Mane Strides Human Intake Form

NAME (FIRST AND LAST) ____________________

☐ CURRENT CLIENT PREFERRED NICKNAME ____________________

☐ NEW CLIENT DATE OF BIRTH ______ ______ GENDER ________

ADDRESS (INCLUDE CITY, STATE & ZIP CODE):

____

PLEASE INCLUDE GATE CODE IF APPLICABLE ____________________

PHONE NUMBER ____________________

EMAIL ____________________

EMERGENCY CONTACT INFORMATION & RELATIONSHIP:

____

OCCUPATION/EMPLOYER ____________________

HOW MANY MONTHS/YEARS HAVE YOU BEEN AT THIS OCCUPATION? ________

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LOCAL & LICENSED MOBILE ANIMAL CHIROPRACTOR CARING FOR EQUINES/SMALL ANIMALS ALONG WITH THEIR HUMANS.

BASED IN FREMONT COUNTY, SERVING RURAL COMMUNITIES & SURROUNDING REGION.

CURRENT STATE

REASON(S) FOR SEEKING CARE ____________________

PRESENT REASON(S) DUE TO INJURY? ☐ YES ☐ NO IF YES, HAS THIS ACCIDENT BEEN REPORTED? ☐ YES ☐ NO

PRIOR DIAGNOSIS RELATED OR UNRELATED TO THIS REASON(S) ____________________

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS REASON(S)? ____________________

CONDITION INFORMATION

ONSET DATE ____________________

LOCATION/REGION ____________________

DOES THE REASON FOR SEEKING CARE:

☐ COME AND GO ☐ CONSTANT

IS YOUR CURRENT REASON FOR SEEKING CARE:

☐ GETTING WORSE ☐ GETTING BETTER

☐ STAYING THE SAME ☐ NOT APPLICABLE

HAVE YOU EXPERIENCED THIS PAIN BEFORE?

☐ YES ☐ NO

TIME OF DAY YOU HAVE COMPLAINT? ________

CHARACTERISTICS OF COMPLAINT:

☐ NUMB ☐ ACHY ☐ ELECTRIC ☐ SPASM ☐ STIFF

☐ DULL ☐ SHARP ☐ BURNING ☐ NEEDLES ☐ DEEP

☐ OTHER: ____________________

ALLEVIATING FACTORS? ____________________

AGGERVATING FACTORS? ____________________

IF SO, WHERE DOES THE PAIN RADIATE?

____

PAIN SCALE ASSESSMENT:
0 BEING NONE, 5 BEING MAX 0 1 2 3 4 5

GENERAL INFORMATION

PRIOR INJURIES AND/OR ILLNESSES:

____

____

PRIOR SURGERIES ____________________

____

CURRENT MEDICATIONS/SUPPLEMENTS:

____

____

SMOKER ☐ YES ☐ NO EXERCISE ☐ YES ☐ NO

CAFFINE ☐ YES ☐ NO ALCOHOL ☐ YES ☐ NO

SIGNATURE **DATE**

Human Informed Consent for Care

YOU ARE THE DECISION MAKER FOR YOUR HEALTH CARE. PART OF MANE STRIDES ROLE IS TO PROVIDE YOU WITH INFORMATION TO ASSIST YOU IN MAKING INFORMED CHOICES. THIS PROCESS IS OFTEN REFERRED TO AS "INFORMED CONSENT" AND INVOLVES YOUR UNDERSTANDING AND AGREEMENT REGARDING THE CARE WE RECOMMEND, THE BENEFITS AND RISKS ASSOCIATED WITH THE CARE, ALTERNATIVES, AND THE POTENTIAL EFFECT ON YOUR HEALTH IF YOU CHOOSE NOT TO RECEIVE THE CARE.

SOME DIAGNOSTIC OR EXAMINATION PROCEDURES, IF INDICATED, MAY BE PERFORMED. ANY EXAMINATIONS OR TESTS CONDUCTED WILL BE CAREFULLY PERFORMED BUT COULD BE INITIALLY UNCOMFORTABLE. CHIROPRACTIC CARE CENTRALLY INVOLVES WHAT IS KNOWN AS A CHIROPRACTIC ADJUSTMENT. THERE MAY BE ADDITIONAL SUPPORTIVE PROCEDURES OR RECOMMENDATIONS AS WELL. WHEN PROVIDING AN ADJUSTMENT, AN INSTRUMENT OR HANDS ARE USED TO REPOSITION ANATOMICAL STRUCTURES, SUCH AS VERTEBRAE. POTENTIAL BENEFITS OF AN ADJUSTMENT INCLUDE RESTORING NORMAL JOINT MOTION, REDUCING SWELLING AND INFLAMMATION IN A JOINT, REDUCING PAIN IN THE JOINT, AND IMPROVING NEUROLOGICAL FUNCTIONING AND OVERALL WELL-BEING.

IT IS IMPORTANT THAT YOU UNDERSTAND, AS WITH ALL HEALTH CARE APPROACHES, RESULTS ARE NOT GUARANTEED, AND THERE IS NO PROMISE TO CURE. AS WITH ALL TYPES OF HEALTH CARE INTERVENTIONS, THERE ARE SOME RISKS TO CARE, INCLUDING, BUT NOT LIMITED TO: MUSCLE SPASMS, AGGRAVATING AND/OR TEMPORARY INCREASE IN SYMPTOMS, LACK OF IMPROVEMENT OF SYMPTOMS, BURNS AND/OR SCARRING FROM ELECTRICAL STIMULATION AND FROM HOT OR COLD THERAPIES, INCLUDING BUT NOT LIMITED TO HOT PACKS AND ICE, FRACTURES (BROKEN BONES), DISC INJURIES, STROKES, DISLOCATIONS, STRAINS, AND SPRAINS. WITH RESPECT TO STROKES, THERE IS A RARE BUT SERIOUS CONDITION KNOWN AS AN "ARTERIAL DISSECTION" THAT TYPICALLY IS CAUSED BY A TEAR IN THE INNER LAYER OF THE ARTERY THAT MAY CAUSE THE DEVELOPMENT OF A THROMBUS (CLOT) WITH THE POTENTIAL TO LEAD TO A STROKE. THE BEST AVAILABLE SCIENTIFIC EVIDENCE SUPPORTS THE UNDERSTANDING THAT CHIROPRACTIC ADJUSTMENT DOES NOT CAUSE A DISSECTION IN A NORMAL, HEALTHY ARTERY. DISEASE PROCESSES, GENETIC DISORDERS, MEDICATIONS, AND VESSEL ABNORMALITIES MAY CAUSE AN ARTERY TO BE MORE SUSCEPTIBLE TO DISSECTION. STROKES CAUSED BY ARTERIAL DISSECTIONS HAVE BEEN ASSOCIATED WITH OVER 72 EVERYDAY ACTIVITIES SUCH AS SNEEZING, DRIVING, AND PLAYING TENNIS. ARTERIAL DISSECTIONS OCCUR IN 3-4 OF EVERY 100,000 PEOPLE WHETHER THEY ARE RECEIVING HEALTH CARE OR NOT. PATIENTS WHO EXPERIENCE THIS CONDITION OFTEN, BUT NOT ALWAYS, PRESENT TO THEIR MEDICAL DOCTOR OR CHIROPRACTOR WITH NECK PAIN AND HEADACHE. UNFORTUNATELY, A PERCENTAGE OF THESE PATIENTS WILL EXPERIENCE A STROKE. THE REPORTED ASSOCIATION BETWEEN CHIROPRACTIC VISITS AND STROKE IS EXCEEDINGLY RARE AND IS ESTIMATED TO BE RELATED IN ONE IN ONE MILLION TO ONE IN TWO MILLION CERVICAL ADJUSTMENTS. FOR COMPARISON, THE INCIDENCE OF HOSPITAL ADMISSION ATTRIBUTED TO ASPIRIN USE FROM MAJOR GI EVENTS OF THE ENTIRE (UPPER AND LOWER) GI TRACT WAS 1219 EVENTS/PER ONE MILLION PERSONS/YEAR AND RISK OF DEATH HAS BEEN ESTIMATED AS 104 PER ONE MILLION USERS. IT IS ALSO IMPORTANT THAT YOU UNDERSTAND THERE ARE TREATMENT OPTIONS AVAILABLE FOR YOUR CONDITION OTHER THAN CHIROPRACTIC PROCEDURES. LIKELY, YOU HAVE TRIED MANY OF THESE APPROACHES ALREADY. THESE OPTIONS MAY INCLUDE, BUT ARE NOT LIMITED TO: SELF-ADMINISTERED CARE, OVER-THE-COUNTER PAIN RELIEVERS, PHYSICAL MEASURES AND REST, MEDICAL CARE WITH PRESCRIPTION DRUGS, PHYSICAL THERAPY, BRACING, INJECTIONS, AND SURGERY. LASTLY, YOU HAVE THE RIGHT TO A SECOND OPINION AND TO SECURE OTHER OPINIONS ABOUT YOUR CIRCUMSTANCES AND HEALTH CARE AS YOU SEE FIT.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE CONSENT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CHIROPRACTIC CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CHIROPRACTIC CARE FROM THIS OFFICE.

NOTICE AND PRIVACY

IT IS UNDERSTOOD THAT MEDICAL INFORMATION ABOUT YOU AND YOUR HEALTH IS PERSONAL, AND MANE STRIDES IS COMMITTED TO PROTECTING MEDICAL INFORMATION ABOUT YOU. THIS NOTICE APPLIES TO ALL RECORDS OF YOUR CARE PRODUCED AND MAINTAINED BY MANE STRIDES.

AS REQUIRED BY FEDERAL AND STATE LAW, MANE STRIDES MUST 1) MAKE SURE THAT MEDICAL INFORMATION THAT IDENTIFIES YOU IS KEPT PRIVATE; 2) MAKE AVAILABLE TO YOU THIS NOTICE OF OUR LEGAL AND PRIVACY PRACTICES WITH RESPECT TO MEDICAL INFORMATION ABOUT YOU; AND 3) FOLLOW THE TERMS OF THE NOTICE THAT IS CURRENTLY IN EFFECT.

FINANCIAL MATTERS

PAYMENT IS DUE AT THE TIME SERVICES ARE PROVIDED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. ALL CHARGES WILL BE EXPLAINED TO YOU PRIOR TO ANY SERVICE BEING PERFORMED.

PAYMENT IS DUE AT THE TIME SERVICES ARE PROVIDED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. ALL CHARGES WILL BE EXPLAINED TO PRIOR TO ANY SERVICE BEING PERFORMED. PLEASE KEEP IN MIND WHILE THERE IS NO CANCELLATION FEES IN PLACE, THAT IS A PRIVILEGE AND NOT A RIGHT TO CANCEL. ONCE MANE STRIDES SETS A SCHEDULE, PLEASE BE RESPECTFUL OF THE SCHEDULE. MANE STRIDES MAKES DECISIONS ON THE DAY OF SERVICE REGARDING CANCELLATIONS DUE TO THE ENVIRONMENT.

I HEREBY CERTIFY THAT THE STATEMENTS AND ANSWERS GIVEN ON THIS FORM ARE ACCURATE TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY HEALTH. I UNDERSTAND I HAVE THE RIGHT TO REQUEST A RESTRICTION ON THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS OF THE PRACTICE, BUT THE PRACTICE IS NOT REQUIRED TO AGREE TO THESE RESTRICTIONS. HOWEVER, IF THE PRACTICE AGREES TO A RESTRICTION THAT I REQUEST, THE RESTRICTION IS BINDING ON THE PRACTICE. I UNDERSTAND I HAVE THE RIGHT TO REVIEW THE PRACTICE'S NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS DOCUMENT. THE NOTICES OF PRIVACY PRACTICES DESCRIBES MY RIGHTS AND THE PRACTICE'S DUTIES REGARDING THE TYPES OF USES AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING, AT ANY TIME, EXCEPT TO THE EXTENT THAT THE CHIROPRACTOR HAS ACTED IN RELIANCE ON THIS CONSENT. I AGREE TO ALLOW THIS OFFICE TO EXAMINE ME FOR FURTHER EVALUATION.

SIGNATURE ______________________ PRINT NAME ______________________ DATE ____________