BACK TO HEALTH CHIROPRACTIC
2504 Monroe Street, LaPorte, IN 46350
PH: (219) 326-5100 FX: (219) 326-0180

Application for Shoulder Treatment

WELCOME TO BACK TO HEALTH CHIROPRACTIC!
Please complete this questionnaire as thoroughly as possible. This confidential history will be part of your permanent medical records and will help us get a better understanding of your health needs. THANK YOU!

PERSONAL INFORMATION

Patient Legal Name: _____ **Date:** _____/_____/_____
Date of Birth: _____/_____/_____ **Age:** _____ **Sex:** ❑ Male ❑ Female **Marital Status:** S / M / D / W
SSN: _____/_____/_____ **Home Phone:** (_____) _____-_____ **Cell Phone:** (_____) _____-_____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Email: _____ **Occupation:** _____
Employer Name/City: _____ **Work Phone:** (_____) _____-_____
Spouse or Guardian's Name: _____ **Spouse Date of Birth:** _____/_____/_____
Emergency Contact: _____ **Phone:** (_____) _____-_____
Any Family/Friend Involved in Your Health/Financial Decisions (Name): _____
Whom May We Thank for Referring You to Us? _____
How Else Did You Hear About Us? ❑ TV ❑ Facebook ❑ Seminar ❑ Mailer ❑ Radio ❑ Other

PRIMARY COMPLAINT – HPI (HISTORY OF PRESENT ILLNESS)

What is Your MAIN SYMPTOM? _____
Location (Where is your main symptom?): _____
Quality (Describe this symptom): _____
Duration (When did this symptom start?): _____
Cause (What started this symptom?): _____
Severity (How severe is this symptom?): _____
Frequency (How often is symptom?): ❑Constant (75-100%) ❑Frequent (50-74%) ❑Occasional (25-49%) ❑Intermittent (24% or less)
Timing (Worse in morning, night, constant?): _____
Change (Getting better, worse, same over time?): _____
Relieving Factors (What activities make it better?): _____
Aggravating Factors (What activities make it worse?): _____
Radiation (Other body areas affected by this pain/problem?): _____

In Addition To the Above Information, How Would You Describe Your Symptoms:

❑ Aching Pain	❑ Burning	❑ Tingling	❑ Numbness	❑ Pins & Needles
❑ Grinding	❑ Soreness	❑ Cramping	❑ Dead Feeling	❑ Electric Shocks
❑ Throbbing	❑ Hot Sensation	❑ Swelling	❑ Sharp/Stabbing	❑ Heavy/Weak Feeling

Please list health complaints you are having currently and mark location(s) on the diagram using the "Key". Then indicate below the severity of the symptom(s) from 1 to 10 with 10 being worst.

	No Pain ▼									Worst Pain ▼
Main Complaint:										
1)_____	1	2	3	4	5	6	7	8	9	10
Additional Health Complaints										
2)_____	1	2	3	4	5	6	7	8	9	10
3)_____	1	2	3	4	5	6	7	8	9	10

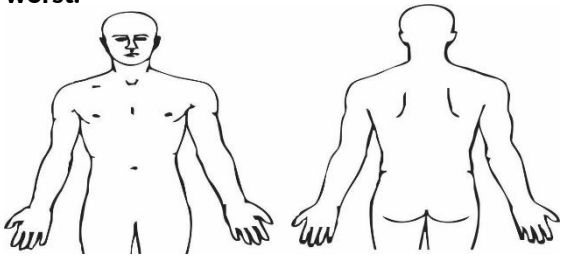

Diagram Key: A=Ache, B=Burning, N=Numbness, P=Pin & Needles, S=Sharp

Doctor Signature: Matthew C. Kirkham, DC, CCSP Date: _____/_____/20_____

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Patient Name: _____ Date: _____/_____/ 20_____

PAST MEDICAL HISTORY

Height: _____ft. _____in. **Current Weight:** _____lbs. **Recently Lost or Gained More Than 10 lbs?** ❑Yes ❑No
Family Medical Doctor: _____ **Last Physical Exam Date?** _____
Have You Seen Other Physicians/Therapists for THIS Shoulder Condition? ❑Yes ❑No
If Yes, List All Doctors or Therapists Consulted for THIS Condition (include approximate dates and diagnosis).
Provider Name: _____ Date of Visit: _____ Diagnosis: _____
Provider Name: _____ Date of Visit: _____ Diagnosis: _____
May We Communicate Our Findings on Your Current Health Condition to The Above Providers? ❑Yes ❑No
On a Scale of 1-10, How Serious and Committed Are You About Taking Care of This Concern/Condition? _____
Have You Been Diagnosed with Shoulder Degeneration/Arthritis? ❑Yes ❑No **If Yes, What Stage?** _____
Have You Been Diagnosed with Shoulder Rotator Cuff Tear? ❑Yes ❑No **If Yes, What Grade?** _____
Have You Tried Physical Therapy? ❑Yes ❑No **If Yes, When/Results?** _____
Have You Tried Steroid/Cortisone Injection(s)? ❑Yes ❑No **If Yes, When/How Many?** _____
Have You Had an MRI Performed on Shoulder or Arms? ❑Yes ❑No **If Yes, When?** _____
Do You Have a Pacemaker/Defibrillator? ❑Yes ❑No **Spinal or Bladder Stimulator?** ❑Yes ❑No
Have You Tried Chiropractic Care? ❑No ❑Yes: When? _____ Satisfied with Care? ❑Yes ❑No

ACTIVITIES OF DAILY LIVING

Work Status: ❑Employed ❑Unemployed ❑Retired ❑Disabled ❑Student ❑Stay-at-home ❑Other: _____
What Daily Activities Has Your Primary Condition Affected?

❑ Raising Arm	❑ Changing Positions	❑ Climbing Stairs	❑ Driving	❑ Lifting
❑ Household Chores	❑ Computer Use	❑ Sleeping	❑ Sitting	❑ Standing
❑ Walking	❑ Getting Dressed	❑ Yard Work	❑ Arising	❑ Exercising

How Has Your Shoulder Pain Affected Recreational Activities/Hobbies? _____
_____
Alcohol: ❑Never ❑Rarely ❑Mod ❑Daily ❑Former User **Tobacco:** ❑Never ❑Rarely ❑Mod ❑Daily ❑Formerly

MEDICATIONS AND PAST TREATMENT

Are You Currently Taking Blood Thinners? ❑Yes ❑No **Taking a Statin?** ❑Yes ❑No
Have You Tried Anti-Inflammatory and/or Pain Medication for at Least 3 Months? ❑Yes ❑No
Which of the Following Have You Used To Try To Relieve Your Symptoms:

❑ Advil / Ibuprofen	❑ Aleve / Naproxen	❑ Meloxicam	❑ CBD / Hemp Products
❑ Capsaicin Creams	❑ Cymbalta	❑ Gabapentin	❑ Tylenol / Acetaminophen
❑ Injections	❑ Tramadol	❑ Motrin	❑ Massage Therapy
❑ Voltaren	❑ Opioids	❑ Celebrex	❑ Muscle Relaxants

❑ Other Medications or Treatment: _____
_____
Have the Things You Have Tried So Far Helped? ❑Yes, a lot ❑A little ❑Not at all ❑Made worse ❑Unsure

PAST HOSPITALIZATIONS & SURGERIES

Please Indicate If You Have Had the Following Surgeries: ❑ NO PRIOR HOSPITALIZATIONS OR SURGERIES

❑ Shoulder Repair	Date: _____	❑ Elbow Surgery	Date: _____
❑ Shoulder Replacement	Date: _____	❑ Wrist Surgery	Date: _____
❑ Neck Surgery	Date: _____	❑ Hand Surgery	Date: _____

Any Other Past Hospitalizations and Surgeries: _____

Doctor Signature: Matthew C. Kirkham, DC, CCSP Date: _____/_____/20_____

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PAST INJURIES

List Any Major Past Injuries (Falls, Auto Accidents, Head Injuries, etc.)**:** _____

_____

_____

QUALITY OF LIFE QUESTIONS

What Do You Feel Your Life Will Be Like in the Next Few Years If This Problem Continues To Get Worse?

_____

How Would Your Life Be Different If You No Longer Had This Problem or It Were To Improve?

_____

What Would Need To Happen in Order For You To Consider Your Treatments Here To Be Successful?

_____

INFORMED CONSENT TO EXAMINATION & TREATMENT & SIGNATURE OF RESPONSIBLE PARTY

Welcome to our Clinic! To ensure transparency and mutual understanding, we require all patients to review and sign the following documents before commencing treatment. These documents are designed to inform you about the nature of the services provided, your rights, and the confidentiality of your health information.

Informed Consent is a process through which you acknowledge understanding the nature, benefits, risks, and alternatives of the proposed chiropractic and therapy treatments. It is essential for establishing a trusting patient-doctor relationship. By signing this document, you agree to the performance of, and authorize and release the doctor and whomever he may designate as his assistants to administer consultation, physical examination, vitals, X-ray studies, treatment, spinal decompression therapy, physical therapy, laser and/or red light therapy, shockwave therapy, muscle rebalance therapy, or any other clinical services that he deems necessary to my case on me or the patient named below for whom I am legally responsible.

Chiropractic care is the specific movement of joints by hand or with an adjusting instrument. Spinal decompression is a specific treatment for spinal disc issues using an intermittent traction machine. Physical therapy consists of active rehab exercise instruction, as well as therapeutic modalities such as laser therapy, red-light therapy, and shockwave therapy used to decrease inflammation, improved circulation, and speed the healing process. In our office, trained assistants may be utilized to assist the doctor with portions of your care including consultation, examination, decompression treatment, therapy and exercise instruction. On the occasion when your doctor is unavailable, your care may be handled by another doctor or trained assistants that he authorized to act on his behalf.

NO ASSURANCE OF RESULT OR GUARANTEE: Chiropractic care, spinal decompression, and physical therapy are systems of healthcare delivery. As with any healthcare delivery system, we cannot promise or guarantee positive resolution or cure for your symptoms, disease, or conditions. We strive to provide you with personalized quality care, and if your symptoms, disease, or conditions are not improving, we will refer you to another healthcare provider.

RISKS: Every form of healthcare is associated with risk, including chiropractic care, spinal decompression, and physical therapy. We want you to be informed about any potential, although rare, problems associated with chiropractic care, spinal decompression, and physical therapy. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some potential risks to treatment, including but not limited to bone fractures, disc injuries, strokes, dislocations, sprain/strain injuries, and muscle soreness. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of treatment which the doctor feels, at the time based upon the facts then known to him, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content. By signing below, I agree to the above name procedures. 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.

The questionnaire has been completed by me and accurately answered to the best of my knowledge. It is my responsibility throughout the course of any future recommended treatment to inform this doctor's office of any changes in my medical status. I also authorize the healthcare staff of this office to perform any necessary services I may need today and in the future.

Patient Name Printed: _____ Date of Birth: _____/_____/_____

Patient, Parent or Guardian Signature: X_____ Date: _____/_____/_____

Doctor Signature: Matthew C. Kirkham, DC, CCSP Date: _____/_____/20_____

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Acknowledgments, Agreements and Authorizations

HIPAA/PATIENT HEALTH INFORMATION CONSENT / HIPAA NOTICE OF PRIVACY PRACTICES

We want you to know your Patient Health Information (PHI) is going to be used in this office and what your rights are concerning those records. Before we begin any healthcare operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. By signing below, you acknowledge receipt of a copy of Back to Health Wellness Center Privacy Notice, Disclosure of Ownership Interest, and Statement of Patient Rights & Responsibilities.

X_____ initials

HIPAA (PHI) Authorized Representatives

Your privacy is of utmost importance to us. If you are over age 18, you are the only one our office is authorized to communicate with regarding any aspect of your care, including appointments, finances, and billing. Please list anyone you are authorizing to obtain verbal medical information about you, including your spouse or anyone else you authorize. If you do not list anyone below, then you will remain the only one authorized for office to communicate with.

Name of Authorized Representative	Phone Number	Relationship to You
1.		
2.		

OFFICE FINANCIAL POLICY & INSURANCE INFORMATION

The financial policy of this office in regards to insurance companies is intended to provide the highest quality comprehensive healthcare that gets results - without the limitations and restrictions that insurance companies dictate on network providers. The patient is responsible for making payment for 100% of any services rendered. All charges for recommended care will be presented to me before any services are rendered, and I can choose at that time whether or not to proceed. All payment will be collected at the time of each visit, unless other arrangements are made between the patient and this office. This office is not a participating provider for any insurance companies and therefore does not file any charges directly to them. However, if the patient chooses to file their insurance, this office will provide the necessary documentation to have the insurance company reimburse the patient directly for some basic chiropractic services; however, our office does not know what type of coverage may be provided until the patient is seen by the doctor and is given a diagnosis. This office will not enter into any dispute with a patient's insurance provider. If there is an issue, it is the responsibility of the patient to contact the insurance carrier for a resolution. This office will make payment plan arrangements on an individual basis in attempt to make care affordable for any patient. Any such plan or arrangement will be discussed during the Report of Findings next visit before any further services are rendered after this first visit.

Signing below, you acknowledge the above policy statements regarding HIPAA and office financial policy:

Patient Name Printed: _____ Date of Birth: _____/_____/_____

Patient, Parent or Guardian Signature: X_____ Date: _____/_____/_____

CONSENT FOR APPOINTMENT REMINDERS & OTHER COMMUNICATION

We have the ability to call, email or text you, reminding you of your scheduled appointments in our office. Patients in our practice may be contacted via phone, text message or email to be reminded of an appointment, to obtain feedback on an experience within our office, to view and obtain your personal health information in a secure way, test results, and to provide general health reminders and office information. **Your information will never be sold and will only be used for direct communication between our office and you.**

Phone Number for VOICE COMMUNICATION: (_____) _____ - _____

Phone Number for TEXT COMMUNICATION: (_____) _____ - _____

E-mail for EMAIL COMMUNICATION: _____

I understand that this request to receive phone calls, emails and/or text messages from our office to you will apply to all future appointment reminders, feedback, health information unless I request a change in writing. By signing below, you consent to the above approved communication methods.

Patient/Guardian Signature: X_____ Date: _____/_____/_____