Dr. Sandra Cunningham, D.C.

•158 Middletown Rd. White Hall, WV 26554• (304) 363-4343•

APPLICATION FOR TREATMENT

Welcome

Dr. Cunningham and staff welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

Patient Information:

Name____Nickname________________

Address__________________________________City___________State_________Zip_________

Telephone (H) ______________________(C)________________________ Gender □Male □Female

Social security number_________________ Age____________ Date of birth________________

Employer____Occupation____________________

Employer Address_______________________________City______________State_______Zip_______

Employer Phone__________________________ Is it ok to call work? □Yes □ No

Relationship Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Name of spouse___________________________ Spouse's Employer_____________________

Race: □White
□ Black/African American
□ Asian
□ Other
□ Do not wish to provide

Preferred Language: □English
□ Spanish
□ Other

Ethnicity: □Hispanic/Latino
□ Non-Hispanic/Latino
□ Other
□Do not wish to provide

(Nearest relative not living with you)

Emergency Contact____Phone______________________

Past Medical History:

Has a physician treated you for any health condition in the last year? □Yes □No

If yes, explain____

Have you received chiropractic treatment previously □Yes □No If yes, explain__________________

Please describe the principal health problems for which you came to this office.

____

How and when did symptoms first occur? ____

Did it begin ☐ gradually ☐ suddenly

Did anything contribute to the onset of the condition?____

Has your condition been getting ☐ better ☐ worse

What makes it better? ☐rest ☐ time of day ☐ position ☐ ice ☐ heat ☐ other

What makes it worse? ☐rest ☐ position ☐ heat ☐ activity ☐ other

Does this interfere with your normal living and work activities? ☐**Yes** ☐ **No**

If yes, in what way?____

Have you lost any days of work? ☐ **Yes** ☐ **No** Dates____

Have you tried over the counter medications? ☐ **Yes** ☐ **No** If yes, describe.____

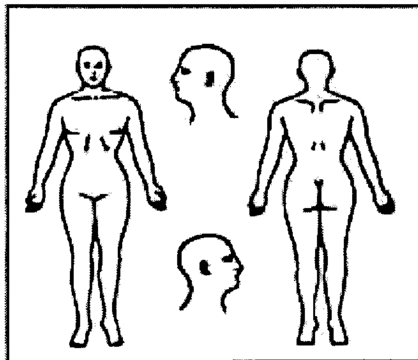
Have you had similar symptoms or injuries before? ☐ **Yes** ☐ **No**

If yes, explain.____

List any other doctors seen for these problems____

List diagnosis (es) and type of treatment (s)____

Please mark your areas of pain on the figure below.



List the conditions that you are most interested in getting corrected. **List in order of importance.**

1. (primary reason you came)

____

2. (other conditions you want addressed)

____

3. ____

What functions induce pain upon performance? List in order of severity.
(Example: sitting, walking, bending, lying down, etc.)
1. ____
2. ____
3. ____
4. ____

Patient Signature:____ **Date:**____

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Dr. Sandra Cunningham, D.C., for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Dr. Sandra Cunningham, D.C.

If I receive Medicare benefits, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

____

*****Patient Signature or Person signing on behalf of patient/relationship*****

I understand that diagnosis or treatment of me by Dr. Sandra Cunningham, D.C., may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Dr. Sandra Cunningham, D.C., is not required to agree to the restrictions that I may request. However, if Dr. Sandra Cunningham, D.C., agrees to a restriction that I request, the restriction is binding on Dr. Sandra Cunningham, D.C. and her practice. I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Cunningham, D.C., or her practice has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review Dr. Cunningham, D.C.'s Notice of Privacy Practices prior to signing this document. Dr. Cunningham, D.C.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices 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 Dr. Sandra Cunningham, D.C. The Notice of Privacy Practices for Dr. Sandra Cunningham, D.C. is also provided in the office at the registration desk. This Notice of Privacy Practices also describes my rights and the duties of Dr. Sandra Cunningham, D.C. with respect to my protected health information. Dr. Sandra Cunningham, D.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative ______________________________

Name of Patient or Personal Representative ______________________________

Description of Personal Representative's Authority ______________________________

Date ______________

Sandra Cunningham, D.C.   158 Middletown Road White Hall, WV 26554
304-363-4343

Acknowledgement of Notice

Sandra Cunningham, D.C. may discuss my protected health information with the following persons.

____
Name

____
Relationship

____
Name

____
Relationship

____
Name

____
Relationship

I acknowledge receipt of Sandra Cunningham, D.C. Notice of Privacy Practices.

________________________ ________________________
Patient's signature **Date**

____
Patient's Name (Please print)

Informed Consent Patient Name ____________________________________

The Primary treatment used by doctors of chiropractic is the spinal adjustment. I will use that procedure to treat you.

The nature of the chiropractic adjustment.
I will use my hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible, "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

The material risks inherent in chiropractic adjustment.
As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Complications could include fractures, disc injuries, dislocations, and muscle strain, Horner's syndrome. Risks also include costoveterbral strains and separations. Some manipulations of the neck have been associated with injuries to the arteries of the neck leading to or contributing to stroke. Some patients feel some stiffness and soreness following the first days of treatment.

Probability of those risks occurring.
Fractures are rare, and are generally result from some underlying pathology of the bone, which we check for during X-rays. Stroke is stated to be a one in a million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests which are designed to identify if you may be susceptible to this kind of injury. Other complications are also generally described as rare.

Additional Treatment (and their risks, none of which are of significant probability)
Myofascial Therapy: possible bruising, release of emboli, spread of unknown infection
Moist Heat: spread of unknown infection, periosteal burns
Ultrasound: spread of unknown infection, burns,
Electrical Muscle Stimulation (EMS): spread of unknown infection, electrical shock, and burns
Other ____________________________________

Availability and nature of other treatment options.

- Self administered, over-the-counter analgesics and rest
- Medical care with prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers
- Hospitalization with traction
- -Surgery

The material risks inherent in such options and the probability of such risks occurring include:
Overuse of over-the-counter medications produces undesirable side effects If complete rest is impractical, premature return to work and household chores may aggravate the condition and extent the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines, including liver, kidney, and stomach problems.

Prescription muscle relaxants and pain-killers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity or the patients discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks- some with rather high probabilities.

Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risk inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.
(continued on next page/back)

The risks and dangers attendant to remaining untreated.
Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time the process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non treatment would further complicate later rehabilitation is high.

DO NOT SIGN UNTIL YOU HAVE READ OR HAVE HAD THIS READ TO YOU AND UNDERSTAND THE ABOVE.

______ I have read the informed consent information, including the explanation of the chiropractic adjustment and related treatments above.

______ I have had read to me the informed consent information, including the explanation of the chiropractic adjustment and related treatments above.

I have discussed it with Dr. Cunningham and have had my questions answered.

By signing below I state I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo treatment recommended having been informed of the risks, I hereby give my consent to that treatment.

Signature ______________________________ Witness ______________________________

Printed Name ___________________________ Date_________________________________

Condition of patient at time of consent based on my personal observation and direct conversation with the patient I conclude during the consent process the patient was:

( ) Oriented to time and place
( ) Coherent and lucid
( ) Able to understand the language used

Comments and Questions and answers supplied

____
____
____
____
____
____

I certify that the above accurately describes the consent process in this case.

Signature of Dr. ______________________________ Witness ______________________________

Date _______________

PATIENT HEALTH HISTORY QUESTIONNAIRE

Name________________________________ File Number ______________ Date ________________

Have you ever experienced or been diagnosed with any of the following? Please indicate by **circling** yes or no. **CORRECTLY ANSWERING THE CONDITIONS CAN INFLUENCE TREATMENT CHOICES AND OUTCOME OF CARE.**

Condition	Circle One		Condition	Circle One	
Abdominal pain	Yes	No	Irritable Bowel Disease	Yes	No
Abnormal weight loss or gain	Yes	No	Jaw pain	Yes	No
Angina	Yes	No	Kidney Disease/Disorder	Yes	No
Aneurysm (aortic or other)	Yes	No	Kidney stones	Yes	No
Arthritis-Rheumatism	Yes	No	Liver or gall bladder problems	Yes	No
Asthma	Yes	No	Loss of appetite	Yes	No
Bladder infection	Yes	No	Loss of bowel or bladder control	Yes	No
Blood disorder	Yes	No	Loss of consciousness	Yes	No
Breast (soreness, lumps, cancer)	Yes	No	Loss of muscle strength or coordination	Yes	No
Chest pain	Yes	No	Low back pain	Yes	No
Cancer	Yes	No	Nausea or vomiting	Yes	No
Chronic cough or hoarseness	Yes	No	Numbness in arms or legs	Yes	No
Constipation/irregular bowel habits	Yes	No	Osteoporosis	Yes	No
Convulsions/seizures	Yes	No	Pain in knees, ankle, or foot	Yes	No
Diabetes	Yes	No	Pain in upper leg or hip	Yes	No
Depression	Yes	No	Pain in shoulder	Yes	No
Dermatitis/Eczema/Rash	Yes	No	Pain in elbow or hands	Yes	No
Difficulty in Swallowing	Yes	No	Pain in neck	Yes	No
Dizziness	Yes	No	Prostate problems	Yes	No
Emphysema	Yes	No	Rapid heart beat	Yes	No
Epilepsy	Yes	No	Rheumatoid Arthritis	Yes	No
Excessive Thirst	Yes	No	Scoliosis	Yes	No
Fainting (pass out easily)	Yes	No	Slurred speech	Yes	No
Frequent Urination	Yes	No	Stroke date ________	Yes	No
General Fatigue	Yes	No	Swelling, stiffness of Joint(s)	Yes	No
Headaches for hours or days	Yes	No	Tinnitus (ringing in ears)	Yes	No
Heart disease	Yes	No	Thyroid disease	Yes	No
Heart attack date ________	Yes	No	Tumor (Explain ______________)	Yes	No
Heart burn/ Indigestion	Yes	No	Ulcer	Yes	No
Hepatitis	Yes	No	Visual disturbances	Yes	No
High Blood Pressure	Yes	No	Other health problems not listed above	Yes	No

Please list all current medications:

Prescription ____

Over the counter medications taken regularly ____________________

Vitamin and herbal supplements ____________________

Have you or your family had any of the following conditions. Family is considered your parents, grandparents, brothers, sisters, aunts, and uncles. If circling yes please indicate if it is self or family member or both.

Heart Problems	Yes	No	self family member	Chronic Headaches	Yes	No	self family member
Cancer	Yes	No	self family member	Lupus	Yes	No	self family member
Rheumatoid Arthritis	Yes	No	self family member	Lung Problems	Yes	No	self family member
Epilepsy	Yes	No	self family member	Strokes	Yes	No	self family member
Chronic Back problems	Yes	No	self family member	High Blood Pressure	Yes	No	self family member
Diabetes	Yes	No	self family membe				

What is your present weight? __________Pounds What is your present height? _______feet _______inches

Please list any known allergies (include medication, food, and other) ____________________

List any hospitalizations and surgical procedures and approx. date ____________________

____

List any previous accidents/injuries (even as a child) include motor vehicle, falls, work related and other. Please include broken bones, dislocations, and sprain/strains. (include approx. date or age). ____________________

____

____

Social History

Cigarette smoking ______ Yes ______ No If yes, how many packs/day? ____________________

Alcohol use ______ Yes ______ No If yes, drinks/day/week/month? ____________________

Exercise ______ Yes ______ No If yes, how often and what type? ____________________

Coffee/Tea/Caffeinated Drinks ______ Yes ______ No If yes, how many cups/cans per day? ____________________

Drug or alcohol dependence ______ Yes ______ No

For Women Only

Date of onset of last Menses __________________ Do you have any reason to believe you may be pregnant? _____Yes ______ No

Have you ever been pregnant? _____Yes ______ No If yes, how many pregnancies? _______ Number of births? ________

Do you experience irregular menstrual cycles? _____Yes ______ No

Do you experience painful menstrual cycles? _____Yes ______ No

Are you taking or have previously taken birth control? _____Yes ______ No

Examination History

Please indicate if you have had any of the following procedures performed and give the approximate dates they were performed.

Blood tests _________ Urine test _________ MRI ________ CT scan _________ X-ray __________

Which Dr. ordered the tests? __________________ Where tests were performed? ____________________

I certify that the above information is complete and accurate to the best of my knowledge, I agree to notify this Doctor immediately whenever I have changes in my health condition

Signature ______________________________ Date ____________________

Insurance Payment Questionnaire & Agreement

The following questions are necessary so that we may properly file your insurance for you. Please answer as fully as possible.

Will you be using insurance in our office? ___ Yes ___ No

If you do not have insurance, or do not have chiropractic benefits with your insurance how do you plan on paying your account? ________ cash ______ check _______ credit card

If you are not using any insurance in our office please skip the questions 1-9 and sign the payment agreement portion of this agreement.

1. Type of insurance: _____ Medicare_____ MedicaidGroup ______ Health Plan______ Workers Comp.
   Other____
2. Patient name:____
3. Insured's name (as it appears on the insurance card) ______________________________________
4. Insured's address (if same as patient, put same) ____
   City________________ State__________ ZIP______________ Tel # _________________
5. Is the condition we are treating related to current or previous employment? ____ Yes ____ No
6. Is the condition we are treating related to an auto accident? ____ Yes ____ No
7. Is the condition we are treating related to another type of accident? ____ Yes ____ No
8. Insured's Policy Number ____________________________________ Group #__________________
   Insured's Employer name ______________________________________ Gender: ___ Male ___Female
   Insured's Social security #__________________________ Insured's date of birth ________________
   Insurance plan name or program name ____
9. Is there another health benefit plan? ___Yes ___No *(If yes, complete the section below.)*
   Secondary or Supplemental Insurance Information
   Name of Insurance ____________________________________ Policy number ____________________
   Policy holder name as it appears on card ____
   Policy holder's social security # _______________________ Policy holders birth date ______________

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

****Assignment of Benefits:** I authorize and direct payment be made directly to **Sandra Cunningham, D.C.** 158 **Middletown Rd. White Hall, WV 26554** For any and all insurance benefits or reimbursement for services rendered by her which amounts would otherwise be payable to me under any insurance or pre-paid health care plan. This authorization is to apply to all occasions of service until it is revoked in writing.

Signed____ Date__________________

****Payment Agreement:** I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges. **I am also responsible for payment if I am not currently covered by insurance.**

Signed____ Date__________________

Please be advised we require a copy of all insurance cards and photo I.D. (if available) prior to submitting claims to insurance. We thank you in advance for having your I.D. and insurance cards ready when you turn in your paper work to the front desk.