Name ____ **Date** ____________________

CONFIDENTIAL PERSONAL INFORMATION

Chiropractic Solutions
April H. Ralph, D.C.
7500 Memorial Pkwy, Ste 114
Huntsville, AL 35802

Welcome to Chiropractic Solutions *. It is our aim to provide you with the best possible chiropractic care. Assisted by my staff, I will gather and review your health history and conduct a thorough physical examination to determine if I can assist you. If I do not believe that your condition will respond to chiropractic care I will not accept you as a patient, but will refer you to another health care provider as appropriate.* ***April H. Ralph, D.C.***

How did you hear about us? (print name and/or circle all below that apply) ____

Web Search Facebook Phone Book Community Event Friend/Co-Worker Referral Other

DATE OF BIRTH _______ / _______ / _______

ADDRESS ____
____
____

PHONES (ONLY IF OK TO CALL)
HOME ( ) ______________________
CELL ( ) ______________________
WORK ( ) ______________________

EMAIL ____ **OCCUPATION** ____

Preferred method of communication for appointment reminders: **Cell Phone** **Home Phone** **Work Phone**

Note: Email may not be a confidential and secure communication method.

GENDER	LEGAL STATUS	SMOKING STATUS	RACE - CIRCLE MORE THAN ONE IF APPLICABLE	ETHNICITY	PREFERRED LANGUAGE
FEMALE	MINOR	EVERY DAY SMOKER	AMERICAN INDIAN OR ALASKA NATIVE	HISPANIC OR LATINO	ENGLISH
MALE	SINGLE	OCCASIONAL SMOKER	ASIAN	NOT HISPANIC OR LATINO	OTHER
	MARRIED	FORMER SMOKER	BLACK OR AFRICAN AMERICAN	DECLINE TO ANSWER	
	DIVORCED	NEVER SMOKED	WHITE (CAUCASIAN)		
	WIDOWED		NATIVE HAWAIIAN OR PACIFIC ISLANDER		
			DECLINE TO ANSWER		

FINANCIAL/INSURANCE INFORMATION

IF PATIENT IS UNDER 19 - PARENT OR LEGAL GUARDIAN'S NAME ____

Is someone other than the patient or the patient's parent /legal guardian listed above financially responsible for the patient's account?
YES NO (Please write name and address on back)

Primary Insurance ______________________ Insured's Name ___________________________ & DOB ___________________

Secondary Insurance ___________________ Insured's Name ___________________________ & DOB ___________________

ACKNOWLEDGEMENTS

To the best of my ability, the information that I will supply to CHIROPRACTIC SOLUTIONS is complete and truthful and I will not misrepresent the presence, severity or cause of my health concern.

I authorize the release of any medical or other information necessary to process claims for any covered service charges incurred by me. I also authorize payment directly to CHIROPRACTIC SOLUTIONS of any benefits due to me as a result of such claims. I acknowledge that any commercial insurance coverage or government benefit I may have is an agreement between the carrier and me and that I am ultimately responsible for the payment of charges for any covered or non-covered services which I receive.

Signature ____ Date _______ / _______ / _______

Name ____ Date ____________________

HISTORY OF PRESENT ILLNESS

CHIEF COMPLAINT

1. BRIEFLY DESCRIBE THE SYMPTOMS THAT PROMPTED YOU TO SEEK CARE TODAY

____

____

2. IS YOUR NEED FOR CARE THE RESULT OF

Auto Accident — Work Accident

Home Injury — Worsening Long-Term Problem

Other ____________________________________

3. **ONSET**: When did you first notice your current symptoms?

____

What were you doing?

____

4. **TIMING:** When do the symptoms occur?

____ Constantly

____ Comes & goes

How often?

____

How long does it last?

____

7. **LOCATION**: Where does it hurt?

"O" for current condition

"X" for conditions experienced in the past

RIGHT SIDE — BACK (LEFT, RIGHT) — FRONT (RIGHT, LEFT) — LEFT SIDE

5. **DURATION:** How long have the symptoms persisted?

____ day(s)

____ week(s)

____ month(s)

____ year(s)

8. **SEVERITY**: How intense are your current symptoms?

0 1 2 3 4 5 6 7 8 9 10

0 - absent

5 - uncomfortable

10 - agonizing

11. **MODIFYING FACTORS**: (such as time of day, certain activities or positions, etc.)

What tends to worsen the problem?

____

What tends to lessen the problem?

____

6. **QUALITY OF SYMPTOMS:**

What does it feel like?

____ Numbness

____ Tingling

____ Stiffness

____ Dull Pain

____ Aching

____ Cramps

____ Nagging

____ Sharp Pain

____ Burning

____ Shooting

____ Throbbing

____ Stabbing

____ __________

9. **RADIATION**: Does the pain affect other areas of your body? To what area does the pain radiate, shoot or travel?

____

____

10. **CONTEXT**: Does this condition interfere with:

____ Job/Work

____ Recreation/Sports

____ Household Tasks

____ Sleep

____ Relationships

____ Self Care (bathing, dressing, etc)

12. **PRIOR TREATMENT**: What have you done to relieve your symptoms?

____ Chiropractic care

____ Ice

____ Heat

____ Prescription Meds

____ Over the Counter Meds

____ Homeopathic remedies

____ Physical Therapy

____ Surgery

____ Acupuncture

____ Massage

____ _______________

Doctor's Notes

ELEMENTS # 4-11

COUNT =

PROBLEM (1-3)-H1

EXPANDED (1-3)-H2

DETAILED (4+)-H3

COMP (4+)-H4

Name ______________________________ **Date** ________________

REVIEW OF SYSTEMS

Doctor's Notes

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body.

Circle "Now" for any condition that you have currently and "Past" for any condition that you have had previously. Circle "None" if none of the conditions apply to you.

	Musculoskeletal System		Neurological System		Cardiovascular System
Now Past	Osteoporosis	Now Past	Anxiety	Now Past	High Blood Pressure
Now Past	Knee Injuries	Now Past	Depression	Now Past	Low Blood Pressure
Now Past	Arthritis	Now Past	Headache	Now Past	High Cholesterol
Now Past	Foot/ankle Pain	Now Past	Dizziness	Now Past	Poor Circulation
Now Past	Scoliosis	Now Past	Pins & Needles	Now Past	Angina
Now Past	Shoulder Problems	Now Past	Numbness	Now Past	Excessive Bruising
Now Past	Neck Pain		None		None
Now Past	Elbow/Wrist Pain		**Respiratory System**		**Digestive System**
Now Past	Back Problems	Now Past	Asthma	Now Past	Axorexia/Bulimia
Now Past	TMJ issues	Now Past	Apnea	Now Past	Ulcer
Now Past	Hip Disorders	Now Past	Emphysema	Now Past	Food Sensitivities
Now Past	Poor Posture	Now Past	Hay Fever	Now Past	Heartburn
	None	Now Past	Shortness of Breath	Now Past	Constipation
		Now Past	Pneumonia	Now Past	Diarrhea
			None		None
			Sensory System		**Integumentary System**
		Now Past	Blurred Vision	Now Past	Skin Cancer
		Now Past	Ringing in Ears	Now Past	Psoriasis
		Now Past	Hearing Loss	Now Past	Eczema
		Now Past	Chronic Ear Infection	Now Past	Acne
		Now Past	Loss of Smell	Now Past	Hair Loss
		Now Past	Loss of Taste	Now Past	Rash
	Constitutional System		None		None
Now Past	Fainting		**Endocrine System**		**Genitourinary System**
Now Past	Low Libido	Now Past	Thyroid Issues	Now Past	Kidney Stones
Now Past	Poor Appetite	Now Past	Immune Disorders	Now Past	Infertility
Now Past	Fatigue	Now Past	Hypoglycemia	Now Past	Bedwetting
Now Past	Sudden Weight Gain	Now Past	Frequent Infection	Now Past	Prostate Issues
Now Past	Sudden Weight Loss	Now Past	Swollen Glands	Now Past	Erectile Dysfunction
Now Past	Weakness	Now Past	Low Energy	Now Past	PMS Symptoms
	None		None		None

SYSTEMS

COUNT =

PROBLEM (0)-H1
EXPANDED (1)-H2
DETAILED (2-9)-H3
COMP (10+)-H4

CURRENT MEDICATIONS

Are you currently taking any prescription medications? YES (list below) NO

Medication Name	Dosage (i.e. 5mg)	Frequency (i.e. once a day)

Do you have any medication allergies? YES (list below) NO

Medication Name	Reaction	Onset Date (approx)

Name ____ **Date** ____________________

1. PERSONAL HEALTH HISTORY					
Please provide your complete past health history, including accidents, injuries, illnesses and treatments.					
Circle "Now" for any condition or treatment that is ongoing currently and "Past" for any condition or treatment that you have had previously.					
Illnesses/Conditions					
Now Past	AIDS	Now Past	Goiter	Now Past	Psychiatric Problems
Now Past	Alcoholism	Now Past	Gout	Now Past	Rheumatic Fever
Now Past	Allergies	Now Past	Heart Disease	Now Past	Scarlet Fever
Now Past	Anemia	Now Past	Hepatitis	Now Past	STD
Now Past	Arteriosclerosis	Now Past	HIV Positive	Now Past	Shingles
Now Past	Cancer	Now Past	Hypoglycemia	Now Past	Spine/Nerve Disorder
Now Past	Chicken Pox	Now Past	Malaria	Now Past	Surgical Implants
Now Past	Congenital Heart Defect	Now Past	Measles	Now Past	Tuberculosis
Now Past	Diabetes	Now Past	Metabolic Syndrome X	Now Past	Typhoid Fever
Now Past	Diptheria	Now Past	Multiple Sclerosis	Now Past	Ulcer
Now Past	Epilepsy	Now Past	Mumps	Now Past	
Now Past	Glaucoma	Now Past	Polio	Now Past	
Treatments					
Now Past	Acupuncture	Now Past	Chiropractic Care	Now Past	Inhaler
Now Past	Blood Transfusions	Now Past	Crutches	Now Past	Massage Therapy
Now Past	Back Brace	Now Past	Dialysis	Now Past	Neck Brace
Now Past	Cane	Now Past	Homeopathy	Now Past	Physical Therapy
Now Past	Chemotherapy	Now Past	Hormone Replacement	Now Past	Walker
Surgeries (Check all that apply; write in if not listed)					
	Appendectomy		Eye		Tonsillectomy
	Heart Bypass		Hysterectomy		Vasectomy
	Cancer		Pacemaker		Gall Bladder
	Cosmetic		Spine		
Injuries/Other (Check all that apply)					
	Broken Bone		Stroke/TIA		Tattoos/Body Piercing
	Knocked Unconscious		Heart Attack		Miscarriage
	Injured in an accident		Hospitalization for other than surgery		

2. FAMILY HEALTH HISTORY		
Some health issues are hereditary; please tell us about your immediate family members' health.		
	Age	Illnesses/Cause of Death
Mother		
Maternal Grandparents		
Father		
Paternal Grandparents		
Siblings		

3. SOCIAL HISTORY				
Please tell us about your health habits and stress levels.				
Alcohol Use		Daily	Weekly	How much?
Illegal Drugs		Yes	No	
Dieting	YES NO	Lose Wt	Gain Wt	
Exercising	YES NO	Daily	Weekly	How much?
Over the Counter Pain Relievers		Daily	Weekly	How much?
Job Pressure/Family Stress		Yes	No	
Average hours of sleep per night				

Doctor's Notes
AREAS # 1-3
COUNT =
PROBLEM (0)-H1
EXPANDED (0)-H2
DETAILED (1)-H3
COMP (3)-H4

CHIROPRACTIC Solutions
HEALTH CARE FOR THE ENTIRE FAMILY

Patient's Name:___________________________
Today's date:______________

Informed Consent

To the patient: Please read this entire document prior to meeting with Dr. Ralph. It is important that you understand the information contained in this document. Please ask questions, if there is anything that is unclear, before you sign .

The Nature of the Chiropractic Adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulations, or adjustments. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That movement may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment you are consenting to the following procedures:
(*Initial* each for which you provide consent – don't use × or ✓)

____vital sign measurement
____observation & palpation
____range of motion testing
____muscle strength testing
____basic neurological testing
____basic orthopedic testing
____chiropractic analysis
____x-ray studies
____chiropractic manipulation (adjustment)
____ultrasound therapy
____electrical stimulation therapy
____hot or cold therapy

Material Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fracture, disc injury, dislocation, muscle strain, cervical myelopathy, costovertebral strains, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

Probability of Risks Occurring

Fractures are rare occurrences, and generally result from some underlying weakness of the bone which I check for during the taking of your medical history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

(Continued on back.)

Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and analgesics
- Hospitalization or Surgery

If you choose to use any of the above noted "other treatment options," you should be aware that there are risks & benefits of each, and you may wish to discuss these with your medical physician.

Risks and Dangers Attendant to Remaining Untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment and make it more difficult and less effective the longer it is postponed.

PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment. If needed, I have discussed it with Dr. Ralph and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.
DO NOT SIGN UNLESS YOU HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.

Dated: _________________ **Dated: _________________**

____
Print Patient's Name

April H. Ralph, D.C.
Doctor's Name

____
Signature of Patient or Responsible Party

____
Doctor's Signature

This patient is a minor under the age of 19. By signing below, I acknowledge that I am the parent, guardian or custodian of this patient.

____
Signature of Parent or Guardian (if appropriate)

SIGMA CHIROPRACTIC SOLUTIONS, LLC dba CHIROPRACTIC SOLUTIONS

7500 Memorial Parkway SW, Suite 114
Huntsville, AL 35802
(256) 650-0051

Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Chiropractic Solutions or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent.

By signing below you acknowledge that you have either received a copy of this Notice or declined a copy of the notice by initialing here ___________

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

______________________________________ ______________
Patient or Legally Authorized Individual Signature Date

____
Print Patient's Full Name

______________________________________ ______________
Witness Signature Date