



211 W. 6th Street, Cedar Falls, IA, 50613
319-277-3166 | drkime@accoi.net | www.accoi.net

Patient Data

Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **Zip Code** _____

Home Phone (____) _____ - _____ **Cell Phone** (____) _____ - _____

Email _____ **Date of Birth** ____/____/____

Sex: Male Female Other _____ **Marital Status:** Single Married Other

Spouse's name _____ **Spouse's number** _____

Employment Status: Employed Unemployed FT Student PT Student Other _____

Employer Name _____ **Occupation** _____

Emergency Contact

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (____) _____ - _____ **Cell Phone** (____) _____ - _____

How did you hear about our office? _____

Patient Signature _____

Date _____

Patient Medical History

Medical Conditions: (Check all that apply to you)

- Arthritis
- Hypertension
- Other _____
- Cancer
- Psychiatric Illness
- Diabetes
- Skin Disorder
- Heart Disease
- Stroke

Surgeries: (Check all that apply to you)

- Appendectomy
- Joint Replacement
- Brain
- Carpal Tunnel
- Other _____
- Cardiovascular procedure
- Prostate
- Shoulder
- Gastro-intestinal
- Cervical spine
- Lumbar spine
- Thoracic spine
- Uro-genital
- Hysterectomy
- Gall Bladder
- Knee
- Hernia

Allergies: (Check all that apply to you)

- Eggs
- Soy
- Fish and Shellfish
- Sulfites
- Milk or Lactose
- Wheat/Glutens
- Peanuts
- Other _____

Social History: (Check all that apply to you)

- Caffeine use: occasional often never
- Drink Alcohol: occasional often never
- Exercise: occasional often never
- Chew Tobacco: occasional often never
- Cigarettes: <1 pack/day >1 pack/day never
- Wear Seat Belts: occasional always never

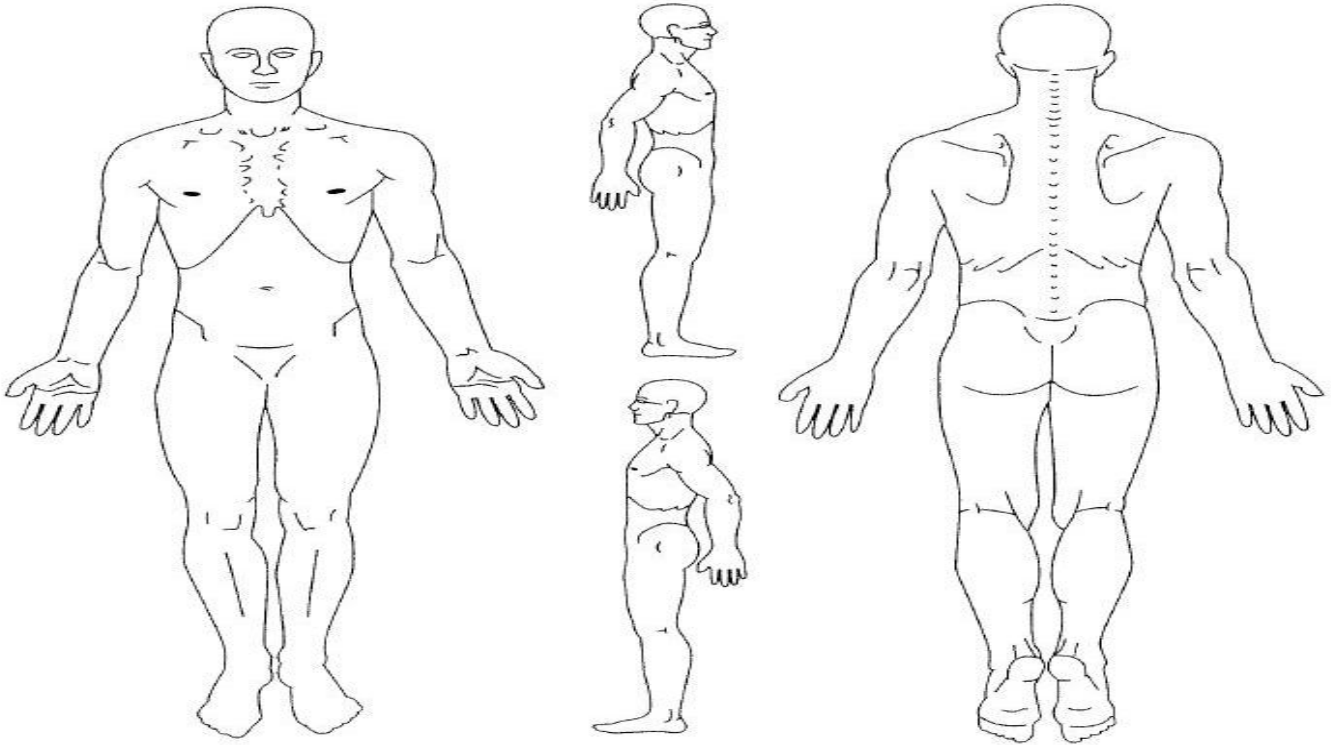
Family History: (Check all that apply)

- Arthritis: Parent Sibling
- Cancer: Parent Sibling
- Diabetes: Parent Sibling
- Heart Disease Parent Sibling
- Hypertension Parent Sibling
- Stroke Parent Sibling
- Thyroid Parent Sibling
- Other _____

Are you pregnant? Yes _____ No _____ N/A _____

Please list all current medications being taken _____

Indicate on the body diagram where you are experiencing the following symptoms:



Describe your symptoms in order of severity, with worse symptom being #1: _____

When did your symptoms begin? Month _____ Day _____ Year _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other _____

How did your symptoms begin? _____

How often do you experience your symptoms?

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Constantly
(76-100% of the day) | <input type="checkbox"/> Frequently
(51-75% of the day) | <input type="checkbox"/> Occasionally
(26-50% of the day) | <input type="checkbox"/> Intermittently
(0-25% of the day) |
|---|--|--|---|

What describes the nature of your symptoms?

- | | | | |
|----------------------------------|------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull ache | <input type="checkbox"/> Numb | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Other _____ |

Acupuncture & Chiropractic Clinic Of Iowa
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HIPAA Patient Consent Form

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment, or health care operations, in order to provide health care that is in your best interest. **Your Personal Health Information (PHI) will never be given to any entity besides what is required for your treatment, payment, and health care operations.**

We also want you to know that we support your full access to your personal medical records. WE may have indirect treatment relationships with you (such as radiologists that only interact with physicians not patients), and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are more often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which replied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA COmpliance Officer.

You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____

Signature: _____ Date: _____

Parent/Legal Guardian: _____

Signature: _____ Date: _____



Consent for Chiropractic Treatment

Chiropractic is an alternative health care option that primarily involves the doctor of chiropractic applying specific adjustments in different areas of the spine. The goal of chiropractic treatment is to remove spinal misalignments (known as subluxations) in an attempt to restore proper nervous system function. Benefits of chiropractic care may include, but are not limited to, an increase in range of motion, a decrease in pain level, or a decrease in muscle spasm.

As with any other health care profession, chiropractic care is not without risks. The following summary outlines some, but not all, of the significant risks and/or probable risks associated with manual therapy techniques used by doctors of chiropractic.

- While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains and/or sprains as a result of manual therapy techniques.
- Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures.
- There are reported cases of an interruption of blood flow to the brain (commonly called a stroke) Associated with visits to medical doctors and chiropractors
- However, you being informed of this reported associated because a stroke may cause serious neurological impairment or even death.
- The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.
- There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment.

The probability of a patient experiencing one of these adverse effects ranges from 1 in 1 million to 1 in 20 million. The doctor of chiropractic has been trained to screen patients to determine if they are at risk for any of these conditions. If the patient is determined to be at risk, then the patient is advised to seek proper care before chiropractic treatment will be attempted.

My signature below indicates that I acknowledge that I have read this consent, that I have had the risks benefits, and costs of chiropractic treatment explained to me and that all of the questions pertaining to my treatment have been satisfactorily answered.

My signature below also represents my consent to the chiropractic treatment recommended to me by my chiropractor including any and all spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

PRINTED NAME: _____

PATIENT SIGNATURE: _____

Date: _____



Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist(s) who now or in the future treat me. I understand that methods of treatment may include, but are not limited to, acupuncture, and nutritional counseling. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the supplements recommended.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including:

- Bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting.
- Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax).
- Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts then known, is in my best interest.

I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PRINTED NAME: _____

PATIENT SIGNATURE: _____

Date: _____