Standards for New Patients

1. All new patients are required to fill out a personal health questionnaire.
2. You will have a consultation with the doctor and discuss your health concerns.
3. The doctor will perform diagnostic chiropractic, orthopedic and neurological examination procedures.
4. You will discuss a care and treatment plan with the doctor.

Confidential Patient Information

Name (First, Middle, Last)		Date
Address		City/State/Zip Code
Home Phone	Work Phone	Cell Phone
Email Address	Date of Birth	Current Age

Work Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Student ☐ Unemployed

Employer		Job Title
Employer Address	City/State	Zip Code

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow Spouse's Name & DOB:______________________________

Whom may we thank for referring you? ______________________________

Minors ONLY – Consent for Treatment

I hereby authorize Dr. Matthew Samson and whomever they may so designate as their assistant, to administer chiropractic care as they deem necessary to my son/daughter, ________________________________, dated at Minot, ND this _______ day of ________________, 20___.

Signature: Witnessed:

ALL PATIENTS – In Case of Emergency

Name of relative or close friend:		
Home Phone	Work Phone	Cell Phone

Why Chiropractic?

People visit chiropractors for a number of reasons. Some need symptomatic relief from pain or discomfort (Relief Care). Others are looking for the cause of the problem as well as the symptoms corrected to avoid relapses (Corrective Care). There are others who are looking for their areas malfunction to be brought to its highest state of health in order to optimize their wellbeing (Comprehensive Care).

At Horizon Family Chiropractic the type of care you receive is YOUR choice. We will honor your decision and take into consideration your needs and desires when recommending your treatment plan. Please indicate which type of treatment you would like to receive below.

☐ Relief Care: Relief from pain or discomfort

☐ Corrective Care: Correcting the cause of the problem as well as the symptoms

☐ Comprehensive Care: Bringing health to the highest state and optimizing physical and emotional wellbeing

☐ I would like to discuss options with the doctor

Please list your major ailments in order of severity (from most debilitating to least debilitating):

1.	**4.**
2.	**5.**
3.	**6.**

Primary Ailment - ____

When did you first notice this condition:
Did it begin: ☐ Immediate or ☐ Gradually? Briefly Describe:
What is the exact location of your symptoms:
Do your symptoms spread? ☐ No ☐ Yes. Where?
How often do you experience these symptoms? ☐ Constant (100% of day) ☐ Frequent (75% of day) ☐ Often (50%) ☐ Seldom (25%) ☐ Rarely (less than 25%)
Is this condition progressively: ☐ Worsening ☐ Improving ☐Unchanged
What is the intensity of your symptoms? ☐ Severe ☐ Moderate ☐ Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
If you have pain, is it: ☐ Deep ☐ Superficial
Please indicate the character of your pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Aching ☐ Knife-like Throbbing
Are you experiencing any of the following associated symptoms? ☐ Pins/Needles ☐ Tingling ☐ Numbness ☐ Twitching If Yes, Please describe:
Please indicate what activities provoke (P) or Aggravate (A) your condition: __Sitting for __min, __Standing, __Walking, __Lying, __Pushing, __Pulling, __Lifting __lbs., __Gripping Hot/Cold, __Bright Lights __Coughing/Sneezing, __Bowel Movements, __Mental Activities, __Bright Lights, __Other_____________, __Other_____________
Please indicate what helps to alleviate the pain. ☐ Lying ☐ Sitting ☐ Walking ☐ Standing ☐ Rest ☐ Heat/Cold ☐ Medications: ______________, __________________, ____________________

Please list what doctors you have seen for this condition. (Please include diagnosis, treatment, and any changes in your condition)

Please include any other relevant history in regards to this ailment.

Secondary Ailment - ____

When did you first notice this condition:
Did it begin: ☐ Immediate or ☐ Gradually? Briefly Describe:
What is the exact location of your symptoms:
Do your symptoms spread? ☐ No ☐ Yes. Where?
How often do you experience these symptoms? ☐ Constant (100% of day) ☐ Frequent (75% of day) ☐ Often (50%) ☐ Seldom (25%) ☐ Rarely (less than 25%)
Is this condition progressively: ☐ Worsening ☐ Improving or ☐ Unchanged
What is the intensity of your symptoms? ☐ Severe ☐ Moderate ☐ Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
If you have pain, is it: ☐ Deep ☐ Superficial
Please indicate the character of your pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Aching ☐ Knife-like Throbbing
Are you experiencing any of the following associated symptoms? ☐ Pins/Needles ☐ Tingling ☐ Numbness ☐ Twitching If Yes, Please describe:
Please indicate what activities provoke (P) or Aggravate (A) your condition: __Sitting for __min, __Standing, __Walking, __Lying, __Pushing, __Pulling, __Lifting __lbs., __Gripping Hot/Cold, __Bright Lights __Coughing/Sneezing, __Bowel Movements, __Mental Activities, __Bright Lights, __Other_____________, __Other_____________
Please indicate what helps to alleviate the pain. ☐ Lying ☐ Sitting ☐ Walking ☐ Standing ☐ Rest ☐ Heat/Cold ☐ Medications: ______________, __________________, ____________________

Please list what doctors you have seen for this condition. (Please include diagnosis, treatment, and any changes in your condition)

Please include any other relevant history in regards to this ailment.

***If you have another ailment that needs further explanation please inquire at the front desk for additional “ailment” forms.**

Past Medical History

General Health History: Have you had any of the following?

Injuries, Accidents, Falls or Traumas: ☐ No ☐ Yes Explain:	
Illnesses/Hospitalizations: ☐ No ☐ Yes Explain:	
Surgeries: ☐ No ☐ Yes Explain:	

Motor Vehicle Accidents: ☐ No ☐ Yes Explain:	
Work Injuries: ☐ No ☐ Yes Explain:	

Females Only – Menopausal Symptoms: ☐ None ☐ Yes Explain:	

Habits

Cigarettes/Cigars	☐ None ☐ Yes How many per week?
Alcohol	☐ None ☐ Yes How many drinks per week? What type of alcohol?
Coffee	☐ None ☐ Yes How many cups per week?
Exercise	☐ None ☐ Yes Hours/Days per week? Types?
Water	☐ None ☐ Yes Glasses per week?
Soft Drinks	☐ None ☐ Yes Amount per week? Types?
Sleep	☐ None ☐ Yes Average per night? Do you have difficulty falling asleep or staying asleep? Hours desired per night?
Eating	Meals per day? What types of food do you eat? Do you consider your diet healthy? ☐ Yes ☐ No Explain:

Medications/Vitamins/Minerals/Supplements

Please list your current medications and supplements, how long you have been taking them, and what they are taken for:

HORIZON FAMILY CHIROPRACTIC

General Health History

Check the left box for any condition YOU had in the PAST, and the right box for any condition YOU have CURRENTLY.

P	C		P	C		P	C		P	C	
☐	☐	Mental Disorders	☐	☐	Diabetes	☐	☐	Pneumonia	☐	☐	Infective Disease
☐	☐	Epilepsy	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Fungal Infection
☐	☐	Tumors	☐	☐	Glaucoma	☐	☐	Hepatitis	☐	☐	Herpes
☐	☐	Alcoholism	☐	☐	Heart Disease	☐	☐	Thyroid Disease	☐	☐	Arthritis
☐	☐	Drug Addiction	☐	☐	Rheumatic Fever	☐	☐	Parasites	☐	☐	Autoimmune Disease
☐	☐	Cancer	☐	☐	Scarlet Fever	☐	☐	Asthma	☐	☐	Chicken Pox

Nervous System			**Eyes/Ears/Nose/Throat**			**Gastrointestinal**			**Musculoskeletal**		
P	C		P	C		P	C		P	C	
☐	☐	Depression	☐	☐	Vision Problems	☐	☐	Change in Appetite	☐	☐	Jaw Pain
☐	☐	Memory Loss	☐	☐	Flashing Lights	☐	☐	Excessive Thirst	☐	☐	Difficulty Chewing
☐	☐	Confusion	☐	☐	Black Spots	☐	☐	Frequent Nausea	☐	☐	Face Pain
☐	☐	Dizziness	☐	☐	Blurriness	☐	☐	Hemorrhoids	☐	☐	Neck Pain
☐	☐	Fainting	☐	☐	Hearing Loss	☐	☐	Black/Bloody Stools	☐	☐	Arm/Elbow Pain
☐	☐	Convulsions	☐	☐	Ringing in Ears	☐	☐	Digestive Problems	☐	☐	Wrist/Hand Pain
☐	☐	Weakness	☐	☐	Swallowing Difficulty	☐	☐	Abdominal Cramping	☐	☐	Mid Back Pain
☐	☐	Poor Balance				☐	☐	Gas/Bloating	☐	☐	Lower Back Pain
☐	☐	Twitches/Tremor				☐	☐	Heartburn	☐	☐	Thigh/Knee Pain
☐	☐	Cold/Tingling				☐	☐	Weight Problems	☐	☐	Ankle/Foot Pain
☐	☐	Sleeping Difficulties				☐	☐	Gall Bladder Issues	☐	☐	Difficulty Walking
☐	☐	Headaches				☐	☐	Liver Problems	☐	☐	Leg/Arm Fatigue

Cardiovascular			**Reproductive**			**Genitourinary**		
P	C		P	C		P	C	
☐	☐	Chest Pain	☐	☐	Erectile Difficulties	☐	☐	Bladder Trouble
☐	☐	Irregular Heartbeat	☐	☐	Sexual Dysfunction	☐	☐	Painful Urination
☐	☐	High Blood Pressure	☐	☐	Menstrual Irregularity	☐	☐	Incontinence
☐	☐	Shortness of Breath	☐	☐	Menstrual Cramping	☐	☐	Discolored Urine
☐	☐	Lung/Congestion Problems	☐	☐	Venereal Infection			
☐	☐	Varicose Veins						

How many times per day do you urinate?	How often do you have a bowel movement?
Do you experience any ☐ urgency, ☐ dribbling, ☐ incontinence?	Do your stools ☐ Float or ☐ Sink?
Is this urination pattern consistent? ☐ Yes ☐ No	Are your bowel movements consistent? ☐ Yes ☐ No

Date of Last:

Physical Exam:	By whom?	Results:	
Blood Work:	By whom?	Results:	
Bone Density Study:	Results:	Mammogram:	Results:
Pelvic Exam:	Results:	Self Breast Exam:	Regularity:
PSA Exam:	Results:	Digital Prostate Exam:	Results:
Chest X-Rays:	Results:	EKG:	Results:
Echocardiogram:	Results:		
Spinal X-Rays:	By whom?	MRI/Cat Scan:	Results:
Other Tests:			

HORIZON FAMILY CHIROPRACTIC

Family History

Mother:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Father:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Brother:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Brother:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Sister:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Sister:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Maternal Grandmother:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Maternal Grandfather:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Paternal Grandmother:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Paternal Grandfather:	☐ Alive & Well, age__ ☐ Deceased age__ from what?	Any health conditions?
Children:	Ages:__________________	Any health conditions?

Have any of your family members ever suffered from any of the following conditions?

☐ Diabetes	☐ Neurological Disorders______________________ ____	☐ Depression/Mental Illness__________________________ ____
☐ Heart Disease	☐ Autoimmune Diseases_______________________ ____	☐ Cancer____ ____
☐ Other	☐ Other___________________________________ ____	☐ Other____ ____

Confidentiality

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization. If you are required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

In the event this office needs to contact you:

May we leave a message for you with someone at your home phone number? ☐ Yes ☐ No

May we leave a message for you on your home answering machine? ☐ Yes ☐ No

May we leave a message for you with someone at your work phone number? ☐ Yes ☐ No

May we fax information that you request? ☐ Yes ☐ No

I have read this consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

____

Patient Signature Date

Informed Consent for Chiropractic Care and Waiver to Treat

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward 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 of the spine) and function (primarily of the nervous system) as that relationship may have an effect on the restoration and preservation of health. Health is the 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 vertebra 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 and ***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 hand held instruments. In addition, ancillary procedures such as adjustments of the extremities, physiotherapy and/or rehabilitative procedures may be included.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to fractures, disc injuries, muscle or ligament injuries, nerve injuries, vascular injuries such as stroke, dislocation and nerve injuries. I will make every reasonable effort during the consultation and examination to screen for contraindications to care: however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

Other treatment options include medications, surgery and alternative treatments. You should be aware that there are risks and benefits of those options which can be discussed with your primary medical physician.

The risks associated with remaining untreated include but are not limited to the formation of adhesions and reduction of mobility which may set up a pain reaction further reducing mobility. Over time and the longer treatment is postponed, this process may complicate future care by making it more difficult and less effective.

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.

Do Not Sign Until You have Read and Understand the Above.

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.

______________________ ______________________ ____________________

Patient Name Signature Date

Agreement for Payment of Services (Please initial all that apply)

_____ I understand that Horizon Family Chiropractic is not familiar with my insurance policy, nor can they determine whether my insurance will pay for all or part of the services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ I acknowledge and agree that I will be personally responsible for all the payments for Horizon Family Chiropractic services, whether or not my insurance pays for all or part of the services.

_____ I acknowledge that if I do not have insurance that payment is expected at the time of service

Patient Signature Date