Ascend

Last Name _____ First Name _____ Date ___/___/____

Address _____ City _____ Zip _____

Cell Phone _____Email _____

Birthday _____/ _____ /_____ Age _____ Gender Identity: M / F / Other: _____

Occupation _____ Employer _____

Marital Status: _____ Spouse's Name _____ Number of Children ____

Emergency Contact (name) _____ (phone) _____ (relationship) _____

How did you hear about our clinic? _____

Can we send you health and wellness emails? Yes / No

What is the main outcome you are hoping for with care at Ascend Chiropractic?

_____

_____

Current Condition(s)

We will discuss your symptoms together, and please let me know where our primary focus will be to begin.

Please rate your primary symptoms individually on a scale of 1-10, 0 being no pain at all and 10 being the most pain you've ever experienced.

Symptom #1: _____ 0 1 2 3 4 5 6 7 8 9 10

Symptom #2: _____ 0 1 2 3 4 5 6 7 8 9 10

Symptom #3: _____ 0 1 2 3 4 5 6 7 8 9 10

Symptoms Additional (List Individually): _____

When did your primary symptoms begin? _____

What was the cause of your symptoms? Auto Accident Work Injury Lifting Slip/Fall Overexertion Strenuous Position Unknown Other: _____

What makes the symptoms better or worse? _____

Describe the quality of the pain (dull, ache, sharp, other) _____

Does the pain radiate down your arms or legs? _____

Have you experienced symptoms like these before? Yes / No (When?) _____

What time of day are your symptoms better or worse? _____

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Current Condition(s) Continued

Please check all that apply:

Spinal:	Neck Pain / Stiffness	Mid Back Pain / Stiffness	Low Back Pain / Stiffness	
Extremity:	**LEFT**	**RIGHT**		
	Shoulder / Arm / Hand Pain	Shoulder / Arm / Hand Pain		
	Hip / Leg / Foot Pain	Hip / Leg / Foot Pain		
Miscellaneous:	Headache	Jaw Pain / TMJ	Chest Pain	Fatigue

Other: _____

Does your pain travel, radiate, or feel numb or tingly in any of the following areas? (Check all that apply):

Extremity:	**LEFT**	**RIGHT**
	Shoulder / Arm / Hand / Fingers	Shoulder / Arm / Hand / Fingers
	Hip / Leg / Foot / Toes	Hip / Leg / Foot / Toes

If you are experiencing Headaches or Neck Pain, have you experienced pain like this before?

- ☐ Yes, I have had headaches/neck pain like this before.
- ☐ No, this pain is different than I have ever experienced in the past.

Is your headache worse in the morning or afternoon? Yes / No

Do your headaches wake you from your sleep? Yes / No

Vascular Screening Symptoms

Have you recently experienced any of the following? (Check all that apply)

Dizziness	Fainting/Loss of Consciousness	Recent decrease in coordination	Visual Disturbances
Trouble Swallowing	Nausea / Vomiting	Slurred Speech	Change in Urination
Recent Unexplained Weight Gain or Loss	Blurred Vision	Double Vision	None of the above

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Medications/Supplements

Please list all medications that you are currently taking:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list vitamin, mineral, and herbal supplements you are currently taking:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Activities of Daily Living / Lifestyle

This next series of questions are about the affect your health has had on your activities of daily living and lifestyle. We will use this information to measure your progress and the results of your treatment if we are able to accept you for care.

Smoking (packs per day): Never 1 2 3 4+ Quit ____ years ago

Caffeinated drinks: (glasses per day) 0 1 2 3 4 5 6+

Alcoholic drinks: (drinks per day) 0 1 2 3 4 5 6+

Drug/Substance use: Yes / No

What do you feel your current level of stress is? (0 being no stress at all and 10 being maximal stress) 0 1 2 3 4 5 6 7 8 9 10

Does your health negatively affect your relationships with your family and friends? Yes / No

Does your health negatively affect your work? Yes / No

Does your health negatively affect your energy? Yes / No

Does your health negatively affect your sleep? Yes / No

Do you struggle to fall asleep or wake up during the middle of the night? Yes / No

Average amount of sleep per night (hours): _____

Does your health negatively affect your exercise / hobbies / recreational activities? Yes / No

Exercise: (times per week) 0 1 2 3 4 5 6 7

Type(s) of Exercise: _____

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Previous/Current Conditions

Do you currently have or have you ever had any of the following:

Hearing Changes	Aneurysm	Anemia	Arthritis	Rheumatic Fever
Blood Press. High / Low	Cancer / Tumor	Change in Appetite	Diabetes	Osteoporosis
Dislocated Joints	Easily Bruised	Emphysema	Epilepsy / Seizures	Pacemaker
Stroke	Heart Disease	Heart Palpitations	Frequent Nose Bleeds	Ulcer
Hypo / Hyper Thyroidism	Insomnia	Kidney Trouble	Liver Trouble	Prostate Trouble
Bone Fracture	Scoliosis	Mental / Emotional Difficulty	STD	Rash / Lesion
Allergies	Hernia	Spinal Disc Disease	Tinnitus / Ears Ringing	Multiple Sclerosis

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Previous Testing and Treatment

What testing have you had done and when?

X-Ray: Yes / No Area: _____ Date: _____

MRI: Yes / No Area: _____ Date: _____

CAT Scan: Yes / No Area: _____ Date: _____

Electrodiagnostic (EMG/NCV): Yes / No Area: _____ Date: _____

Was there a previous diagnosis for your condition? _____

Have you ever seen anyone else for this condition? Yes / No

If Yes, who and when? _____

Have you ever received: (Check all that apply)

Physical Therapy Chiropractic Care Acupuncture Therapy Massage Therapy Coaching Other: _____

Have you considered any other treatment? Yes / No **If yes, what?** _____

What were the results from each type of treatment? _____

_____

_____

Is there any type of treatment that you would not consider at this time? _____

_____

What is your most important treatment objective? (Reduce pain, increase function, correct cause, prevent progression…)

_____

Previous Accidents/Injuries/Hospitalizations/Surgeries

Do you have a history of the following: Work Injury Auto Accident Slip and Fall Accident

If so, please list approximate dates and incident: **Date** ____/_____/_____ **Incident:** _____

Date ____/_____/_____ **Incident**: _____

Have you ever been hospitalized? Yes / No

If so, when and for what condition? **Date** ____/_____/_____ **Condition:** _____

Date ____/_____/_____ **Condition**: _____

Have you had surgeries? Yes / No

If so, when and for what condition? **Date** ____/_____/_____ **Surgery:** _____

Date ____/_____/_____ **Surgery**: _____

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for 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 or not 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 the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a 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 become misaligned and/or do 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 physiotherapy and/or rehabilitative procedures may be included.

If during the course of 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.

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.

_____	_____	_____
Print Name	Signature	Date

MISSED VISIT POLICY

All scheduled visits must be cancelled with 24 hours advanced notice.

Any missed cash visits are charged the cash price for the session.

I , _____, understand I will be responsible financially for any and all care given. This includes charges for non-covered services and/or the cash price for missed visits or visits cancelled/rescheduled within 24 hours of the appointment time.

Patient's Signature: _____ Date: _____

Ascend Notice of Privacy Practices

THIS NOTICE, EFFECTIVE 1/1/2021, DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Ascend is required by law to maintain the privacy and confidentiality of your Protected Health Information (PHI) and to provide our patients with notice of our legal duties and privacy practices with respect to your Protected Health Information (PHI).

Disclosure of your Health Care Information:

Treatment: We may disclose your healthcare information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations. A few examples are listed below:

- It may be necessary to seek consultation regarding your treatment from other healthcare providers associated with Ascend.
- It is our policy to provide a substitute healthcare provider, authorized by Ascend to provide assessment and/or treatment to our patients, without advance notice, in the event of your primary healthcare provider's absence due to vacation, sickness, or emergency situation.
- Due to the nature of Ascend's adjusting areas; others may overhear conversations between the doctor and patient although every effort will be made to avoid loss of confidentiality. At any time, you may request a private consultation with the doctor.

Payment: We may disclose your PHI to your insurance provider for the purpose of payment or healthcare operations. As a courtesy to our patients, we will submit an itemized statement to your insurance carrier for the purpose of payment to Ascend for healthcare services rendered. If you pay for your healthcare services personally, we will, as a courtesy to you, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information including diagnosis, date of injury or condition, and codes which may describe the healthcare services received.

Workers Compensation: We may disclose your PHI as necessary to comply with State Workers Compensation Laws.

Emergencies: We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition in the event of an emergency.

Public Health: As required by law, we may disclose your PHI to public health authorities for the purpose related to, but not limited to preventing or controlling disease, injury disability, reporting child abuse or neglect, reporting domestic violence, report to the Food & Drug Administration problems with products and reactions to medications, and reporting disease or infectious exposure.

Law Enforcement: We may disclose your PHI to law enforcement officials for the purposes such as, but not limited to identifying or locating a suspect, fugitive, material witness, missing persons, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons: We may disclose your PHI to coroners or medical examiners.

Organ Donation: We may disclose your PHI to researchers conducting research that has been approved by the Institutional Review Board.

Public Safety: It may be necessary to disclose your PHI to appropriate persons in order to prevent or lessen a serious and imminent threat to the health and/or safety of a particular person or to the general public.

Specialized Government Agencies: We may disclose your PHI for military, national security, prisoner, and government benefits purposes.

Marketing: We may contact you for marketing purposes or fundraising purposes. It is our practice to participate in charitable events to raise awareness, food donations, etc. During these times, we may send you a letter, postcard, email, or call you to invite you to participate in the event/activity. We will provide you with information about the type of activity, dates and times, and may request your participation. It is not our policy to disclose your PHI for the purpose of Ascend sponsored fundraising or marketing events to outside parties.

Change of Ownership: In the event Ascend is sold or merged with another organization, your PHI will become property of the new owner(s).

Continued on next page...

Your health information rights:

- You have the right to request restrictions on certain uses and disclosures of your PHI. Please be advised, Ascend is not required to agree to the restrictions you request.
- The right to receive confidential communications of protected health information from Ascend by alternate means or at alternate locations as provided by the Privacy Rule.
- Ascend is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.
- You have the right to receive a copy of your PHI *after* a written request has been signed per our Office Policy. A fee may be charged for necessary copies.
- You have the right to request that Ascend amend your PHI. Please be advised that Ascend is not required to amend your PHI. If your request to amend has been denied, you will be provided with an explanation of our denial reason(s) and information how to dispute the denial.
- You have the right to receive an accounting of disclosures of your PHI by Ascend.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.
- It is our policy that a Records Release Form is signed by you before your PHI is disclosed to a requesting physician, aside from provisions stated in this notice.

Changes to the Notice of Privacy Practices: Ascend reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all the information that it maintains. Until such amendment is made, Ascend is required by law to comply with this Notice. Any questions about this Notice or if you would like more information about your privacy rights, please contact the Office at 970-430-6175. You may make an appointment for a personal conference. A revised copy will be available for you in our office at all times.

Complaints: Complaints about your privacy rights should be directed to the Office Manager by calling (425) 444-4815. If he/she is not available, you may make an appointment for a personal conference. If you are not satisfied with the manner your PHI has been handled, it is your right to contact DHHS at 200 Independence Ave SW, Washington, DC 20201.Thank you!

It is our goal at Ascend to protect your Private Health Information!

Acknowledgment of receipt of Notice of Privacy Practices

I acknowledge that I have read and understand the Notice of Privacy Practices for Ascend and that I may receive a copy of this Notice immediately upon request.

_____

Print Patient Name

_____ Date _____

Patient/Parent Signature