211 W. 6th Street, Cedar Falls, IA, 50613
319-277-3166 | drkime@accoi.net | www.accoi.net

Patient Data____

Title: (Circle One) ☐ Mr. ☐ Mrs. ☐Ms. ☐ Miss ☐ Dr. ☐ Other _______

First Name __________________ **Middle Initial** ____ **Last Name** _________________________

Address Line 1 ____

Address Line 2 ____

City ______________________________ **State** __________________ **Zip Code** _____________

Home Phone (_____) ________-__________ **Cell Phone (_____)** ________-___________

Email __________________________________ **Date of Birth** _____/_____/______

Sex:(Circle One) Male ☐ Female ☐ Other ________ **Marital Status:**(Circle One) Single ☐ Married ☐ Other

Spouse's name____________________ **Spouse's number** ______________________________

Employment Status: (Circle One) ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other_____

Employer Name ________________________________ **Occupation** ________________________

Emergency Contact____

Contact Name ___________________________ **Relationship to Patient** __________________

Contact Home Phone (_____) _______-________ **Cell Phone (_____)** ________-______________

How did you hear about our office? ____

Patient Signature____Date____________________
Patient Medical History____

Medical Conditions: (Circle all that apply to you)
☐Arthritis Cancer Diabetes Heart Disease Hypertension
Psychiatric Illness Skin Disorder Stroke Other _______________

Surgeries: (Circle all that apply to you)
☐Appendectomy Cardiovascular procedure Cervical spine Hysterectomy
Joint Replacement Prostat Lumbar spine Gall Bladder Brain Shoulder
Thoracic spine Knee Carpal Tunnel Gastro-intestinal Uro-genital Hernia
Other _______________

Allergies: (Circle all that apply to you)
☐Eggs Fish and Shellfish Milk or Lactose Peanuts Soy Sulfites
Wheat/Gluten Other __________

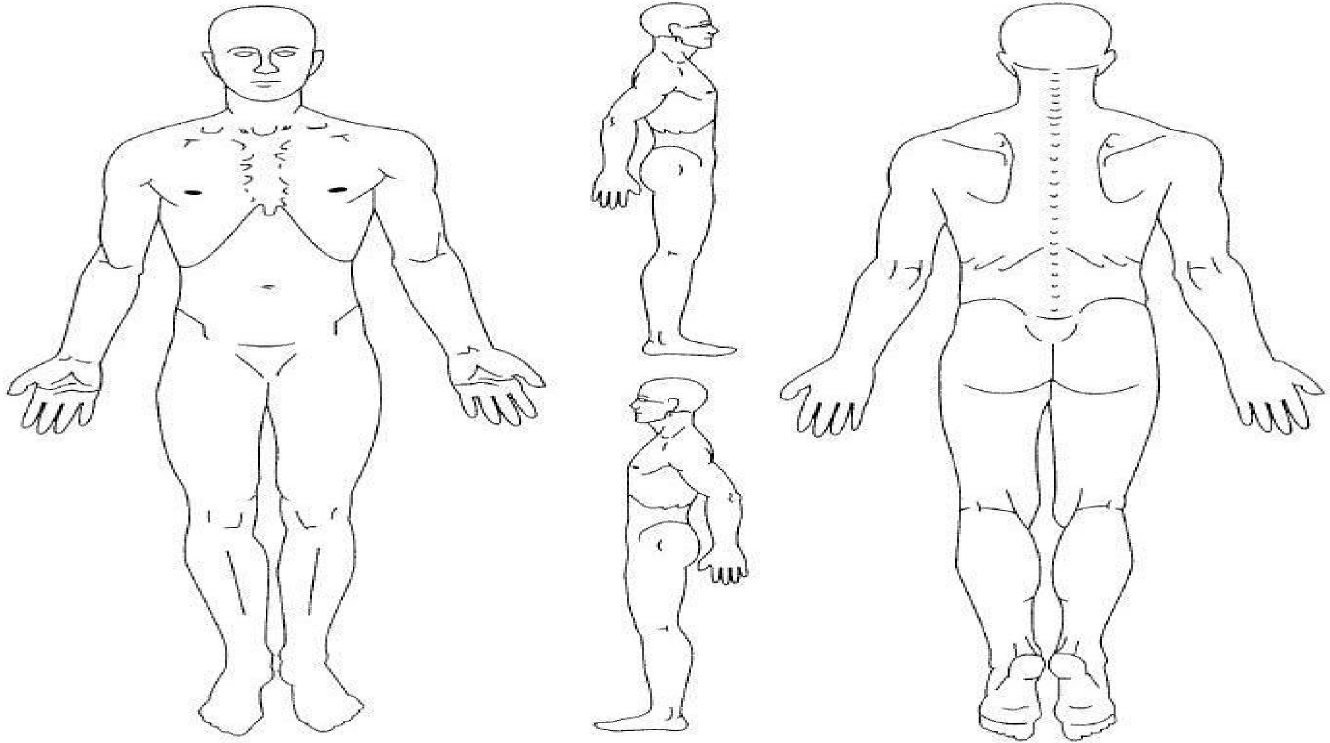
Social History: (Circle all that apply to you)
Caffeine use: ☐ occasional ☐ often ☐ never
Drink Alcohol: ☐ occasional often ☐ never
Exercise: ☐ occasional ☐ often ☐ never
Chew Tobacco: ☐ occasional ☐ often ☐ never
Cigarettes: ☐<1 pack/day >1 pack/day ☐ never
Wear Seat Belts: ☐ occasional ☐ always never

Family History: (Circle all that apply to you)
Arthritis: ☐ Parent ☐ Sibling
Cancer: ☐ Parent ☐ Sibling
Diabetes: ☐ Parent ☐ Sibling
Heart Disease ☐ Parent ☐ Sibling
Hypertension ☐ Parent ☐ Sibling
Stroke ☐ Parent ☐ Sibling
Thyroid ☐ Parent ☐ Sibling
Other ___________________

Are you pregnant? Yes_____ No ______N/A______

Please list all current medications being taken ____

Indicate on the body diagram where you are experiencing the following symptoms:



Describe your symptoms in order of severity, with worse symptom being #1: ___________________
____
____
____

When did your symptoms begin? **Month**_____________ **Day**___________**Year** ______________

Are your symptoms a result of: (Circle all that apply to you) ☐ Motor Vehicle Accident ☐ Work related Accident ☐ Other__________________________

How did your symptoms begin? ____
____

How often do you experience your symptoms? (Circle all that apply to you)

☐ Constantly	☐ Frequently	☐ Occasionally	☐ Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What describes the nature of your symptoms? (Circle all that apply to you)

□ Sharp Dull ache Numb Shooting Burning Tingling
Stabbing
Other ______________________________

Acupuncture & Chiropractic Clinic Of Iowa
211 W. 6th Street, Cedar Falls, IA, 50613
319-277-3166 | drkime@accoi.net | www.accoi.net

HIPAA Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment, or health care operations, in order to provide health care that is in your best interest. **Your Personal Health Information (PHI) will never be given to any entity besides what is required for your treatment, payment, and health care operations.**

We also want you to know that we support your full access to your personal medical records. WE may have indirect treatment relationships with you (such as radiologists that only interact with physicians not patients), and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are more often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which replied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA COmpliance Officer.

You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

Print Name: ____

Signature: __________________________________ Date: ___________________

Parent/Legal Guardian: ____

Signature: ____ Date: ___________________

Consent for Chiropractic Treatment

Chiropractic is an alternative health care option that primarily involves the doctor of chiropractic applying specific adjustments in different areas of the spine. The goal of chiropractic treatment is to remove spinal misalignments (known as subluxations) in an attempt to restore proper nervous system function. Benefits of chiropractic care may include, but are not limited to, an increase in range of motion, a decrease in pain level, or a decrease in muscle spasm.

As with any other health care profession, chiropractic care is not without risks. The following summary outlines some, but not all, of the significant risks and/or probable risks associated with manual therapy techniques used by doctors of chiropractic.

- While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains and/or sprains as a result of manual therapy techniques.
- Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures.
- There are reported cases of an interruption of blood flow to the brain (commonly called a stroke) Associated with visits to medical doctors and chiropractors
- However, you being informed of this reported associated because a stroke may cause serious neurological impairment or even death.
- The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.
- There are rate reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment.

The probability of a patient experiencing on of these adverse effects ranges from 1 in 1 million to 1 in 20 million. The doctor of chiropractic has been trained to screen patients to determine if they are at risk for any of these conditions. If the patient is determined to be at risk, then the patient is advised to seek proper care before chiropractic treatment will be attempted.

My signature below indicates that I acknowledge that I have read this consent, that I have had the risks benefits, and costs of chiropractic treatment explained to me and that all of the questions pertaining to my treatment have been satisfactorily answered.

My signature below also represents my consent to the chiropractic treatment recommended to me by my chiropractor including any and all spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

PRINTED NAME: ____

PATIENT SIGNATURE: ____

Date: ____________________

Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist(s) who now or in the future treat me. I understand that methods of treatment may include, but are not limited to, acupuncture, and nutritional counseling. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the supplements recommended.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including:

- Bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting.
- Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax).
- Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts then known, is in my best interest.

I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

PRINTED NAME: ____

PATIENT SIGNATURE: ____

Date: ____________________