On The River Chiropractic

Date:_____

Name:_____ Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____

Zip: _____ Email: _____ Marital Status: S M W D

Birthdate: _____ Age: _____

Cell Phone: _____ Work Phone:_____

Occupation: _____

How did you hear about us? _____

Are you or could you be pregnant? ☐ Yes ☐ No Date of last period: _____

Emergency Contact: _____ Phone Number:_____

Tobacco Use: ☐ Never Have ☐ Currently ☐ Quit, When? _____ ☐ Vape

Alcohol Use: ☐ None ☐ Occasionally ☐ Frequently

Returned checks will be subject to a $40.00 Fee Signature:_____

Main Problem

What symptom causes you to come to the office? _____

What causes this symptom? _____

When did pain start? _____ Has it been getting better, worse or staying the same? _____

How bad is this symptom? ☐ Mild ☐ Moderate ☐ Severe ☐ Intolerable

How would you best describe the sensation of the symptom? (Check all that apply)

___Cramping ___Aching ___Dull ___Sharp ___Shooting ___Burning ___Tingling/Numb

___Throbbing ___Crawling ___Stinging ___Pounding ___Stabbing ___Pins & Needles

How often does the symptom occur? ☐ Occasional ☐ Frequent ☐ Constant

Does this symptom travel or radiate to any other area?_____

What makes this symptom better? _____

What makes the symptom worse? _____

What else have you done to treat this symptom? _____

Problem 2

What other symptom do you have? _____

What causes this symptom? _____

When did pain start? _____ Has it been getting better, worse or staying the same? _____

How bad is this symptom? ☐ Mild ☐ Moderate ☐ Severe ☐ Intolerable

How would you best describe the sensation of the symptom? (Check all that apply)

___Cramping ___Aching ___Dull ___Sharp ___Shooting ___Burning ___Tingling/Numb

___Throbbing ___Crawling ___Stinging ___Pounding ___Stabbing ___Pins & Needles

How often does the symptom occur? ☐ Occasional ☐ Frequent ☐ Constant

Does this symptom travel to any other area? _____

What makes this symptom better? _____

What makes the symptom worse? _____

What else have you done to treat this symptom? _____

Medical History

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations_____

Surgeries_____

Car Accidents_____

Other Spine injuries_____

Health issues? (Ex: diabetes, heart condition, high blood pressure, pacemaker, anxiety, depression etc.)_____

_____

_____

Medications you have taken in the last 3 months include prescriptions, over-the-counter, vitamins, herbs_____

_____

_____

Allergies_____

Marketing

I __ do __do not authorize On The River Chiropractic to use any or all of my written comments, photos, names, audios, and/or videos in any way, for as long as desired. (Includes but not limited to; social media, educational material, advertisements, and in the office)

☐ Yes, I would like to receive emails from On The River Chiropractic.

Signature: _____ Date: _____

Insurance Verification

If your insurance is in your name and we have your card, please just sign this part. However, if your insurance is in someone else's name fill out with their information.

Insured's name: _____

Relationship of insured to patient:_____ Insured's date of birth: _____

Insured's employer: _____Member ID:_____

Address _____

I hereby authorize and direct my insurance benefits to be paid directly to Dr. Travis S. Thaler for an unexpired period of time. I understand that I am responsible for any portion of my bill my insurance company does not pay for or for non-covered services. I also authorize the provider to release any information required to process insurance claims. Our office requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the doctor or staff.

Signature:_____ Date:_____

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of individual's home. A valid driver's license will be required at the time of pickup.

Who do you give permission to pick up your medical records?

1. _____ 2. _____

Signature:_____ Date: _____

Consent to Initiate Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to treat subluxations. It is important that each patient understand both the objective and the method that will be used to obtain it. This will prevent any confusion or disappointment.

A vertebral subluxation is a misalignment in one or more of the 2 vertebra that make up the spine. Subluxation cause nerve interference and disrupt the function and transmission of impulses. These disruptions can cause pain, discomfort and other physical ailments as well as those not felt. Nerve interference can cause organs to not work properly, blood flow to decrease, as well as other serious health problems that may not "hurt" until it's too late.

To correct these subluxations, the doctor will use an adjustment. This is a gentle way to relieve the nerve interference and take pressure off the spinal discs and nerves that stem from the spinal column. There are different types of adjustments, including hand adjustments and instrument adjustments. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom, and the vertebral subluxations.

To initiate care at our office there are 2 visits you will be scheduled for. If you cannot attend both visits, the negative impact on your care will be profound.

1. Initial interview and Examination: This visit will consist of a health history, a chiropractic examination and any necessary x-rays. This visit usually takes 40-60 minutes (and is probably the visit you are here for now).
2. Report of Findings: This visit will consist of a detailed report of findings and recommendations for your care with Dr. Thaler. He will explain findings in your x-rays and the best care plan to benefit you and help reach your maximum potential health. The staff will also go over financial care plan and any insurance benefits you may have. We recommend that spouses and adult family members attend this visit with the patient. This visit usually last 20-40 minutes.

I wish to initiate care at On The River Chiropractic. I have read and understand the Consent to Initiate Chiropractic Care and agree to all terms. All questions regarding the doctor's objectives pertaining to my care in this office has been answered to my complete satisfaction.

Signature: _____ Date:_____

Provider Signature:_____ Date:_____