BLANTON
Chiropractic & Wellness

TERMS OF ACCEPTANCE

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. 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.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. This is the actual re-alignment of the vertebra. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

Also, acknowledge that x-rays are not taken at Blanton Chiropractic & Wellness, LLC. There are other ways to indicate if a vertebra is misaligned and that is through static, muscle, motion palpation, and leg checks. If Dr. Lisa A. Blanton feels that it is necessary to have a patient x-rayed or the patient simply would like to have spinal x-rays before a chiropractic adjustment then the patient will be referred out to Piedmont Imaging or Sherman College of Chiropractic for specific x-rays. X-rays will be determined on a case by case basis, some indications or need for x-rays would include but are not limited to: if the patient has sustained a significant traumatic injury, if any type of joint disease is suspected (such as arthritis causing joint pain), any suspected spinal instability, and/or long-standing pain that has not responded to or resolved with previous health care treatment.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis _____ _____

(Signature) (Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and Dr. Lisa A. Blanton and her associates have my permission to refer me for x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____.

_____ _____

Signature Date

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instances per one million to one per two million cervical spine (neck) adjustments may be vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care at Blanton Chiropractic & Wellness, a health history and examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining what kind of chiropractic care is needed, or if further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the Doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

_____

Print Name

_____ _____

Signature Date

PLEASE READ AND SIGN

1. I have been informed that a copy of Blanton Chiropractic & Wellness "Notice of Privacy Practices for Protected Health Information (HIPAA)" brochure is available for my review both in the office and at Blanton Chiropractic & Wellness website (if applicable). Blanton Chiropractic & Wellness, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, ask for one at the time of my next appointment or accessing Blanton Chiropractic & Wellness website (if applicable).

2. I understand that most care is given in an open setting. Private rooms are available upon request.

3. I request to receive communication from Blanton Chiropractic & Wellness via email, postal mail, text and telephone messaging in connection with my care. □Yes □No If I should withdraw my consent, I will notify the office in writing.

4. Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine and/or voicemail.

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give Dr. Lisa A. Blanton at Blanton Chiropractic & Wellness permission to render care to me today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Name: (Printed) _____ Date: _____

Signature: _____ Date: _____

Signature of Parent (for minor):_____ Date: _____

CONSENT TO RELEASE MEDIA

OPTIONAL: (The authorization or non- authorization of photos will not affect the posting of testimonials) I hereby authorize Blanton Chiropractic & Wellness to use my photo(s) with my patient testimonial on their web site (if applicable) or in any public relations efforts that they see fit. This is including but not limited to their web site, advertising, mailers, social media, etc. I understand that I may withdraw the use of my photo at any time by writing to: Blanton Chiropractic & Wellness 272 Giles Drive, Boiling Springs, SC 29316.

_____ _____

Patient's Signature (Optional) Date

Welcome and thank you for choosing Blanton Chiropractic & Wellness!

WELCOME

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in casue and prevention of disease." –**Thomas Edison**

Patient Information (Please print in ink)

Name: _____Date:_____SS/HIC/Patient ID#:_____
First Middle Initial Last
Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐Male ☐Female Birth Date: _____ E-mail: _____
Home Phone: _____ Cell Phone: _____ Carrier: _____

Do you prefer to receive calls at: ☐Home ☐Work ☐Cell ☐No preference

☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Partnered for___years
Patient Employer/School: _____ Occupation: _____
Spouse or Parent's Name: _____Whom may we thank for referring you to us? _____
Person to contact in case of emergency: _____ Phone: _____

Symptoms

Reason for visit_____ When did you first notice the symptoms? _____
Is this condition getting progressively worse? _____
Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying down ☐Other

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning
☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other

Rate the severity of your pain (1 mild pain or discomfort, to 10 severe pain): 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go? _____
What treatment have you already received for this condition? _____

☐Medication ☐Surgery ☐Physical Therapy ☐Other_____
Name and address of other doctor(s) who have treated you for your condition _____

Physical Stress: Birth & Infancy

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please CHECK where and how you were birthed. (If you do not know, please skip to the next question.)
☐Home ☐Natural ☐Hospital ☐Caesarian section ☐Forceps ☐Breech
☐Cord around neck ☐Prolonged labor ☐Drug induced labor ☐Suction

Physical Stress: Childhood through Adult

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

1.) Have you had any accidents due to any of the following? (Check all that apply)
☐Automobile ☐Motorcycle ☐Bicycle ☐Sports ☐Playground ☐Abuse

If yes, state type of injury and date: _____
2.) Have you ever hurt, broken, fractured, sprained, injured or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? □Yes □No
If yes, list body parts injured and dates of injuries:
_____
3.) Have you ever been knocked unconscious? □Yes □No
If yes, please explain _____

Medical History

1.) Have you ever been hospitalized or had surgery? □Yes □No
If yes, state reason and dates _____

2.) Have you had any spinal x-rays, CAT scans or MRI imaging of your spine, head, neck, back or hips? □Yes □No
If yes, what were you told about them? _____Where are these films now? _____

3.) Have you consulted a physician or other health care provider in the past 3 months? □Yes □No
If yes, reason for visit, date of last visit, & what was done or suggested?
_____

Chemical Stress

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Are you taking any of the following medications? ☐Nerve Pills ☐Pain Killers (including aspirin) ☐Muscle Relaxers ☐Stimulants ☐Blood Thinners ☐Tranquilizers ☐Insulin ☐Blood Pressure medication ☐Antidepressants ☐Other_____

1.) Are you now taking any drug (prescription or over-the-counter) regularly? □Yes □No

If yes, please list the drugs, when prescribed and reasons for taking them_____
_____

2.) Did a physician prescribe these drugs? □Yes □No
3.) Were you previously taking any medications regularly? □Yes □No
4.) Have you been immunized? □Yes □No

Daily Habits

1.) What type of exercise do you perform on a daily basis? ☐None ☐Moderate ☐Heavy
2.) What do your daily work habits include? (e.g. sitting, standing, light labor, heavy labor, computer work)_____
_____
3.) What kind of other nutritional supplements do you take (if any)? _____
4.) Do you smoke? □Yes □No How much per day? _____
5.) How much liquor do you consume on a weekly basis? _____
6.) How much coffee or caffeinated beverages do you consume on a daily basis? _____
7.) Do you use artificial sweeteners? □Yes □No If yes, what kind? _____
8.) Do you drink sodas? □Yes □No If yes, how much and what kind? _____
9.) How much water do you drink daily? _____

Health History

Do you have or have you ever had any of the following conditions? (Check only those that apply.)

☐Aids/HIV	☐Depression	☐Hepatitis	☐Psychiatric care
☐Alcoholism	☐Diabetes	☐Hernia	☐Reflux
☐Allergy Shots	☐Difficulty breathing	☐Herniated disc	☐Rheumatoid arthritis
☐Anemia	☐Difficulty holding urine	☐Herpes	☐Rheumatic fever
☐Anorexia	☐Difficult to start/stop urine	☐High blood pressure	☐Ringing in ears
☐Appendicitis	☐Digestive problems	☐High cholesterol	☐Scarlet fever
☐Arthritis	☐Drug abuse	☐Kidney disease	☐Shingles
☐Artificial valves	☐Emphysema	☐Kidney stone	☐Sinus problems
☐Artificial limbs/joints	☐Epilepsy	☐Liver disease	☐Stroke
☐Asthma	☐Eyesight problems	☐Low back pain	☐Suicide attempt
☐Balance problems	☐Excessive gas	☐Measles	☐Thyroid problems
☐Bleeding disorders	☐Floating stools	☐Migraine Headaches	☐Trouble hearing
☐Breast lumps	☐Fractures	☐Miscarriage	☐Tonsillitis
☐Bronchitis	☐Frequent neck pain	☐Mitral valve prolapse	☐Tuberculosis
☐Bulimia	☐Gallbladder stones	☐Mononucleosis	☐Tumors, growths
☐Cancer	☐Glaucoma	☐Multiple Sclerosis	☐Typhoid fever
☐Cataracts	☐Goiter	☐Mumps	☐Ulcers
☐Changes in stool color	☐Gonorrhea	☐Osteoporosis	☐Vaginal infections
☐Chemical dependency	☐Gout	☐Pacemaker	☐Vaginal disease
☐Chemotherapy/radiation	☐Headaches	☐Parkinson's disease	☐Venereal disease
☐Chicken pox	☐Heart attack	☐Pinched nerve	☐Whooping cough
☐Chron's disease	☐Heart surgery	☐Pneumonia	☐Other
☐Colonitis	☐Heart murmur	☐Polio	_____
☐Congenital heart disease	☐Heart disease	☐Prostate problems	_____
☐Corrective lenses	☐Hot flashes	☐Prosthesis	_____

Experience with Chiropractic

Have you ever been adjusted by a chiropractor? ☐Yes ☐No Reason for those visits _____
Doctor's name _____ Approximate date of last visit _____
Has any adult in your family seen a chiropractor? ☐Yes ☐No
Has any child in your family seen a chiropractor? ☐Yes ☐No

Awareness of Chiropractic Principles –Were you aware that:

Doctors of chiropractic work with the nervous system? □Yes □No
The nervous system controls all bodily functions and systems? □Yes □No
Chiropractic is the largest natural healing profession in the world? □Yes □No
If chiropractic starts at birth, you can achieve a higher level of health throughout your life? □Yes □No

Goals for My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, and others for the correction of whatever is malfunctioning in their bodies. Dr. Blanton will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

□ Relief care – symptomatic relief of pain or discomfort.
□ Corrective care – correcting and relieving the cause of the problem as well as symptoms.
□ Comprehensive care – bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.
□ I want the Doctor to select the type of care appropriate for my condition.

_____ _____
Patient's Signature Date

Authorization for Care

I hereby authorize Dr. Blanton to work with my condition through the use of adjustments to my spine as she deems appropriate.

I clearly understand and agree that payment is due at the time services are rendered. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed condition nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment for my insurance rights and benefits (if applicable) directly to the provider of services rendered.

_____ _____ _____
Patient's Signature Guardian or Spouse's Signature Date

Our partnership for Healing: *True healing is a process. Our relationship as Doctor and patient is a partnership where the rate of healing is totally dependent on both of us bringing all that we can bring. I covenant to you the very best care I can deliver. You can facilitate this healing process by honoring your plan of care, being on time for your appointments and knowing that this type of healing is not a quick fix, but a journey we both elect to take. Thank you for trusting me with your care. I look forward to building and maintaining a healthy relationship.*

_____ _____
Patient's Signature Date

_____ _____
Doctor's Signature Date

Lisa A. Blanton, D.C.
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