Standards for New Patients

1. All new patients are required to fill out a personal health questionnaire.
2. You will have a consultation with the doctor and discuss your health concerns.
3. The doctor will perform diagnostic chiropractic, orthopedic and neurological examination procedures.
4. You will discuss a care and treatment plan with the doctor.

Confidential Patient Information

Name (First, Middle, Last)		Date of Birth
Address		City/State/Zip Code
Home Phone ( )	Work Phone ( )	Cell Phone ( )

Work Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Student ☐ Unemployed

Employer	Job Title	
Employer Address	City/State	Zip Code

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Spouse's Name & DOB: _____

Whom may we thank for referring you? _____

Minors ONLY – Consent for Treatment

I hereby authorize Dr. Matthew Samson and whomever they may so designate as their assistant, to administer chiropractic care as they deem necessary to my son/daughter, _____, dated at Minot, ND this _____ day of _____, 20___.

Signature of Parent/Guardian: Witnessed:

ALL PATIENTS – In Case of Emergency

Name of relative or close friend:		
Home Phone ( )	Work Phone ( )	Cell Phone ( )

Why Chiropractic?

People visit chiropractors for a number of reasons. Some need symptomatic relief from pain or discomfort (Relief Care). Others are looking for the cause of the problem as well as the symptoms corrected to avoid relapses (Corrective Care). There are others who are looking for their areas malfunction to be brought to its highest state of health in order to optimize their wellbeing (Comprehensive Care).

At Horizon Family Chiropractic the type of care you receive is YOUR choice. We will honor your decision and take into consideration your needs and desires when recommending your treatment plan. Please indicate which type of treatment you would like to receive below.

☐ Relief Care: Relief from pain or discomfort

☐ Corrective Care: Correcting the cause of the problem as well as the symptoms

☐ Comprehensive Care: Bringing health to the highest state and optimizing physical and emotional wellbeing

☐ I would like to discuss options with the doctor

Please list your major ailments in order of severity (from most debilitating to least debilitating):

1.	**4.**
2.	**5.**
3.	**6.**

Primary Ailment - _____

When did you first notice this condition:
Did it begin: ☐ Immediate or ☐ Gradually? Briefly Describe:
What is the exact location of your symptoms:
Do your symptoms spread? ☐ No ☐ Yes. Where?
How often do you experience these symptoms? ☐ Constant (100% of day) ☐ Frequent (75% of day) ☐ Often (50%) ☐ Seldom (25%) ☐ Rarely (less than 25%)
Is this condition progressively: ☐ Worsening ☐ Improving ☐ Unchanged
What is the intensity of your symptoms? ☐ Severe ☐ Moderate ☐ Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
If you have pain, is it: ☐ Deep ☐ Superficial
Please indicate the character of your pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Aching ☐ Knife-like Throbbing
Are you experiencing any of the following associated symptoms? ☐ Pins/Needles ☐ Tingling ☐ Numbness ☐ Twitching If Yes, Please describe:
Please indicate what activities provoke (P) or Aggravate (A) your condition: __Sitting for __min, __Standing, __Walking, __Lying, __Pushing, __Pulling, __Lifting __lbs., __Gripping Hot/Cold, __Bright Lights __Coughing/Sneezing, __Bowel Movements, __Mental Activities, __Other_____, __Other_____
Please indicate what helps to alleviate the pain. ☐ Lying ☐ Sitting ☐ Walking ☐ Standing ☐ Rest ☐ Heat/Cold ☐ Medications: _____, _____, _____

Please list what doctors you have seen for this condition. (Please include diagnosis, treatment, and any changes in your condition)

Please include any other relevant history in regards to this ailment.

Secondary Ailment - _____

When did you first notice this condition:
Did it begin: ☐ Immediate or ☐ Gradually? Briefly Describe:
What is the exact location of your symptoms:
Do your symptoms spread? ☐ No ☐ Yes. Where?
How often do you experience these symptoms? ☐ Constant (100% of day) ☐ Frequent (75% of day) ☐ Often (50%) ☐ Seldom (25%) ☐ Rarely (less than 25%)
Is this condition progressively: ☐ Worsening ☐ Improving or ☐ Unchanged
What is the intensity of your symptoms? ☐ Severe ☐ Moderate ☐ Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
If you have pain, is it: ☐ Deep ☐ Superficial
Please indicate the character of your pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Aching ☐ Knife-like Throbbing
Are you experiencing any of the following associated symptoms? ☐ Pins/Needles ☐ Tingling ☐ Numbness ☐ Twitching If Yes, Please describe:
Please indicate what activities provoke (P) or Aggravate (A) your condition: __Sitting for __min, __Standing, __Walking, __Lying, __Pushing, __Pulling, __Lifting __lbs., __Gripping Hot/Cold, __Bright Lights __Coughing/Sneezing, __Bowel Movements, __Mental Activities, __Bright Lights, __Other_____, __Other_____
Please indicate what helps to alleviate the pain. ☐ Lying ☐ Sitting ☐ Walking ☐ Standing ☐ Rest ☐ Heat/Cold ☐ Medications: _____, _____, _____

Please list what doctors you have seen for this condition. (Please include diagnosis, treatment, and any changes in your condition)

Please include any other relevant history in regards to this ailment.

***If you have another ailment that needs further explanation please inquire at the front desk for additional "ailment" forms.**

HORIZON FAMILY CHIROPRACTIC

Past Medical History

General Health History: Have you had any of the following?

Injuries, Accidents, Falls or Traumas: ☐No ☐Yes Explain:
Illnesses/Hospitalizations: ☐No ☐Yes Explain:
Surgeries: ☐No ☐Yes Explain:

Motor Vehicle Accidents: ☐No ☐Yes Explain:
Work Injuries: ☐No ☐Yes Explain:

Females Only – Menopausal Symptoms: ☐None ☐Yes Explain:

Habits

Cigarettes/Cigars	☐ None ☐ Yes How many per week?
Alcohol	☐ None ☐ Yes How many drinks per week? What type of alcohol?
Coffee	☐ None ☐ Yes How many cups per week?
Exercise	☐ None ☐ Yes Hours/Days per week? Types?
Water	☐ None ☐ Yes Glasses per week?
Soft Drinks	☐ None ☐ Yes Amount per week? Types?
Sleep	☐ None ☐ Yes Average per night? Do you have difficulty falling asleep or staying asleep? Hours desired per night?
Eating	Meals per day? What types of food do you eat? Do you consider your diet healthy? ☐ Yes ☐ No Explain:

Medications/Vitamins/Minerals/Supplements:
Allergies:

General Health History

Check the left box for any condition YOU had in the PAST, and the right box for any condition YOU have CURRENTLY.

P	C		P	C		P	C		P	C	
☐	☐	Mental Disorders	☐	☐	Diabetes	☐	☐	Pneumonia	☐	☐	Infective Disease
☐	☐	Epilepsy	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Fungal Infection
☐	☐	Tumors	☐	☐	Glaucoma	☐	☐	Hepatitis	☐	☐	Herpes
☐	☐	Alcoholism	☐	☐	Heart Disease	☐	☐	Thyroid Disease	☐	☐	Arthritis
☐	☐	Drug Addiction	☐	☐	Rheumatic Fever	☐	☐	Parasites	☐	☐	Autoimmune Disease
☐	☐	Cancer	☐	☐	Scarlet Fever	☐	☐	Asthma	☐	☐	Chicken Pox

Nervous System			**Eyes/Ears/Nose/Throat**			**Gastrointestinal**			**Musculoskeletal**		
P	**C**		**P**	**C**		**P**	**C**		**P**	**C**	
☐	☐	Depression	☐	☐	Vision Problems	☐	☐	Change in Appetite	☐	☐	Jaw Pain
☐	☐	Memory Loss	☐	☐	Flashing Lights	☐	☐	Excessive Thirst	☐	☐	Difficulty Chewing
☐	☐	Confusion	☐	☐	Black Spots	☐	☐	Frequent Nausea	☐	☐	Face Pain
☐	☐	Dizziness	☐	☐	Blurriness	☐	☐	Hemorrhoids	☐	☐	Neck Pain
☐	☐	Fainting	☐	☐	Hearing Loss	☐	☐	Black/Bloody Stools	☐	☐	Arm/Elbow Pain
☐	☐	Convulsions	☐	☐	Ringing in Ears	☐	☐	Digestive Problems	☐	☐	Wrist/Hand Pain
☐	☐	Weakness	☐	☐	Swallowing Difficulty	☐	☐	Abdominal Cramping	☐	☐	Mid Back Pain
☐	☐	Poor Balance				☐	☐	Gas/Bloating	☐	☐	Lower Back Pain
☐	☐	Twitches/Tremor				☐	☐	Heartburn	☐	☐	Thigh/Knee Pain
☐	☐	Cold/Tingling				☐	☐	Weight Problems	☐	☐	Ankle/Foot Pain
☐	☐	Sleeping Difficulties				☐	☐	Gall Bladder Issues	☐	☐	Difficulty Walking
☐	☐	Headaches				☐	☐	Liver Problems	☐	☐	Leg/Arm Fatigue

Cardiovascular			**Reproductive**			**Genitourinary**		
P	**C**		**P**	**C**		**P**	**C**	
☐	☐	Chest Pain	☐	☐	Erectile Difficulties	☐	☐	Bladder Trouble
☐	☐	Irregular Heartbeat	☐	☐	Sexual Dysfunction	☐	☐	Painful Urination
☐	☐	High Blood Pressure	☐	☐	Menstrual Irregularity	☐	☐	Incontinence
☐	☐	Shortness of Breath	☐	☐	Menstrual Cramping	☐	☐	Discolored Urine
☐	☐	Lung/Congestion Problems	☐	☐	Venereal Infection			
☐	☐	Varicose Veins						

How many times per day do you urinate?	How often do you have a bowel movement?
Do you experience any ☐ urgency, ☐ dribbling, ☐ incontinence?	Do your stools ☐ Float or ☐ Sink?
Is this urination pattern consistent? ☐ Yes ☐ No	Are your bowel movements consistent? ☐ Yes ☐ No

Date of Last

Physical Exam:	By whom?	Results:	
Blood Work:	By whom?	Results:	
Bone Density Study:	Results:	Mammogram:	Results:
Pelvic Exam:	Results:	Self Breast Exam:	Regularity:
PSA Exam:	Results:	Digital Prostate Exam:	Results:
Chest X-Rays:	Results:	EKG:	Results:
Echocardiogram:	Results:		
Spinal X-Rays:	By whom?	MRI/Cat Scan:	Results:
Other Tests:			

Family History

Mother:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Father:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Brother:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Brother:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Sister:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Sister:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Maternal Grandmother:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Maternal Grandfather:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Paternal Grandmother:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Paternal Grandfather:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Children:	Ages:_____	Any health conditions?

Have any of your family members ever suffered from any of the following conditions?

☐ Diabetes	☐ Neurological Disorders_____ _____	☐ Depression/Mental Illness_____ _____
☐ Heart Disease	☐ Autoimmune Diseases_____ _____	☐ Cancer_____ _____
☐ Other	☐ Other_____ _____	☐ Other_____ _____

Patient Consent for Use and Disclosure of Protected Health Information

Our Privacy Pledge

We are very concerned about protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. Our Notice of Privacy Practices outlines how we may use or disclose your Protected Health Information (PHI). By signing this form, you acknowledge having reviewed our notice and give consent for the following uses and disclosures:

You have the right to review our full Notice of Privacy Practiced before you sign this consent form (164.520)

Use and Disclosure for Treatment, Payment, and Healthcare Operations:

Your PHI can be used for treatment, obtaining payment for treatment, and internal healthcare operations. This includes, but is not limited to, consultations with other healthcare providers, billing activities, and quality improvement initiatives.

Changes to Privacy Policy:

Our privacy practices are subject to change. Should there be significant change, you will be notified at your next visit for acknowledgement.

Right to Restrict PHI Use:

You have the right to request restrictions on certain uses and disclosures of your PHI. While we are not required to agree to these restrictions, we will abide by any agreed-upon restrictions.

Revocation of Consent:

You may revoke this consent at any time in writing. However, the revocation will not affect any prior uses or disclosures of PHI made under this.

Communication Preferences

Please indicate your preferences for how we may contact you:

Appointment Confirmations

May we call you to confirm appointments? YES NO

Messages *(May we leave messages regarding appointments or other non-sensitive information?)*

Home answering machine YES NO
Cell phone voicemail YES NO

By signing below, I acknowledge that I have read and understood this form and agree to the use and disclosure of my PHI as described above. I also acknowledge my rights and the practice's right to change its privacy policy.

Patient Signature **Date**

Informed Consent for Chiropractic Care and Waiver to Treat

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily of the spine) and function (primarily of the nervous system) as that relationship may have an effect on the restoration and preservation of health. Health is the state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a ***vertebral subluxation***. This occurs when one or more of the 24 vertebrae in the spinal column becomes misaligned and/or does not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an ***adjustment.*** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as adjustments of the extremities, physiotherapy and/or rehabilitative procedures may be included.

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 fractures, disc injuries, muscle or ligament injuries, nerve injuries, vascular injuries such as stroke, dislocation, and nerve injuries. I will make every reasonable effort during the consultation and 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.

Other treatment options include medications, surgery, and alternative treatments. You should be aware that there are risks and benefits of those options which can be discussed with your primary medical physician.

The risks associated with remaining untreated include but are not limited to the formation of adhesions and reduction of mobility which may set up a pain reaction further reducing mobility. Over time and the longer treatment is postponed, this process may complicate future care by making it more difficult and less effective.

If during care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

Do Not Sign Until You Have Read and Understand the Above.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Patient Name	**Signature**	**Date**

Agreement for Payment of Services: (Please initial all that apply, sign and date below)

_____ I understand that Horizon Family Chiropractic is not familiar with my insurance policy, nor can they determine whether my insurance will pay for all or part of the services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ I acknowledge and agree that I will be personally responsible for all the payments for Horizon Family Chiropractic services, whether my insurance pays for all or part of the services.

_____ I acknowledge that if I do not have insurance that payment is expected at the time of service

Patient Signature **Date**