Date: _____

COMMONWEALTH CHIROPRACTIC CENTER, PSC
1827 Ky Route 321
Prestonsburg, KY 41653
(606) 889-9222

NAME_____AGE_____DATE OF BIRTH___/___/___SEX_____

HEIGHT ___'___" WEIGHT_____

DOMINANT HAND R or L RACE_____ ETHNICITY_____LANGUAGE_____

SMOKER YES OR NO IF YES, EVERYDAY, SOMEDAY,OR FORMER SMOKER

E-MAIL ADDRESS_____ DRIVER'S LICENSE_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE_____CELL PHONE_____S.S.#_____/____/_____

MARITAL STATUS_____ CHILDREN: | | NO | | YES HOW MANY? _____BREASTFEEDING Y OR N

EMPLOYER/OCCUPATION_____PHONE_____

SPOUSE'S NAME_____S.S.#_____/_____/_____DATE OF BIRTH___/_____/_____

EMPLOYER/OCCUPATION_____PHONE_____

IN CASE OF EMERGENCY, CONTACT_____PHONE_____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE_____

HEALTH INFORMATION (FILL OUT ALL THAT APPLY)

MAJOR COMPLAINT_____HOW LONG_____

ARE YOUR SYMPTOMS RELATED TO AN ACCIDENT OR INJURY? _____IF YES, EXPLAIN_____

_____

DURING THE ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? _____

HAVE YOU EXPERIENCED YOUR SYMPTOMS BEFORE THIS ACCIDENT? _____IF YES, EXPLAIN_____

_____

IF YOUR SYMPTOMS ALREADY EXISTED WERE THEY MADE WORSE BY THIS ACCIDENT_____OR

WERE YOUR SYMPTOMS DORMANT PRIOR TO THIS ACCIDENT_____

DOCTORS SEEN FOR THIS CONDITION_____

NAME/ADDRESS OF YOUR MEDICAL DOCTOR_____

HAVE YOU EVER HAD PREVIOUS CHIROPRACTIC CARE? | | NO | | YES DOCTOR_____

HAVE YOU HAD ANY OF THE FOLLOWING: AUTO ACCIDENTS-SEVERE FALLS-SURGERIES-FRACTURES

PLEASE EXPLAIN_____

_____

MEDICAL HISTORY/REVIEW OF SYSTEMS

HAVE YOU EVER HAD A HISTORY OF OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING (CHECK BELOW)

IF YES EXPLAIN

YES	**NO**	
_____	_____	**EPILEPSY/SEIZURES** _____
_____	_____	**ANEURYSM** _____
_____	_____	**CHEST PAIN** _____
_____	_____	**HEART ATTACK** _____
_____	_____	**STROKE/TIA** _____
_____	_____	**HIGH BLOOD PRESSURE** _____
_____	_____	**BLOOD CLOTS** _____
_____	_____	**HEART MURMUR/VALVE DISEASE** _____
_____	_____	**IRREGULAR HEARTBEAT** _____
_____	_____	**CONGESTIVE HEART FAILURE** _____
_____	_____	**ARTIFICIAL JOINTS OR HEART VALVES** _____
_____	_____	**INTERNAL PACEMAKER OR DEFIBRILLATOR** _____
_____	_____	**BRAIN STIMULATOR** _____
_____	_____	**CANCER (IF SO, WHAT KIND)** _____
_____	_____	**SKIN CANCER/MELANOMA** _____
_____	_____	**BROKEN/IRRITATED SKIN** _____
_____	_____	MIGRAINE HEADACHES/OTHER HEADACHES _____
_____	_____	ANEMIA _____
_____	_____	EXCESSIVE SCARRING OR BLEEDING _____
_____	_____	VISUAL PROBLEMS/EYE DISEASE _____
_____	_____	ARTHRITIS _____
_____	_____	GOUT
_____	_____	DIABETES _____
_____	_____	BREAST DISEASE _____
_____	_____	LIVER PROBLEMS/HEPATITS/JAUNDICE _____
_____	_____	KIDNEY/BLADDER PROBLEMS _____
_____	_____	LUNG DISEASE/RESPIRATORY PROBLEMS/TB _____
_____	_____	GALLBLADDER PROBLEMS _____
_____	_____	STOMACH/BOWEL PROBLEMS _____
_____	_____	ASTHMA/HAY FEVER/ECZEMA _____
_____	_____	DEPRESSION/MENTAL ILLNESS _____
_____	_____	BLOOD TRANSFUSIONS _____
_____	_____	HIV DISEASE, AIDS _____
_____	_____	BREAST AUGMENTATION _____
_____	_____	ALLERGIES _____
_____	_____	HYPOTHYROIDISM _____
_____	_____	OTHER DISEASES _____
_____	_____	METALLIC IMPLANTS
_____	_____	NEURO STIMULATOR
_____	_____	STENT,SHUNT, PAIN PUMP
_____	_____	SHRAPNEL
_____	_____	CLAUSTRAPHOBIC

Have you recently had a CT/MRI within the last year? YES NO if yes where? _____

Are you currently taking Ibuprofen/Motrin? YES OR NO if yes How long, and milligram _____

Have you had Physical Therapy within the last year? If so, how long and where? _____

ANSWER THE FOLLOWING FOR AUTO ACCIDENT OR WORK COMP INJURY ONLY

Have you experienced any of the following since your accident or injury:

A. Loss of Range of Motion: yes/no
   a. What body parts: _____
B. Visual Disturbance : yes/no (please explain):_____
C. Dizziness: yes/no How often: _____
D. Anxiety: yes/no How often: _____
E. Depression: yes/no How often: _____
F. Difficulty Sleeping: yes/no How often: _____

MEDICATIONS_____

KNOWN MEDICATION ALLERGIES_____

Family Health History:

Associated health problems of relatives:

_____

_____

Deaths in immediate family:
Cause of parents or siblings death **Age at death**

_____

_____

_____

Social and Occupational History:

A. Recreational activities:
   _____

B. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):
   _____

SIGNATURE

X_____ **DATE**_____

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1827 Kentucky Route 321
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Dr. C.R. Salyers, II BS DC

Phone: 606-889-9222
606-889-9220

Fax: 606-886-1605

AUTHORIZATION, ASSIGNMENT, AND RELEASE FORM
AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me of you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company(the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action in my name as you see fir and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Kentucky.
5. I further agree that this Authorization and Assignment is irrevocable an ongoing until all monies owed are paid in full.
6. This Authorization for Assignment will be in continual effect until revoked by both parties.

_____ X_____

DATE **PATIENT/INSURED SIGNATURE**

RECORDS RELEASE

To_____, I hereby authorize you to release to **Dr. Charles R. "Chip" Salyers II** any information including the diagnosis and records of treatment or examination rendered to me for all care during the period from _____ thru _____.

_____ X_____

DATE **PATIENT/INSURED SIGNATURE**

MEDICATIONS AUTHORIZATION FOR RELEASE FROM DR. FIRST

Authorization to Dr. First Website. I hereby authorize Dr**. Charles R. "Chip" Salyers II,** to retrieve any and all prescription information on my behalf to be in compliance with the "Meaningful Use regulations".

_____ X_____

DATE **PATIENT/INSURED SIGNATURE**

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INFORMED CONSENT

PATIENT'S NAME X_____

Dear Patient:

State law requires us to obtain your informed consent prior to examination and treatment. The purpose of this form is to inform you, not to alarm you. What you are being asked to sign is simply a confirmation that we have discussed the following:

ASSOCIATES AND ASSISTANTS

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, and treatment.

EXAMINATIONS

X-ray: Concerning x-ray examination, this office uses direct digital radiography that provides the highest quality of xrays with the least exposure. Please note that on your initial visit and re-exam (which includes new complaint(s) and x-ray videos) you will receive xrays if warranted, unless pregnant. This is important since certain conditions will call for the retaking of certain x-rays when circumstances warrant.

The only noteworthy inherent risk with taking x-rays, deals with pregnancy. **If there is a possibility that you are pregnant, inform this office prior to x-ray examination.** If there is no possibility of this condition, the inherent risks are so rare that I have no available statistics to quantify their probability.

TREATMENT

The Chiropractic Adjustment: I will use my hands or a mechanical device upon your body in such a way as to move your joints. This procedure may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. There are some material risks involved in doing this and they are as follows:

INHERENT RISKS

Pain: It is common for an adjustment as well as traction, massage therapy, exercise, in fact almost any treatment, to result in a temporary increase in soreness in the region being treated.

Rib Fractures: The force of an adjustment might "crack" a rib. This can happen with anyone; however it occurs most often on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays and when detected, we proceed with extra caution. These problems occur so rarely that I haven't been able to find available statistics to quantify their probability.

Disc Herniation: Occasionally treatment will aggravate or cause a problem if the disc is in a weaken state. It is possible that surgery may become necessary for correction, but again these problems occur so rarely that I haven't been able to find available statistics to quantify their probability.

Stroke: Even though strokes happen with some frequency in our world, strokes resulting from a chiropractic adjustment are rare. So rare that you have the same chance of getting hit by lightening; one in a million. In fact, according to the Journal of the Canada Chiropractic Association Vol. 37, No. 2 June, 1993, the risk of a stroke from

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chiropractic is one per every three million upper neck adjustments. Even though the risk of stroke in this office is small, we have implemented procedures, and tests that reduce your risk of stroke even more.

The type of adjustment related to vertebral artery stoke is called the extension-rotation-thrust atlas adjustment. This type of adjustment is not done in this office. Our patients are also given certain tests that warn of certain conditions more susceptible to stroke, thus reducing your risk even more.

Physical Therapy Burns: Some of the machines we use generate heat. We also use ice in the office. Since everyone's skin has different sensitivity to these modalities, we test our patients for sensitivity deficiencies prior to therapy use. If a burn is obtained, there will be a temporary pain and possible blistering. This should be reported to the doctor. This is so rare that I haven't found any statistics to quantify its probability.

Other Problems: There may be other problems or complications that might arise from treatment, such as massage, traction, etc., than noted above. These other problems or complications occur so rarely that it is not plausible to anticipate and/or explain them all in advances of treatment.

NON TREATMENT
Remaining untreated results in adhesions, pain and, reduction in associated joint mobility which. The probability that these adhesions will interfere with the motion, function, and enjoyment of life is very high.

OTHER PROBLEMS
There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery. As with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

I hereby authorize and direct the above named doctor with assistants to provide such additional services as they may deem reasonable and necessary.

I hereby state that I have read or have had read to me this consent form, and all blanks were filled in prior to my signature.

DATE: _____ TIME: _____ A.M. P.M.

Patient's Printed Name: X _____

Patient's Signature: X _____

Signature of Guardian: _____

Witness' Printed Name: _____

Witness' Signature: _____

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Consent to use PHI

Acknowledgment 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 Commonwealth Chiropractic Center, PSC 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. I have received a copy of the Notice of Patient Privacy Policy ____ Patient Initials

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.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

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.

X _____ _____
Patient or Legally Authorized Individual Signature — Date

X _____ _____
Print Patient's Full Name — Time

_____ _____
Witness Signature — Date

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Name_____ **Date**_____

Please initial one of the following:

_____ **I, hereby give Dr. Charles R. "Chip" Salyers II and/or his staff at Commonwealth Chiropractic Center, consent to give to my spouse or other family member any information pertaining to me (medical or financial). I also understand that at some point, if I change my mind, or divorce, it is my responsibility to inform this office of such changes pertaining to my medical records and finances.**

_____ **I, hereby decline to give Dr. Charles R. "Chip" Salyers II and/or his staff at Commonwealth Chiropractic Center, consent to give to my spouse or other family member any information pertaining to me (medical or financial). I also understand that at some point, if I change my mind, or divorce, it is my responsibility to inform this office of such changes pertaining to my medical records and finances.**