RELENTLESS
—CHIROPRACTIC—

Today's Date:_____ **ID #:** _____

PATIENT DEMOGRAPHICS

Name:_____ Birth Date:____-____-____ Age: _____ □ Male □ Female

Address:_____ City:_____ State:_____ Zip: _____

E-mail Address: _____ Home Phone _____ Mobile Phone _____

Marital Status: □ Single □ Married Work Phone: _____

Employer:_____ Occupation:_____

Spouse's Name:_____ Spouse's Employer: _____

Number of Children and Ages: _____

Emergency Contact Name:_____ Number:_____ Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office, on a scale of **0** to **10** with **10** being the worst pain and **0** being no pain; rate your complaint by **circling the number**.

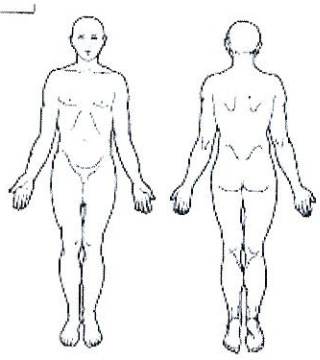
Primary Complaint:_____ **Scale** 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Secondary Complaint: _____ **Scale** 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third Complaint: _____ **Scale** 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

PLEASE MARK the areas on the diagram with the following letters to describe your symptoms:

R: Radiating **B: B**urning **D: D**ull **A: A**ching **N: N**umbness **S: S**harp/**S**tabbing **T: T**ingling



Identify any other injury(s) to your spine, minor or major, that the doctor should know about: _____

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all form of health care, holds certain risks. While the risk is most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Relentless Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Patient or Authorized Person's Signature _____ Date __/__/__ Witness Initials _____

REGARDING: X-rays/Imaging Studies

□ I understand that a member of the staff will instruct me to remove all metal items (belt buckles, jewelry, bra underwire, etc.) from my person before imaging begins. I am aware that if I chose to keep metal items on my person during imaging that it could obstruct visibility of underlying structures and can lead to the doctor being unable to diagnose any abnormalities including but not limited to tumors, fractures, lung disease, etc. By my signature below I am acknowledging that I understand the risk of not removing metal before x-rays and the staff is not responsible for poor visibility if I chose to leave any removable metal on my person.

Patient or Authorized Person's Signature _____ Date __/__/__ Witness Initials _____

FEMALES ONLY ➔ please read carefully and check the boxes.

□ The first day of my last menstrual cycle was on _____ (Date)

□ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient or Authorized Person's Signature _____ Date __/__/__ Witness Initials _____

RELENTLESS CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a summary of these circumstance.

PERMITTED DISCLOSURES:

1. **Treatment purposes** – discussion with other health care providers involved in your care.
2. **Inadvertent disclosures** – open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. **For payment purposes** – to obtain payment from your insurance company or any other collateral source.
4. **For workers compensation purposes** – to obtain payment from your insurance company or any other collateral source.
5. **Emergency** – in the event of a medical emergency we may notify a family member.
6. **For Public health and safety** – to prevent or lessen a serious or eminent threat to the health or safety of aperson or general public.
7. **To Government agencies or Law enforcement** – to identify or locate a suspect, fugitive, material witness or missing person.

8. **For military, national security, prisoner, and government** benefits purposes.
9. **Deceased persons** – discussion with coroners and medical examiners in the event of a patient's death.
10. **Telephone calls or emails and appointment reminders – we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. **Change of ownership** – in the event this practice is sold, the new owners would have access to your **PHI**.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records, and you are therefore not entitled to them. If you would like us to outsource them to an imaging center,to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, then please call Sean Ostrowski, D.C. at (706) 642-4476. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the way this office handles yourcomplaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient Name:_____ Date of Birth: _____

RELENTLESS CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY

I have received a copy of Relentless Chiropractic's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me, and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____
Patient's Signature Date

MEDICAL RELEASE

Release of Information:

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse: _____

[ ] Child(ren):_____

[ ] Other:_____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

_____ _____ _____

Patient's Signature Date HR#

_____ _____

Witness Signature Date

FINANCIAL AGREEMENT

Our experience has shown that it is wise to have an understanding with our patients as to our office policy and fees. Therefore, this form has been prepared for your convenience and information. As an office policy, we will discuss your treatment plan and all expected financial obligations **before** beginning corrective care or receiving an adjustment in our office so that you can make an informed decision about your health.

There are several cost-effective ways to receive care in our office and each will be discussed with you before beginning any corrective care plan. If at any time your financial situation changes, it will be your responsibility to contact our billing department for updates.

As always, our main concern is your **health** and **well-being,** and we will work with you to provide that care in a way that is most appropriate for you.

A financial estimate will be completed and reviewed with you before a corrective care plan begins.

NO CHARGES WILL BE INCURRED IN OUR OFFICE WITHOUT PRIOR CONSENT FROM THE PATIENT. IF YOU EVER FEEL A CHARGE HAS BEEN MADE IN ERROR, PLEASE CONTACT OUR OFFICE IMMEDIATELY. YOU ARE ONLY RESPONSIBLE FOR SERVICES RENDERED.

If chiropractic care is discontinued, I understand that there will be no refunds unless a written medical condition preventing further treatment is given. All adjustments already paid for will be credited to the Practice Member's account and any reoccurring charges will be stopped.

I agree to pay all costs of collection including reasonable attorney fees where past due balance is turned over to an attorney for collection. I hereby waive all rights of exemptions under the constitution and laws of the State of Georgia and the United States of America.

_____ _____-_____-_____

Patient or Authorized Person's Signature Date Completed

_____ _____-_____-_____

Doctor's Signature Date Reviewed

Patient's Name:_____ Date:_____

RELENTLESS
CHIROPRACTIC

Patient Quality of Life Survey

Name: _____ Date: _____

Please take several minutes to answer these questions so we can help you get better.
(Please circle as many that apply)

1. How have you taken care of your health in the past?
   a. Medications
   b. Emergency Room
   c. Routine Medical
   d. Exercise
   e. Nutrition/Diet
   f. Holistic Care
   g. Vitamins
   h. Chiropractic
   i. Other (please specify): _____

2. How did the previous method(s) work out for you?
   a. Bad results
   b. Some results
   c. Great results
   d. Nothing changed
   e. Did not get worse
   f. Did not work very long
   g. Still trying

3. How have others been affected by your health condition?
   a. No one is affected
   b. Haven't noticed any problems
   c. They tell me to do something
   d. People avoid me

4. What are you afraid this has affected, might begin to affect, or will affect?
   a. Job
   b. Kids
   c. Future Ability
   d. Marriage
   e. Self-esteem
   f. Sleep
   g. Time
   h. Finances
   i. Freedom

5. What health conditions you are afraid this might turn into?
   a. Family health problems
   b. Heart Disease
   c. Cancer
   d. Diabetes
   e. Arthritis
   f. Fibromyalgia
   g. Depression
   h. Chronic Fatigue
   i. Need Surgery

RELENTLESS CHIROPRACTIC

Patient Quality of Life Survey

6. How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

7. What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

8. What are you most concerned with regarding your problem?

9. Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.

10. What would be different/better without this problem? Please be specific.

11. What do you desire most to get from working with us?

12. What would that mean to you?

blueprint nutrition

Wellness Evaluation

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition.

Let's get started.

Please circle any that apply to you:

Sub-Clinical symptoms including:
Headaches
Migraines

Hormone Imbalance including:
PMS
Emotional imbalance

Gastrointestinal issues including:
Abdominal bloating, cramps or painful gas
Irritable Bowel Syndrome
Ulcerative Colitis
Crohn's Disease and other intestinal disorders

Respiratory Conditions including:
Chronic sinusitis
Asthma
Allergies

Joint Conditions including:
Knee, Shoulder or Spine

Autoimmune Conditions including:
Diabetes Mellitus
Lupus
Rheumatoid Arthritis
Fibromyalgia
Chronic Fatigue

Thyroid Conditions including:
Hashimotos
Hypothyroidism
Hyperthyroidism

Developmental and Social Concerns including:
Autism
ADD/ADHD

Skin Conditions including:
Eczema
Skin rashes
Hives

Circle the number that most closely fits, then add up your results.

	None	Mild	Mod	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Mod	Severe
Asthma, Hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Gluten sensitivity or Celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight issues	0	1	2	3

YOUR TOTAL: _____