INFORMED CONSENT FOR CHIROPRACTIC CARE

By beginning chiropractic care at Compass Chiropractic, I acknowledge that the objective of the chiropractor is to identify and correct vertebral subluxations through the administration of a chiropractic adjustment. The adjustment is a specific manual force applied to the spine by hand or instrument, in which a quick thrust or impulse is delivered to the involved area(s). In some cases, Kevin McDade DC may need to touch otherwise sensitive areas of the body to properly deliver an adjustment or analyze my spine. I acknowledge that some techniques require the body to be placed into seemingly awkward positions to better receive the chiropractic adjustment. I hereby request and consent to the performance of chiropractic care and various other procedures and modalities, on myself (or on the patient named below for whom I am legally responsible) by the licensed doctor of chiropractic, Kevin McDade DC.

Many patients report benefits while under chiropractic care including increased range of motion, pain relief, and others. Although most people do respond positively to care, no guarantees of cure have been implied or given. As with any health care procedure, there are some associated risks which your doctor is required to bring to your attention. Though uncommon, you should note the possibility of: fracture, disc injury, muscle strain, ligament sprain, dislocation, and costovertebral separation. Strokes have been reported following chiropractic manipulation. The probability of this is exceedingly rare, estimated between one in one million and one in two million, and can be further reduced by screening procedures. Complications and injuries usually result from an underlying weakness of the bone or tissue which will be screened for during the initial exam. I understand all such risks and complications.

I understand that I am ultimately responsible for my health, and therefore may seek concurrent care from other related health care fields on my own accord. I agree to allow this office to use my confidential health information for the purposes of treatment, payment, healthcare operations and coordination of care with my medical physician(s) about my condition and treatment.

At this point in time, all of my questions have been adequately answered, but I am free to discuss any concerns with the doctor as the need arises. In the event that my conduct or cooperation become contrary to this agreement, Kevin McDade DC has the right to remove me from his care.

I have voluntarily read, understand, and agree to the aforementioned principles. By my signature below, I consent to all treatments deemed by this office to be in my best interest. I intend this document to cover the entire course of care, now and in the future, and agree to its provisions. I hereby authorize Kevin McDade DC, or whomever he designates as an assistant, to administer treatment to:

Printed Name: _____

Patient Signature: _____ Date: _____

Consent to Treatment of a Minor Child:

I hereby authorize Kevin McDade DC, and/or whomever he may designate as assistants, to administer treatment as deemed necessary to _____.

Signature of Parent/ Guardian: _____ Date: _____

Relationship to Minor: _____

HIPAA - Health Insurance Portability and Accountability Act
Notice of Privacy Policy

Compass Chiropractic
13146 Midlothian Turnpike
Midlothian, VA 23113
P: 804.499.6020
F: 804.499.6030

The following is an explanation of our Privacy Policy and your rights as a patient.

- Our office does not distribute or make available to any outside source your "protected health information," or (PHI).
- Your personal health information is secure and used only for treatment, claims submission to third party insurance carriers for the purposes of payment, and other health care operations.
- A family member may be present when taking a case history, hearing the results of exams or tests, or during normal office visits. Family or friends will only have access to your PHI with your written authorization.
- Our office may send you seasonal, birthday, or reminder cards to the address supplied on your intake forms.
- Our office may call or text you to confirm or reschedule an appointment. We may leave a message on the answering machine unless you have specifically instructed us to the contrary.
- You have the right to withdraw consent and terminate care at any time for any reason. A withdrawal of consent must be made in writing and submitted to the front desk.
- You have the right to ask questions about the status of your health at any time.
- You have the right to view and copy your own file. Copying and mailing charges may apply.

By my signature below, I acknowledge that I have read, understood, and agree with the privacy policies set forth by Compass Chiropractic. At my request, I am entitled to view and keep a copy of this abbreviated form or the corresponding full privacy statement, which is also made available on the practice's website: www.CompassChiroVA.com.

Printed Name:_____

Patient Signature: _____ Date:_____

Compass Chiropractic: Health Profile

Please fill out this form to the best of your ability. All of your information is strictly confidential.

Legal Name: _____ Date: _____

Mailing Address: _____ Occupation: _____

_____ (If retired/unemployed, list former occupation)

Email: _____ Height: _____

Weight: _____lbs

How did you hear about our office? _____

Have you been to a chiropractor before? ❑ Yes ❑ No

If Yes, was it a good experience? ❑ Yes ❑ No Dr._____ Last visit: _____

Are you nervous about being adjusted? ❑ Yes ❑ No

1. Lifestyle:

Smoking: ❑ 0 Cigarettes/day (non-smoker) ❑ 1-3 Cigarettes/day
❑ 0 Cigarettes/day (former-smoker) ❑ 1-2packs/day ❑ 2+ packs/day

Alcohol: ❑ Abstainer (none at all) ❑ Heavy drinker
❑ Light/Moderate drinker ❑ Former Alcoholic (sober since: _____)

Activity Level: ❑ Sedentary (none) ❑ Moderate activity (jogging)
❑ Light activity (i.e. walking) ❑ Vigorous activity (max exertion)

Any hobbies/sports you participate in regularly? _____

_____

2. Medical History:

Hospitalizations/Surgeries: please check the boxes if you have had any of these particular surgeries.

❑ Spine ❑ Shoulder (R/L) ❑ Brain ❑ Lung ❑ Gallbladder
❑ Hip (R/L) ❑ Knee (R/L) ❑ Heart ❑ Breast ❑ Appendix

Year: _____ Area/reason: _____ Procedure: _____
Year: _____ Area/reason: _____ Procedure: _____
Year: _____ Area/reason: _____ Procedure: _____

Prior Accidents/Injuries: includes car accidents, falls, sports injuries, etc.

Year: _____ Area injured: _____ How? _____
Year: _____ Area injured: _____ How? _____
Year: _____ Area injured: _____ How? _____

Ongoing Condition(s)? ❑ No ❑ Yes, please list: _____

Allergies? ❑ No ❑ Yes, please list: _____

Prescription Medications: If you have a medication list, please give us a copy and skip this section.

Medication	Reason	Date Started

Family History: this pertains to siblings, parents, and grandparents **only**

❑ Cancer ❑ Stroke ❑ Arthritis ❑ Seizures ❑ Diabetes
❑ Thyroid ❑ Heart Attack ❑ Osteoporosis ❑ Blood clots ❑ Kidney Disease
❑ Other: _____

Were there any deaths directly related to the above conditions? ❑ No ❑ Yes (fill in below)

Who _____ Condition _____ Age _____
Who _____ Condition _____ Age _____

Review of Systems: have **you** had a problem, whether now or in the past, with any of the following?

❑ Cancer
❑ Stroke/TIA
❑ Diabetes
❑ Hot/Cold Intolerance

❑ Seizures
❑ Double vision
❑ Sleeping problems
❑ Thyroid disorders

❑ Vertigo
❑ Dizziness
❑ Ringing in ears
❑ Ear Infections

❑ Heart attack/disease
❑ Blood clots/DVT
❑ Arrhythmias/Palpitations
❑ Heartburn/Gastric reflux

❑ Jaw pain
❑ Difficulty swallowing
❑ Asthma
❑ Allergies

❑ Osteoporosis
❑ Joint pain
❑ Fatigue
❑ Muscle weakness

❑ Excessive thirst
❑ Inability to hold urine/feces
❑ Constipation/Irritable Bowel

❑ Frequent urination
❑ Weak urine flow
❑ Bloating/Indigestion

❑ Burning/painful urination
❑ Difficulty controlling urination
❑ Food Sensitivity (Gluten, Dairy, etc.)

Other Medical History:

Any steroid/epidural injections? ❑ No ❑ Yes, part of body: _____ Date: _____

Recent infections/immunizations? ❑ No ❑ Yes, please list: _____

Recent unintentional weight loss? ❑ No ❑ Yes, I've lost about _____ pounds in the last _____

FEMALES ONLY: is there any possibility that you are pregnant? ❑ No ❑ Yes ❑ Unsure

3. Primary Complaint: Please fill out this section in regards to your primary complaint only. If you have other health concerns, the doctor will discuss them with you in person.

Briefly describe the main reason you are here: _____

_____

When did this start? _____ ❑ Started suddenly ❑ Started gradually

The problem is: ❑ Right-sided ❑ Left-sided ❑ Both sides ❑ N/A

The problem is: ❑ Constant ❑ Frequent ❑ On and off ❑ Occasional

How severe is your complaint at its worst? Grade from 1-10 where 10 is very severe: _____ /10

Describe how it feels: ❑ Pain ❑ Stiffness ❑ Weakness ❑ Numbness ❑ Tingling

Check all that apply: ❑ Aching ❑ Burning ❑ Dull ❑ Sharp ❑ Stabbing

Please check off all boxes that apply to this problem

This problem is made worse by:		This problem is usually relieved by:	
❑ Activity	❑ Arising from chair	❑ Cold	❑ Stretching
❑ Bending	❑ Job	❑ Heat	❑ Support brace
❑ Lifting	❑ Lying down	❑ Activity	❑ Chiropractic
❑ Standing	❑ Morning	❑ Lying down	❑ Massage
❑ Stress	❑ Night	❑ OTC medication	❑ Morning
❑ Temp change	❑ Touch/Pressure	❑ Postural change	❑ Night
❑ Twisting	❑ Ice	❑ Rx medication	❑ Nothing
❑ Sitting	❑ Kneeling	❑ Rest	❑ Standing

When present, how long does it last? ❑ Always ❑ Days ❑ Hours ❑ Minutes ❑ Seconds ❑ No pattern

Overall, this problem has been: ❑ Improving ❑ Staying the same ❑ Worsening

Do any of these apply to your job? ❑ Prolonged standing ❑ Prolonged sitting ❑ Heavy lifting

- do you think your job contributed to this problem? ❑ Yes ❑ No

Did we miss something? Please indicate if there is anything else you would like us to know about this problem.

_____

_____

4. Other:

What are your expectations/goals? _____

Emergency Contact: Name: _____ Relationship: _____ Phone: _____

Primary Care Physician: Dr._____ Office Name: _____

Last Visit: _____ Town: _____

I have read and completed the above information and certify it to be true to the best of my knowledge. I hereby permit this office to use my responses to provide me with chiropractic care, according to the state's regulations.

Patient Name (printed): _____

Signature of Patient/Guardian: _____ Date: _____