INFORMED CONSENT FOR CHIROPRACTIC CARE

By beginning chiropractic care at Compass Chiropractic LLC, I acknowledge that the objective of the chiropractor is to identify and correct vertebral subluxations through the administration of a chiropractic adjustment. The adjustment is a specific manual force applied to the spine by hand or instrument, in which a quick thrust or impulse is delivered to the involved area(s). In some cases, Kevin McDade DC may need to touch otherwise sensitive areas of the body to properly deliver an adjustment or analyze my spine. I acknowledge that some techniques require the body to be placed into seemingly awkward positions to better receive the chiropractic adjustment. I hereby request and consent to the performance of chiropractic care and various other procedures and modalities, on myself (or on the patient named below for whom I am legally responsible) by the licensed doctor of chiropractic, Kevin McDade DC.

Many patients report benefits while under chiropractic care including increased range of motion, pain relief, and others. Although most people do respond positively to care, no guarantees of cure have been implied or given. As with any health care procedure, there some associated risks which your doctor is required to bring to your attention. Though uncommon, you should note the possibility of: fracture, disc injury, muscle strain, ligament sprain, dislocation, and costovertebral separation. Strokes have been reported following chiropractic manipulation. The probability of this is exceedingly rare, estimated between one in one million and one in two million, and can be further reduced by screening procedures. Complications generally result from an underlying weakness of the bone or tissue which will be screened for during the initial exam. I understand all such risks and complications.

I understand that I am ultimately responsible for my health, and therefore may seek concurrent care from other related health care fields on my own accord. I agree to allow this office to use my confidential health information for the purposes of treatment, payment, healthcare operations and coordination of care with my medical physician(s) about my condition and treatment.

As of today, all of my questions have been adequately answered, but I am free to discuss any concerns with the doctor as the need arises. In the event that my conduct or cooperation become contrary to this agreement, Kevin McDade DC has the right to remove me from his care.

I have voluntarily read, understand, and agree to the aforementioned principles. By my signature below, I consent to all treatments deemed by this office to be in my best interest. I intend this document to cover the entire course of care, now and in the future, and agree to its provisions. I hereby authorize Kevin McDade DC, or whomever he designates as an assistant, to administer treatment to:

Printed Name: _____

Patient Signature: _____ Date: _____

Consent to Treatment of a Minor Child:

I hereby authorize Kevin McDade DC, and/or whomever he may designate as assistants, to administer treatment as deemed necessary to _____.

Signature of Parent/Legal Guardian: _____ Date: _____

Relationship to Minor: _____

HIPAA - Health Insurance Portability and Accountability Act
Notice of Privacy Policy

Compass Chiropractic LLC
13146 Midlothian Turnpike
Midlothian, VA 23113
804-499-6020

The following is an explanation of our Privacy Policy and your rights as a patient.

- Our office does not distribute or make available to any outside source your "protected health information," or (PHI).
- Your personal health information is secure and used only for treatment, claims submission to third party insurance carriers for the purposes of payment, and other health care operations.
- A family member may be present when taking a case history, hearing the results of exams or tests, or during normal office visits. Family or friends will only have access to your PHI with your written authorization.
- Our office may send you seasonal, birthday, or reminder cards to the address supplied on your intake forms.
- Our office may call you to confirm or reschedule an appointment. We may leave a message on the answering machine unless you have specifically instructed us to the contrary.
- You have the right to withdraw consent and terminate care at any time for any reason. A withdrawal of consent must be made in writing.
- You have the right to ask questions about the status of your health at any time.
- You have the right to view and copy your own file. Copying and mailing charges may apply.

By my signature below, I acknowledge that I have read, understand, and agree with the privacy policies set forth by Compass Chiropractic LLC. At my request, I am entitled to view and keep a copy of this abbreviated form or the corresponding full privacy statement, which is also made available on the practice's website: www.CompassChiroVA.com.

Printed Name:_____

Patient Signature: _____Date:_____

Compass Chiropractic LLC
13146 Midlothian Turnpike
Midlothian, VA 23113
Phone: 804.499.6020
Fax: 804.499.6030

Diagnostic X-Ray Consent Form

Patient Consent to X-Ray:

I authorize the performance of diagnostic X-ray on myself, which Compass Chiropractic LLC considers necessary or advisable in the course of my examination and treatment. At this time, I know of no condition which the taking of X-rays would further complicate.

Printed Name: _____

Patient Signature: _____ Date:_____

Consent to X-Ray a Minor:

I am a parent or legal guardian of (patient) _____, who is a minor, _____years of age. I hereby authorize the performance of diagnostic X-rays on this minor by Compass Chiropractic LLC for further diagnostic purposes. At this time, I know of no condition which the taking of X-rays would further complicate.

Patient Name: _____

Parent/Guardian Signature: _____ Date:_____

Females Regarding Possibility of Pregnancy:

X-rays, particularly those involving the pelvis, can be hazardous to an unborn child. It is advisable that, in women of child-bearing potential, X-rays be taken in the first ten (10) days following the onset of a menstrual cycle, as this is generally considered to be safe for X-ray exams.

With these considerations in mind, I certify that to the best of my knowledge I am NOT pregnant, and the doctor has permission to perform diagnostic X-rays.

Patient Signature: _____ Date:_____

Compass Chiropractic LLC: Health Profile

Please fill out this form to the best of your ability. All of your information is strictly confidential.

Legal Name: _____ Date: _____

Mailing Address: _____ Occupation: _____

_____ (If retired/unemployed, list former occupation)

Email: _____ Height: _____

Weight: _____lbs

How did you hear about us? _____

Emergency Contact (Required)

Have you been to a chiropractor before? ❑ Yes ❑ No Name: _____

If Yes, was it a good experience? ❑ Yes ❑ No Relationship: _____

Are you nervous about being adjusted? ❑ Yes ❑ No Phone: _____

1. Lifestyle:

Smoking: ❑ 0 Cigarettes/day (non-smoker) ❑ 1-3 Cigarettes/day
❑ 0 Cigarettes/day (former-smoker) ❑ 1-2packs/day ❑ 2+ packs/day

Alcohol: ❑ Abstainer (none at all) ❑ Heavy drinker
❑ Light/Moderate drinker ❑ Former Alcoholic (sober since: _____)

Activity Level: ❑ Sedentary (none) ❑ Moderate activity (jogging)
❑ Light activity (i.e. walking) ❑ Vigorous activity (max exertion)

Any hobbies/sports you participate in regularly? _____

_____

2. Medical History:

Hospitalizations/Surgeries: please check the boxes if you have had any of these particular surgeries.

❑ Spine ❑ Shoulder (R/L) ❑ Brain ❑ Lung ❑ Gallbladder
❑ Hip (R/L) ❑ Knee (R/L) ❑ Heart ❑ Breast ❑ Appendix

Year: _____ Area/reason: _____ Procedure: _____
Year: _____ Area/reason: _____ Procedure: _____
Year: _____ Area/reason: _____ Procedure: _____

Prior Accidents/Injuries: includes car accidents, falls, sports injuries, etc.

Year: _____ Area injured: _____ How? _____
Year: _____ Area injured: _____ How? _____
Year: _____ Area injured: _____ How? _____

Ongoing Condition(s)? ❑ No ❑ Yes, please list: _____

Allergies? ❑ No ❑ Yes, please list: _____

Prescription Medications: If you have a medication list, please give us a copy and skip this section.

Medication	Reason	Date Started

Family History: this pertains to your direct siblings, parents, and grandparents **only**

❑ Cancer ❑ Stroke ❑ RA ❑ Seizures ❑ Diabetes
❑ Thyroid ❑ Heart Attack ❑ Osteoporosis ❑ Blood clots ❑ Kidney Disease

❑ Other: _____

Were there any deaths directly related to the above conditions? ❑ No ❑ Yes (fill in below)

Who _____ Condition _____ Age _____
Who _____ Condition _____ Age _____

Review of Systems: have **you** had a problem, whether now or in the past, with any of the following?

❑ Lethargy/Weakness
❑ Recurring Fever
❑ Recent Weight Loss/Gain
❑ Dizziness/Vertigo
❑ Chills
❑ Headaches
❑ Night Sweats

❑ Cancer
❑ Diabetes (Type I/II)
❑ Excessive Thirst
❑ Frequent Urination
❑ Thyroid Disorders
❑ Heart attack/disease
❑ Blood clots/DVT
❑ Ringing in ears
❑ Asthma/Allergies

❑ Migraines
❑ Memory Loss
❑ Poor Balance
❑ Numbness/Tingling
❑ Seizures
❑ Stroke/TIA
❑ Tremors
❑ Head Trauma
❑ Anxiety
❑ Depression
❑ Sleep Problems
❑ Weak Muscles
❑ Loss of Taste/Vision
❑ Double Vision
❑ Difficulty concentrating
❑ Difficulty controlling urination
❑ Incontinence of bowels

❑ Arthritis
❑ Joint Pain/Swelling
❑ Neck Pain
❑ Back Pain
❑ Trauma
❑ Osteoporosis
❑ Scoliosis
❑ Cramping
❑ Fractures
❑ Implants/Screws/Pins
❑ Hip Disorders
❑ Knee Injuries
❑ Foot/Ankle Pain
❑ Shoulder Problems
❑ Elbow/Wrist Pain
❑ Poor Posture
❑ Gout

Other Medical History:

Any steroid/epidural injections? ❑ No ❑ Yes, part of body: _____ Date: _____

Recent infections/immunizations? ❑ No ❑ Yes, please list: _____

Recent unintentional weight loss? ❑ No ❑ Yes, I've lost about _____ pounds in the last _____

FEMALES ONLY: is there any possibility that you are pregnant? ❑ No ❑ Yes ❑ Unsure

3. Primary Complaint: Please fill out this section in regards to a **single body area** only.

List the **body region only of your #1 problem**: _____

When did this start? _____ ❑ This is a recurring problem for me

What happened? _____ ❑ Started suddenly ❑ Started gradually

This problem is:	❑ Right-sided only	❑ Left-sided only	❑ Both	❑ In the middle
This problem is:	❑ Constant	❑ Frequent	❑ On/Off	❑ Occasional
When present, it lasts:	❑ Days	❑ Hours	❑ Minutes	❑ Seconds

On **average**, the severity of the complaint is: _____ /10 At its **worst**: _____ /10

Describe how it feels: (check all that apply)	❑ Aching	❑ Burning	❑ Dull	❑ Sharp	❑ Stabbing
	❑ Throbbing	❑ Stiffness	❑ Weakness	❑ Numbness	❑ Tingling

This problem is worsened by:			This problem is improved by:		
❑ Activity	❑ Twisting	❑ Lying Down	❑ Cold	❑ Rx Meds	❑ Morning
❑ Bending	❑ Getting Up	❑ Morning	❑ Heat	❑ Rest	❑ Night
❑ Lifting	❑ Everything	❑ Night	❑ Activity	❑ Stretching	❑ Sitting
❑ Standing	❑ Ice	❑ Overhead Reach	❑ Lying down	❑ Support brace	❑ Standing
❑ Stress	❑ Job	❑ Sitting	❑ OTC Meds	❑ Chiropractic	❑ TENS Unit
❑ Temp change	❑ Kneeling	❑ Touch/Pressure	❑ Posture change	❑ Massage	❑ Time off Work

Overall, this problem has been: ❑ Improving ❑ Staying the same ❑ Worsening

Which of these apply to your job? ❑ Prolonged standing ❑ Prolonged sitting ❑ Heavy lifting

Check the box if there is more to your problem than this, and the doctor will ask you about it: ❑ There is more

4. Secondary Complaint: Please fill out this section in regards to a **single body area** only.

List the **body region only of your #2 problem**: _____

When did this start? _____

What happened? _____ ❑ Started suddenly ❑ Started gradually

This problem is:	❑ Right-sided only	❑ Left-sided only	❑ Both	❑ In the middle
This problem is:	❑ Constant	❑ Frequent	❑ On/Off	❑ Occasional
When present, it lasts:	❑ Days	❑ Hours	❑ Minutes	❑ Seconds

On **average**, the severity of the complaint is: _____ /10 At its **worst**: _____ /10

Describe how it feels: (check all that apply)	❑ Aching	❑ Burning	❑ Dull	❑ Sharp	❑ Stabbing
	❑ Throbbing	❑ Stiffness	❑ Weakness	❑ Numbness	❑ Tingling

This problem is worsened by:			This problem is improved by:		
❑ Activity	❑ Twisting	❑ Lying Down	❑ Cold	❑ Rx Meds	❑ Morning
❑ Bending	❑ Getting Up	❑ Morning	❑ Heat	❑ Rest	❑ Night
❑ Lifting	❑ Everything	❑ Night	❑ Activity	❑ Stretching	❑ Sitting
❑ Standing	❑ Ice	❑ Overhead Reach	❑ Lying down	❑ Support brace	❑ Standing
❑ Stress	❑ Job	❑ Sitting	❑ OTC Meds	❑ Chiropractic	❑ TENS Unit
❑ Temp change	❑ Kneeling	❑ Touch/Pressure	❑ Posture change	❑ Massage	❑ Time off Work

Overall, this problem has been: ❑ Improving ❑ Staying the same ❑ Worsening

Which of these apply to your job? ❑ Prolonged standing ❑ Prolonged sitting ❑ Heavy lifting

Check the box if there is more to your problem than this, and the doctor will ask you about it: ❑ There is more

5. Other:

Optional: Describe any goal, expectations, or reservations you have at this time.

_____

_____

_____

I have read and completed the above information and certify it to be true to the best of my knowledge. I hereby permit this office to use my responses to provide me with chiropractic care, according to the state's regulations.

Patient Name (printed): _____

Signature of Patient/Guardian: _____ Date: _____

6. Doctor's Notes: Patients Leave Blank

BP: _____ Pulse: _____

1° _____ MOI: _____ 2° _____ MOI: _____

Notes: _____

_____

_____

❑ Painful SST ❑ Normal CLC ❑ Normal NSM

Codes: ❑ 98940 ❑ 98941 ❑ 98943 ❑ 72040 ❑ 72100 ❑ 72110 ❑ 99202 ❑ 99203 ❑ 97012 ❑ 97014

TP: ❑ 8 ❑ 16 ❑ 24 ❑ PPV ❑ MWP ❑ CNB12 ❑ Actiflex

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short -form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.