opportunity to review Haggard Chiropractic's privacy practices and have a staff member explain them to my satisfaction.

I, _____, have read or have had read to me and
(print name)
fully understand the above Informed Consent. I have also had an opportunity to ask questions, and all my questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I therefore consent to chiropractic care.

_____ _____
Signature Date

Haggard Chiropractic

Informed Consent for Diagnostic Imaging

Doctors of Chiropractic, like other primary care providers, often utilize diagnostic imaging techniques that depend on ionizing radiation such as X-rays and CT scans. Although examinations involving radiation are an accepted and fundamental part of medical practice, it is important to remember that the health hazards of radiation are cumulative. The Biological Effects of Ionizing Radiation (BEIR VII) 2005 report from the National Academy of Sciences concludes that even low doses of ionizing radiation are dangerous and that there are no safe limits. Given the potential risks associated with conventional radiography, this clinic follows evidence-based practice guidelines for diagnostic imaging.[1]

For Female Patients – Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Consent

I, _____, have read or have had read to me and
(print name)
fully understand the above Informed Consent. I have also had an opportunity to ask questions, and all my questions regarding the doctor's diagnostic procedures utilized in this office have been answered to my complete satisfaction. I intend this consent form to cover any diagnostic procedures during the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I therefore consent to the performance of diagnostic X-rays, any other recommended imaging and physical exam procedures.

_____ _____
Signature Date

[1] Bussieres, A. E., C. Peterson, et al. (2007). "Diagnostic imaging practice guidelines for musculoskeletal complaints in adults--an evidence-based approach: introduction." J Manipulative Physiol Ther **30**(9): 617-683.