VITAL HEALTH & BODY

DR. JOHN R. MARIAN D.C.

Personal information

Name:_____ Date: _____

Address: _____ City/State: _____Zip: _____

Gender: M ☐ F ☐ Are you Pregnant? Yes ☐ No ☐ Children?___ Marital Status: Single ☐ Married ☐ Other ☐

Social Security # _____-____-_____ Date of Birth: ____/____/_____ Occupation: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____Work Phone: ( ) _____

Email Address:_____

How were you referred to this office? _____

Name of Spouse or Nearest Relative: _____ Phone: ( ) _____

Reason for visit

Describe the Condition or reason for this visit: _____

How did it happen?_____

How long have you had this condition?_____ Have you had it before?_____

Date of Illness or Injury: _____

Overall Frequency of Complaint: (circle one please)

Constant-100% of the time ☐ **Frequent**-75% ☐ **Intermittent**-50% ☐ **Occasional**-25% ☐

Overall Intensity of Complaint: (circle one please)

Minimal (An annoyance but has no effect on activity) ☐ **Moderate** (Tolerable with marked impairment of activity) ☐

Slight (Tolerable with some impairment to activity) ☐ **Severe** (Intolerable and cannot perform any activities) ☐

What aggravates the problem? _____ What relieves the problem? _____

Is this condition getting worse? Yes ☐ No ☐ Constant ☐ Comes and Goes ☐

Is this condition interfering with your: Work ☐ Sleep ☐ Daily Routine ☐

Describe: _____

Have you seen any other Doctors for this condition? If yes, whom?_____

Have you been treated by a Chiropractor before? If yes, By Whom? When? For what? _____

_____

Health History/ Family History

Are you taking any medications? If yes, what?_____

_____

Are you allergic to any medications? If yes, what? _____

_____

Do you currently smoke? ☐ Yes ☐ No Have you ever smoked? ☐ Yes, former smoker ☐ No, never smoked

Family History:

☐ Arthritis ☐ Cancer ☐ High Blood Pressure ☐ Cardiovascular Disease/ Stroke ☐ Diabetes

Do you have or have you ever had any of the following?

- ☐ History of Recent Infection
- ☐ Recent Fever
- ☐ HIV/AIDS
- ☐ Diabetes
- ☐ Corticosteroid Use
- ☐ Birth Control Pills
- ☐ High Blood Pressure
- ☐ Stroke (date) _____
- ☐ Dizziness/ Fainting
- ☐ Numbness in Groin/ Buttock
- ☐ Urinary Retention
- ☐ Aortic Aneurysm
- ☐ Cancer/ Tumor
- ☐ Osteoporosis
- ☐ Recent Trauma
- ☐ Prostrate Problems
- ☐ Pregnancy, # of Births _____
- ☐ Abnormal Weight Gain/ Loss
- ☐ Epilepsy/ Seizures
- ☐ Visual Disturbances
- ☐ History of Low/ Mid Back Pain
- ☐ History of Neck Pain
- ☐ Numbness/ Tingling
- ☐ Arthritis
- ☐ Heart Disease
- ☐ Skin Problems
- ☐ History of Alcohol Use
- ☐ History of Tobacco Use
- ☐ Swollen Joints
- ☐ Tendonitis

Additional Information:

_____

_____

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_____

AUTHORIZATION FOR CARE

I certify that the above information is complete and accurate. I hereby authorize the doctor to work with my condition through the use of adjustments to my spine, extremities as well as the use of therapeutic modalities as he or she deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for my payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be responsible for any pre-existing medical diagnosis. I also understand that if I terminate or suspend my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

If you are under the age of 18 Parental Consent is required for treatment

Patient's Signature: _____ Date: _____

Parent or Legal Guardian's signature: _____ Date: _____

Dr. John Marian D.C.

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient of Dr. John Marian we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, phone number, email address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use of disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to you health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with the respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. John R Marian.

If you would like further information about our privacy policies and practices please contact: Dr. John R Marian

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of January 1, 2016. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (Printed please)	Signature	Date

If you are a minor, or if you are being represented by another party.

_____	_____	_____
Personal Representative Printed	Personal Representative Sign.	Date

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Description of the authority to act on behalf of the patient.

INFORMED CONSENT

I, the undersigned, have voluntarily requested that Dr. John Marian and/or their staff assist me in the management of my health concerns. I understand the Doctors of Chiropractic & the Chiropractic clinic itself offer services are a form of conservative and alternative health care.

Medical doctors, Doctors of Chiropractic and Osteopaths who perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manual therapies, manipulations, and/or adjustments involving the movement of the joints and soft tissues. Physical therapy, home exercises, and nutritional supplements/dietary recommendations may also be used.

Routine chiropractic examination and treatment involves some of the following methods:

- Observation: General assessment/appraisal in all postures.
- Inspection: Viewing/looking at your body parts. Visualization includes general body viewing in a standing position, front, back, and side. All symptomatic (painful) areas of complaint may be viewed if necessary.
- Auscultation: Using a stethoscope to listen for blood pressure and other body sounds.
- Palpation: This means a doctor will touch you feeling for tenderness, heat, swelling, nodularity, laxity/integrity of tissues, and other abnormalities.
- Percussion: Using a rubber hammer to tap on bones or tendons.
- Orthopedic/Neurological testing: These are standard tests to assess your neuromusculoskeletal systems.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Risks from Treatment

Soreness: I am aware that like exercise, it is common to experience muscle soreness in the first few treatments. I understand that this is a normal response to treatment and agree to notify the Doctor immediately if I experience pain that feels beyond minor muscle soreness.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare. Please inform the Doctor if you experience any of these symptoms.

Manipulations/Adjustments: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury from manipulations/adjustments. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution to avoid injury.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Modalities: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.
A thorough health history and tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve those benefits.

I realize that the practice of medicine as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other person's of the doctor's choosing.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain and inflammation. I am aware that long-term use or overuse is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for conditions such as joint instability or serious disk rupture, among others. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have read to me the above explanation of chiropractic treatment. I have made my decision to undergo care voluntarily and freely. To attest my consent to these examination and treatment procedures, I hereby affix my signature to this Informed Consent document.

Signature of Patient (Legal Guardian if a minor):

_____

Date: _____

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This notice is effective as of January 1, 2016. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (Printed please)	Signature	Date

If you are a minor, or if you are being represented by another party.

_____	_____	_____
Personal Representative Printed	Personal Representative Sign.	Date

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Description of the authority to act on behalf of the patient.