

Chiropractic Works P.C

Dr. Duncan Mukeku D.C, DAAML, President

21790 Coolidge Hwy | Oak Park Mi 48237

Tel (248) 398-1650 | Fax (248) 398-1653

Consent for Purpose of Treatment, Payment and Healthcare Operations

I acknowledge that Chiropractic Works' "Notice of Privacy Practices" has been provided to me.

I understand I have the right to review Chiropractic Works' Notice of Privacy Practices prior to signing this document. The notice of Privacy Practices for Chiropractic Works describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Chiropractic Works.

The Notice of Privacy Practices of Chiropractic Works is also provided on request at the Main Administrative desk of this practice. This Notice of Privacy Practices also describes my rights and Chiropractic Works' duties with respect to my protected health information.

Chiropractic Works reserves the right to change the Privacy Practices that are described in the notice of privacy practices by calling the office and requesting a revised copy to be sent in the mail or ask for one at the time of my appointment.

I have the right to revoke this consent, in writing, except to the extent that Chiropractic Works has acted in reliance on the consent.

Patient Acknowledgement

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Patient/ Personal Representative Signature

Name of Patient/ Representative
(PRINT)

Date

Informed Consent to Massage Therapy Treatment

I hereby request and consent to the performance of massage therapy by the Doctor of Chiropractic or therapist/technician named below or other therapists/technicians at Chiropractic Works P.C.

Chiropractic care and massage therapy are often used in conjunction. While chiropractic centers on the nervous system and musculoskeletal dysfunction related to hard tissues like the spine, bones, and joints, massage therapy focuses on both the hard and soft tissues, these compatible therapies often benefit the patient in many ways. Receiving chiropractic care either before or after a therapeutic massage can increase the effectiveness of both treatments, improve range of motion, promote faster healing, extend the length of both treatments' benefits, and improve range of motion, promote faster healing, extend the length of both treatments' benefits, and improve overall function.

I understand and agree (initial each below):

_____ I hereby consent to receiving massage therapy for the above noted purposes, including such assessments, examinations, and techniques that may be recommended by my chiropractor and/or therapist.

_____ No sexual advances of any kind will be tolerated either from the chiropractor, massage therapist or the patient. Sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature will constitute sexual harassment and will not be tolerated, resulting in immediate termination of the session, and I will be liable for payment of the scheduled treatment.

_____ I acknowledge that the technician, when explaining the proposed treatment to me, will explain the nature of the treatment, the expected benefits of the treatment, the material risks and side effects of the treatment proposed (and any alternative options), potential consequences of not having the treatment, and the precise area(s) of the body that will be touched. I acknowledge that physical touch or contact is only in the context of assessment and treatment processes for which I have given informed consent.

By signing, I affirm that I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

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 from Chiropractic Works P.C. I understand that at any time I may withdraw my consent and treatment will be stopped.

Patient Name
(Print)

Patient/ Guardian Signature

Date

Patient Intake Form

Name _____ Date _____

What is the chief complaint? _____

Area of complaint _____

What was the date of onset of this condition? _____

Give details on how the pain started _____

Frequency of pain:

() Other () Constant (~100% of the time) () Frequent (~75%-50% of the time) () Occasional (~50%-25% of the time) () Intermittent (<25% of the time) () On and Off pain () Random () Recurring

If the discomfort radiates, where does it travel to (choose all that apply)? If it does not travel, choose NON RADIATING

() Non Radiating () Radiating,

Where is the pain radiating? () Arms () Legs

Rate you pain from 1 to 10? 10 being the worsts

1 2 3 4 5 6 7 8 9 10

Additional Complaints Present _____

Allergy or Sensitivity Y/N? Describe _____

Describe the quality of this complaint's discomfort (please circle all that apply):

Dull Sharp Aching Burning Shooting Tightness Stiffness
Tingling Numbness Nausea Palpitations Anxiety/Panic Depression General Malaise
Fatigue

Is the condition getting better/ worse? Explain _____

What functional activity has noticeably worsened from said condition?

() None () Employment () Homemaking () Lifting () Personal Care () Sitting () Standing
() Walking () Sleeping () Social Life () Traveling and/or Driving

Past Patient History (mark all that applies)

Musculoskeletal Complaints

☐ None ☐ Arthritis ☐ Back Pain ☐ Neck Pain ☐ Shoulder Pain ☐ Cramping ☐ Elbow/ Wrist Pain ☐ Foot/ Ankle Pain ☐ Gout ☐ Fracture ☐ Hip Disorders ☐ Implants/ Plates ☐ Joint/ Muscle Pain/ Stiffness ☐ Knee Pain ☐ Osteoporosis ☐ Poor Posture ☐ Scoliosis ☐ Swelling, Redness or Deformity of Joints ☐ TMJ Issues

Neurological Complaints

☐ None ☐ Temporary Loss of Vision, Smell, Taste, or Hearing ☐ Anxiety/ Panic ☐ Depression ☐ Difficulty Concentrating ☐ Dizziness ☐ Epilepsy / Seizures ☐ Headaches ☐ Memory Issues ☐ Numbness ☐ Pins and Needles Sensation ☐ Sleeping Issues ☐ Stroke ☐ Wake Muscles ☐ Other _____

Head and ENT Complaints

☐ None ☐ Blurred or Double Vision ☐ Cataracts ☐ Earaches ☐ Ringing of the Ears ☐ Changes in Head Dimensions ☐ Hearing Loss ☐ Ear Infections ☐ Dental Problems ☐ Difficulty Swallowing ☐ Eye/ Vision Problems ☐ Eye Surgery ☐ Eye Glasses/ Contact Lenses Needed ☐ Glaucoma ☐ Gum Problems ☐ Headaches/ Migraines ☐ Hoarseness ☐ Nose Congestion/ Sinus Problems ☐ Postnasal Drip ☐ Sore Throat ☐ Swollen Lymph Nodes ☐ TMJ issues ☐ Other _____

Cardiovascular Complaints

☐ None ☐ Blood Clots ☐ Chest Pain/ Tightness ☐ Congenital Heart Defects ☐ Coronary Artery Disease ☐ Dyspnea ☐ Excessive Bruising ☐ Heart Attack ☐ Heart Murmur ☐ High Blood Pressure ☐ High Cholesterol/ Triglycerides ☐ Leg Pain when Walking ☐ Low Blood Pressure ☐ Lower Extremity Edema ☐ Palpitations ☐ Rheumatic Fever ☐ Swollen Legs/ Feet ☐ Varicose Veins ☐ Postnasal Drip ☐ Other _____

Respiratory Complaints

☐ None ☐ Apnea ☐ Asthma ☐ Blood in Sputum ☐ Emphysema ☐ Hay Fever ☐ Persistent Cough ☐ Pneumonia ☐ Shortness of Breath ☐ Snoring Issues ☐ Tuberculosis ☐ Wheezing ☐ Other _____

Gastrointestinal Complaints

☐ None ☐ Abdominal Pain ☐ Black/ Bloody Stool ☐ Bloating ☐ Bowel Changes ☐ Colitis ☐ Colon Cancer ☐ Constipation ☐ Chron's Disease ☐ Difficulty Swallowing ☐ Food Sensitivities ☐ Gastric Reflux ☐ Heartburn ☐ Hemorrhoids ☐ Jaundice ☐ Liver Disease ☐ Nausea/ Vomiting ☐ Pancreatitis ☐ Severe Diarrhea ☐ Ulcer ☐ Other _____

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Name _____ Date _____

Genitourinary Complaints

☐ None ☐ Blood in Urine ☐ Incontinence ☐ Kidney Stones ☐ Painful/ Frequent Urination
☐ Urinary Infections ☐ Sexual Dysfunction ☐ Other _____

Endocrine Complaints

☐ None ☐ Cushing's Syndrome ☐ Diabetes ☐ Excessive Thirst ☐ Constantly Feeling Hot/ Cold
☐ Heat/ Cold Intolerance ☐ Hyperparathyroidism ☐ Hypoparathyroidism ☐ Increased size of
Hands/ Feet ☐ Increased Urination ☐ Pancreatic Conditions ☐ Polydipsia ☐ Polyuria ☐ Purple
Striae ☐ Steroid Treatment ☐ Testosterone Deficiency ☐ Estrogen Deficiency ☐ Other _____

Dermatological/ Hemopoietic Complaints

☐ None ☐ Blood in Stool ☐ Change in Hair/ Nails ☐ Easy Bruising ☐ Eczema ☐ Excessive Acne
☐ Excessive Hair Loss ☐ Flushing ☐ Gum Bleeding ☐ Hypo/ Hyper Pigmentation ☐ Psoriasis
☐ Skin Cancer ☐ Psoriasis ☐ Skin Pigmentation Issues ☐ Skin Trouble/ Rashes ☐ Other _____

Previous Chiropractic Care? Yes/ No, if yes describe _____

Medications Y/ N, if yes, list all _____

Surgeries Y/ N, if yes, describe _____

Other Illnesses? List all _____

Any Accidents Y/N? describe _____

For Mothers: Any Children Y/ N? How many? _____

Social Habits

☐ None ☐ Social Drinker ☐ Light Drinker ☐ Moderate Drinker ☐ Heavy Drinker ☐ Alcoholic
☐ Recovering Alcoholic ☐ Does Drink, Smoke and/ or do other Drugs ☐ Doesn't Drink, Smoke and/
or do other Drugs ☐ Every day Smoker ☐ Social Smoker ☐ Occasional Smoker ☐ Ex-Smoker
☐ Use of Chewing Tobacco ☐ Drinks Caffeine ☐ Drinks Caffeine Daily ☐ Drinks Caffeine Occasionally
☐ Doesn't use Recreational Drugs ☐ Uses Recreational Drugs ☐ Heavy use of Recreational Drugs
☐ Drug Addicted ☐ Recovering Drug Addict ☐ Other _____

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Name _____ Date _____

Family History

☐ None ☐ Diabetes ☐ Cancer ☐ Tumor ☐ Hypertension ☐ Progressive Neurological Disorders
☐ Congenital Anomaly ☐ Extremity Issues ☐ Fractures ☐ Hereditary Disorders
☐ Hospitalization ☐ Neuromuscular Issues ☐ Trauma/ Injury ☐ AIDS/ HIV/ Venereal Disease
☐ Alcoholism ☐ Alzheimer's ☐ Anemia ☐ Anorexia ☐ Arthritis ☐ Asthma ☐ Bleeding Disorder
☐ Breast Lumps ☐ Bronchitis ☐ Bulimia ☐ Chemical Dependency ☐ Depression ☐ Emphysema
☐ Epilepsy ☐ Heart Disease ☐ Hepatitis ☐ Herniated Disk ☐ High Blood Pressure ☐ Low Blood Pressure
☐ High Cholesterol ☐ Kidney Disease ☐ Liver Disease ☐ Migraines ☐ Miscarriages
☐ Multiple Sclerosis ☐ Natural Labors ☐ C- Section ☐ osteoarthritis ☐ Osteoporosis ☐ Pacemaker
☐ Parkinson's Disease ☐ Pinched Nerves ☐ Pneumonia ☐ Polio ☐ Previous Chiropractic Care
☐ Prostate Problems ☐ Psychiatric Care ☐ Rheumatoid Arthritis ☐ Stroke ☐ Suicide Attempts
☐ Thyroid Problems ☐ Ulcer ☐ Vaginal Infection ☐ Other _____

Doctor's Notes _____

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Name_____ **Date**_____

For insurance Purposes and Health Compliance records, we need some information on your primary care medical physician.

Physician's Name

Phone No.

Fax No.

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Medical Release Form

Authorization for Release of Medical Information

Patient Name _____

Date of Birth _____ Social Security No _____

Phone No _____

Address _____
Street Apt. # City State Zip

To Release my Health Information to:

Chiropractic Works P.C

Name of Person/Organization			
21790 Coolidge HWY	Oak Park	MI	48237
Street Address	City	State	Zip

This Authorization applies to the Fellow Information:

All Records X-Rays MRI CT Office Notes Exams & Reports

I here authorize the above, it's director, admin and clinical staff or assignees, medical information services and billing department to release any and all medical records and information relating to my care and treatment including x-rays, photographs, electronic and digital files and any other records, unless I expressly direct or specify otherwise. I understand that medical information may include records, if any relating to treatment for alcohol and drug abuse protected under the regulations in 42 C.F.R part 2; psychiatric/ psychological services and social work records and any information regarding communicable diseases and infections, defined by Michigan Department of Public Health Rule, which can include tuberculosis, venereal diseases, sexually transmitted diseases, acquire immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or ARC. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the Federal Privacy Rules.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and sent it to the hospital, doctor, or other custodian or medical information. I understand that revocation will not apply to information that has already been released in response to this authorization. A copy of this authorization is a valid as the original.

Signature of Patient/ Representative _____ Date _____

Name of Patient/ Representative (PRINT)	Description of Representative's Authority
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