

# Metzler Chiropractic Clinic, Inc.

## Patient Data

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**Title:** Mr. Mrs. Ms Miss (check one) **Date:** \_\_\_\_\_

**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Address Line 1:** \_\_\_\_\_

**Address Line 2:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Cell Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Sex:** M F **Email:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Marital Status:** Single Married Other

**Employment Status:** Employed Full Time Student Part Time Student Other (check one)

### Spouse Data

Is your spouse a patient in the clinic? Yes No

**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

If your spouse is listed as "primary" on insurance, we need the following in order to submit your claims:

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Employer Data

**Name:** \_\_\_\_\_

**Address Line 1:** \_\_\_\_\_

**Address Line 2:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

### Emergency Contact

**Contact Name:** \_\_\_\_\_

**Contact Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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Is it okay to call you at work?

- Yes  No

How did you hear about our clinic? Or who referred you?

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Family member | <input type="checkbox"/> Attorney         | <input type="checkbox"/> Internet web site | <input type="checkbox"/> Health class   |
| <input type="checkbox"/> Friend        | <input type="checkbox"/> Yellow Pages     | <input type="checkbox"/> Billboard         | <input type="checkbox"/> Brochure       |
| <input type="checkbox"/> Physician     | <input type="checkbox"/> Newspaper ad     | <input type="checkbox"/> TV Commercial     | <input type="checkbox"/> Direct mail ad |
| <input type="checkbox"/> Employer      | <input type="checkbox"/> Sign on building | <input type="checkbox"/> Radio             | <input type="checkbox"/> Other          |

If you selected 'Yellow Pages' please indicate which Yellow Pages:

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If you selected 'family member', 'friend', or 'physician' please enter their name below:

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If you selected 'other' please describe

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### Medical Conditions:

- |                                       |  |  |  |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke        |

### Surgeries:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Appendectomy      | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical disc procedure | <input type="checkbox"/> Hysterectomy                   |
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Laminectomies            | <input type="checkbox"/> Radical prostatectomy   | <input type="checkbox"/> Transurethral prostate surgery |

### Allergies:

- |                               |   |  |                                 |
|-------------------------------|---|--|---------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish and Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanut |
| <input type="checkbox"/> Soy  | <input type="checkbox"/> Sulfites           | <input type="checkbox"/> Wheat/Gluten    |                                 |

### Social History:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Caffeine used occasionally | <input type="checkbox"/> Caffeine used often            | <input type="checkbox"/> Chew tobacco occasionally | <input type="checkbox"/> Chew tobacco often           |
| <input type="checkbox"/> Drink alcohol occasionally | <input type="checkbox"/> Drink alcohol often            | <input type="checkbox"/> Exercise not at all       | <input type="checkbox"/> Exercise occasionally        |
| <input type="checkbox"/> Exercise often             | <input type="checkbox"/> Experience stress occasionally | <input type="checkbox"/> Experience stress often   | <input type="checkbox"/> Smoke 1 pack or less per day |
| <input type="checkbox"/> Smoke more than 1 day      | <input type="checkbox"/> Wear seat belts always         | <input type="checkbox"/> Wear seat belts never     | <input type="checkbox"/> Wear seatbelts usually       |

### Family History:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Arthritis (parent)      | <input type="checkbox"/> Arthritis (sibling)      | <input type="checkbox"/> Cancer (parent)              | <input type="checkbox"/> Cancer (sibling)              |
| <input type="checkbox"/> Cholesterol (parent)    | <input type="checkbox"/> Cholesterol (sibling)    | <input type="checkbox"/> Diabetes (parent)            | <input type="checkbox"/> Diabetes (sibling)            |
| <input type="checkbox"/> Heart problems (parent) | <input type="checkbox"/> Heart problems (sibling) | <input type="checkbox"/> High blood pressure (parent) | <input type="checkbox"/> High blood pressure (sibling) |
| <input type="checkbox"/> Psychiatric (parent)    | <input type="checkbox"/> Psychiatric (sibling)    | <input type="checkbox"/> Stroke (parent)              | <input type="checkbox"/> Stroke (sibling)              |
| <input type="checkbox"/> Thyroid (parent)        | <input type="checkbox"/> Thyroid (sibling)        |   |  |

### Substance Use:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Alcohol (past)      | <input type="checkbox"/> Alcohol (present)      | <input type="checkbox"/> Amphetamines (past) | <input type="checkbox"/> Amphetamines (present) |
| <input type="checkbox"/> Barbiturates (past) | <input type="checkbox"/> Barbiturates (present) | <input type="checkbox"/> Cocaine (past)      | <input type="checkbox"/> Cocaine (present)      |
| <input type="checkbox"/> Crystal Meth (past) | <input type="checkbox"/> Crystal Meth (present) | <input type="checkbox"/> Heroine (past)      | <input type="checkbox"/> Heroine (Present)      |
| <input type="checkbox"/> Marijuana (past)    | <input type="checkbox"/> Marijuana (present)    |  |   |

### Male Children:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|--|---|---|

### Female Children:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|--|---|---|

### Occupational Activities:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business owner           | <input type="checkbox"/> Clerical/secretarial | <input type="checkbox"/> Computer user         |
| <input type="checkbox"/> Construction   | <input type="checkbox"/> Daycare/childcare        | <input type="checkbox"/> Executive/legal      | <input type="checkbox"/> Food service industry |
| <input type="checkbox"/> Health care    | <input type="checkbox"/> Heavy equipment operator | <input type="checkbox"/> Heavy manual labor   | <input type="checkbox"/> Home services         |
| <input type="checkbox"/> Household      | <input type="checkbox"/> Light manual labor       | <input type="checkbox"/> Manufacturing        | <input type="checkbox"/> Medium manual labor   |

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### Review of Systems:

Have you had trouble with any of the following:

#### Cardiovascular:

	No _____		
	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

#### Genitourinary:

	No _____		
	Present	Past	No
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in urine			
Kidney Stone			

#### Hematologic/lymphatic:

	No _____		
	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

#### Neurologic:

	No _____		
	Present	Past	No
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			

#### Respiratory:

	No _____		
	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

#### Ears/Nose/Throat:

	No _____		
	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			

#### Eyes:

	No _____		
	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

#### Integumentary:

	No _____		
	Present	Past	No
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

#### Psychiatric:

	No _____		
	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

#### Constitutional:

	No _____		
	Present	Past	No
Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

#### Allergic/Immunologic:

	No _____		
	Present	Past	No
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

#### Gastrointestinal:

	No _____		
	Present	Past	No
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

#### Musculoskeletal:

	No _____		
	Present	Past	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

#### Endocrine:

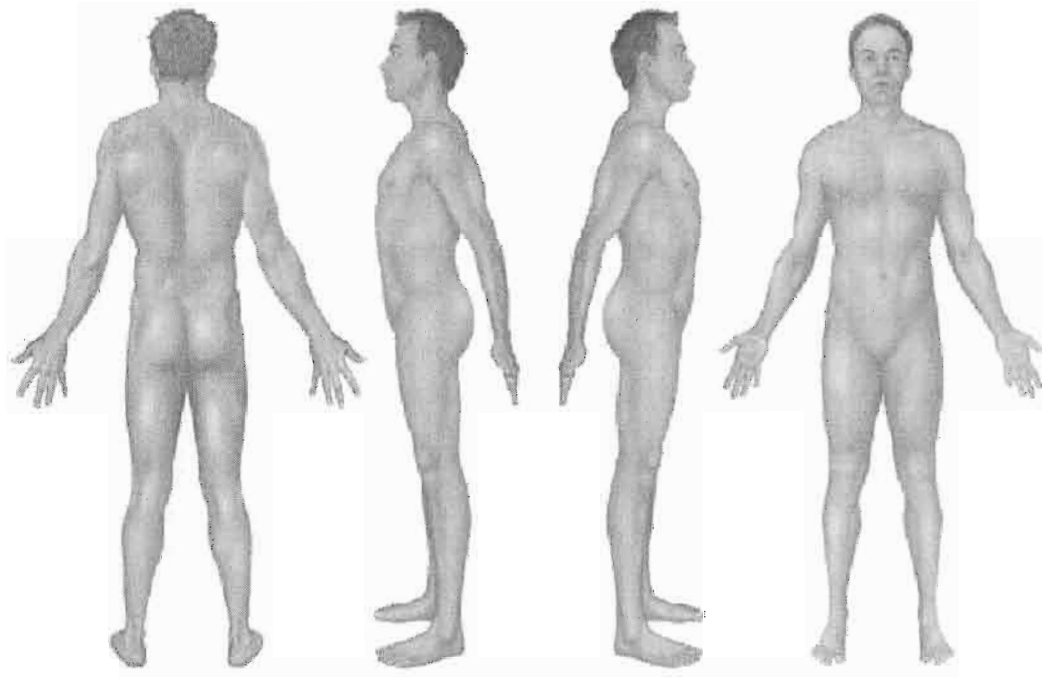
	No _____		
	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			

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By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

# = Numbness      X = Burning      / = Stabbing      0 = Pins & Needles      + = Dull Ache



Describe your symptoms: \_\_\_\_\_

When did your symptoms start?    Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

How did your symptoms begin? \_\_\_\_\_

**How often do you experience your symptoms?**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Constantly<br>(76-100% of the day) | <input type="checkbox"/> Frequently<br>(51-75% of the day) | <input type="checkbox"/> Occasionally<br>(26-50% of the day) | <input type="checkbox"/> Intermittently<br>(0-25% of the day) |
|---|--|--|---|

**What describes the nature of your symptoms?**

- |                                  |                                    |                                   |                                   |
|----------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp   | <input type="checkbox"/> Dull ache | <input type="checkbox"/> Numb     | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling  | <input type="checkbox"/> Stabbing |                                   |

**How are your symptoms changing?**

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> Getting better | <input type="checkbox"/> Not changing | <input type="checkbox"/> Getting worse |
|---|---------------------------------------|--|

**During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)**

- |                                 |                            |  |                            |
|---------------------------------|----------------------------|--|----------------------------|
| <input type="checkbox"/> 0 None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2             | <input type="checkbox"/> 3 |
| <input type="checkbox"/> 4      | <input type="checkbox"/> 5 | <input type="checkbox"/> 6             | <input type="checkbox"/> 7 |
| <input type="checkbox"/> 8      | <input type="checkbox"/> 9 | <input type="checkbox"/> 10 Unbearable |                            |

**During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):**

- |                                     |                                       |                                     |                                      |
|-------------------------------------|---------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Not at all | <input type="checkbox"/> A little bit | <input type="checkbox"/> Moderately | <input type="checkbox"/> Quite a bit |
| <input type="checkbox"/> Extremely  |                                       |                                     |                                      |

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**During the past 4 weeks, how much of the time has your condition interfered with your social activities?**

- All of the time       Most of the time       Some of the time       A little of the time  
 None of the time

**In general, would you say your overall health right now is....**

- Excellent       Very good       Good       Fair  
 Poor

**Who have you seen for your symptoms:**

- No one       Other Chiropractor       Medical Doctor       Physical Therapist  
 Other

**What treatment did you receive for your symptoms?**

- Adjustments       Physical Therapy       Medication       Surgery  
 Other

**When did you receive this treatment?**

- In the last month       2 – 3 months ago       3 – 6 months ago       6 months to 1 year ago  
 1 – 2 years ago       2 – 5 years ago       5 – 10 years ago

**What tests have you had for your symptoms?**

- X-rays       MRI       CT Scan       Other

**When were these tests done?**

- In the last month       2 – 3 months ago       3 – 6 months ago       6 months to 1 year ago  
 1 - 2 years ago       2 – 5 years ago       5 – 10 years ago

**Have you had similar symptoms in the past?**

- Yes       No

**If you have seen treatment in the past for the same or similar symptoms, who did you see?**

- This Office       Other Chiropractor       Medical Doctor       Physical Therapist  
 Other

**What is your occupation?**

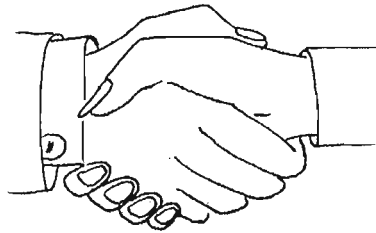
- Professional/Executive       White Collar/Secretarial       Tradesperson       Laborer  
 Homemaker       Full-time Student       Retired       Other

**If you are not retired, a homemaker or a student, what is your work status?**

- Full-time       Part-time       Self-employed       Unemployed  
 Off work       Other

**Thank you. Please return to the front desk.**

# Metzler Chiropractic Clinic, Inc.



WHEN IT COMES TO YOUR  
HEALTH, CHIROPRACTORS AND  
MEDICAL DOCTORS SHOULD BE  
WORKING TOGETHER  
FOR YOUR BENEFIT!

Dr. Metzler, I agree! I give you permission to inform my personal medical doctor of my condition, treatment and expected / actual response to care at this office.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print your name

Your Medical Doctor \_\_\_\_\_

Doctor's Town \_\_\_\_\_

Doctor's Phone, if known \_\_\_\_\_

# Metzler Chiropractic Clinic, Inc.

## Informed Consent

PATIENT NAME: \_\_\_\_\_

Clinic Name: Metzler Chiropractic Clinic, Inc. \_\_\_\_\_

Doctor's Name: Bradley Metzler, D.C. \_\_\_\_\_

Address: 12015 Pacific Street, Omaha, NE 68154 \_\_\_\_\_

Phone: 402-916-9492 \_\_\_\_\_ Fax: 402-916-9984 \_\_\_\_\_

The primary treatment used by doctors of chiropractic is the spinal manipulation, sometimes called spinal adjustment.

- ◆ **The nature of the chiropractic adjustment.**

I will use my hands or a mechanical instrument 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 healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

- ◆ **The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

- ◆ **Ancillary treatment.**

In addition to chiropractic adjustments, I intend to use the following treatments:

EMS, Intersegmental Traction, Active Physiotherapy, Graston, Kinesotape

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These treatments involve the following additional significant risks:

EMS – Stiffness and soreness. Contraindications to treatment include: Malignancy, infection, pregnancy, pacemaker, areas of reduced sensation. Intersegmental traction – Stiffness and Soreness. Contraindications to treatment include: Fractures to affected areas. Active Physiotherapy – Stiffness and soreness

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- ◆ **The availability and nature of other treatment options.**

Other treatment options for your condition include:

- ◆ Self-administered, over-the-counter analgesics and rest
- ◆ Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers.
- ◆ Hospitalization with traction
- ◆ Surgery

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## Informed Consent

♦ **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 extend 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.
- ♦ Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's 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 risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.

♦ **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, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Bradley Metzler and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

DATE \_\_\_\_\_

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

WITNESSES

\_\_\_\_\_  
Signature of Parent or Guardian (if a minor)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

## Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
8. From time to time we may send you birthday cards or letters, use your name in a birthday list or use your name on a referral board in our office. By your signature below you have given us permission to do this.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

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Name of Patient

Date