Riverbend Chiropractic
New Patient Questionnaire

Patient Information

Patient I.D. _____

Please Print

Name_____ Date_____ SS#_____

Address_____City_____ State_____ Zip_____

Seasonal Address_____City_____ State_____ Zip_____

❑Male ❑Female ❑Married ❑Single ❑Widowed ❑Divorced ❑Separated

Birthdate_____ Home Phone_____ Cell_____

Work Phone_____ E-mail Address_____

Employer_____ Occupation_____ #years_____

Business Address_____City_____ State_____ Zip_____

Spouse or Parent's Name_____ Birthdate_____ Phone _____

Emergency Contact_____ Phone _____ Relation_____

Whom may we thank for referring you to us? _____

Did you see our Newspaper Flyer?_____ Yellow Page Ad? _____ Other?_____

Name of local primary Physician_____ May we contact them?____

Insurance Information – *If Insured, Please provide copy of insurance card*

SYMPTOMS

Main Complaint_____ How Bad?_____ How Often?_____

When did it start?_____Getting Worse?_____Getting Better?_____

What activity bothers it the most? _____

When is it at its best?_____ When is it at its worst?_____

Rate the pain - (0 is pain free - 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10

Other Chiropractors?_____ Positive Experience?_____

Other type of physician or therapist?_____ Positive Experience?_____

Secondary Complaint_____

Health History - *Please circle all that apply*

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M. S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V. D.	Whooping Cough	
Chronic Fatigue	High Blood Pressure		Fibromyalgia	Other_____			

Women - How many children?_____Pregnant?_____Date of last Menstrual Cycle_____

Nursing?_____Taking Birth Control Pills?_____

Previous Surgeries and Dates? _____

_____

List ALL Medications you are currently taking _____

_____

What kind of exercise do you do? _____

What supplements do you take?_____

How much do you smoke per day?_____ Drink per week? _____

*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize- this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.

Patient Signature_____ Date_____

Riverbend Chiropractic

1972 Ormond Blvd., Suites A - C Destrehan, LA 70047
Phone: (985) 307-0977 Fax: (985) 307-0984

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: **I have had the following unusual risks of my case explained to me.**
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

Printed Name	Signature	Date

1972 Ormond Blvd., Suites A - C Destrehan, LA 70047
Phone: (985) 307-0977 Fax: (985) 307-0984

Patient Name: _____

Thank you for choosing us as your health care provider. Please understand that payment of your bill is considered part of your treatment. The following statements refer to our office policies, which we require you to read, accept, sign, and date before any treatment can begin.

- Every new patient is required to fill out forms concerning his/her history and general information prior to being examined.
- Each insurance company or group has specific guidelines that we must follow to warrant payments for our services. As a courtesy to you, we file all claims to your insurance or group. Please remember that YOU have the contract with the insurance company or group and YOU are ultimately responsible for payment. We cannot accept responsibility for collecting from your insurance company or group nor negotiating a settlement on a dispute of a claim. If you do need assistance with your insurance, please see our office manager who will readily assist you.
- Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary of our area. Please understand that you are responsible for payment in full regardless of an insurance company's arbitrary determination of the usual and customary rates.
- Open accounts with no acceptable payment activity for 60 days will be considered past due. A billing charge may be assessed to the account balance along with a finance charge of 15% per month. You will be responsible for the original past due balance along with these additional charges. Acceptable payment activity will be determined on an individual basis. Please speak with our office manager to avoid misunderstanding.
- Open accounts with no acceptable payment activity for 120 days will automatically be placed with our collection agency. You will be responsible for payment of the original balance plus any billing charges. Finance charges, collection fees, and attorney fees assessed to your account administered.
- Please be courteous and on time to all scheduled appointments. Please give us at least a 24 hour notice if you need to cancel or reschedule any chiropractic and/or massage therapy appointments. We completely understand how hectic life can be, and will be more than happy to accommodate a better appointment time for you.

The adult accompanying a minor is responsible for full payment. The adult (i.e. parent legal guardian) must be present with minor and sign the treatment consent form before any service can be administered.

_____ _____
Patient Signature Date

_____ _____
Guardian Signature (If Minor) Date

I authorize Riverbend Family Chiropractic to release medical records, radiographs, and reports to any physicians, other health care providers, or insurance companies/ groups that may be consulted or who need direct access to their records for health care.

_____ _____
Patient Signature Date

Information and Consent for Dry Needling as a Procedure

For the Assessment and treatment of Myofascial Trigger Points and Tender Points

Myofascial trigger points or tender points, which may appear painful in soft tissue reflect abnormal nervous system activities associated with many neuro-musculo-skeletal conditions that are treated in our office. The procedure known as Dry Needling, is an important tool for diagnosing, testing, and monitoring changes in myofascial trigger/tender points. During this procedure a very thin, sterile filament needle is inserted into tissue that may be associated with one or more of your complaints. One or more needles may be used and the procedure may be performed during more than one office visit. There is little to no pain or bleeding with this procedure. While an infection is an unlikely event with this procedure, whenever there is penetration of the skin, there is the risk of infection. Other unlikely but possible events include: fainting, soreness, or pneumothorax (lung puncture). If you have a fear of needles, a genetic bleeding disorder, a history of a blood disorder that can be transmitted to another person, are regularly taking any blood thinning medication (for example, Coumadin or Warfarin), or are regularly taking any pain relievers containing ibuprofen, NSAIDS, aspirin or acetaminophen (for example, Tylenol, Advil, Aleve, or Bufferin), please inform us by placing a check as indicated below:

_____ I have a fear of needles.

_____ I have a genetic bleeding disorder. If yes, please specify: _____

_____ I have a history of a blood disorder that can be transmitted to another person. If yes, please specify: _____

_____ I am regularly taking blood thinning (anti-coagulation) medication. If yes, please specify:

_____

_____ I am regularly taking pain relievers. If yes, please specify: _____

I have read this Patient Information and Consent carefully, **I understand this procedure is not acupuncture** and I have had an opportunity to ask questions and obtain any desired clarification, and I consent to having the procedure of Dry Needling performed on me. I give permission to have the treated region(s) photographed for records/educational purposes.

Patient Name (please print): _____ _____

Signature: _____ Date: _____

If patient is less than 18 years of age parent or legal guardian must sign.

Name of Parent/Legal Guardian (Please print): _____

Signature: _____ Date: _____