# Guardian Chiropractic, LLC

Dr. Amanda Angell, DC
972 Western Avenue, Manchester ME 04351

## Patient Health History Form

In order to provide you the best possible care, please complete this form.
** Please also provide staff with most current insurance card(s)**

### Patient Information

First Name: _____ Last Name: _____ Todays Date: _____
Birth Date: _____ Age: _____ Social Security Number: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ [ ] Cell [ ] Home Other Number: _____ [ ] _____
E-Mail* _____
Your e-mail will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

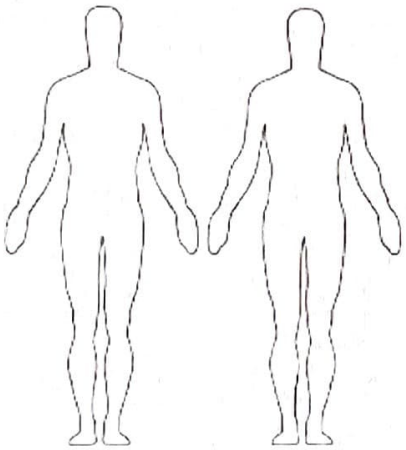
Referred By: _____ Occupation: _____ Employer: _____
Emergency Contact: _____ Relation: _____ Phone Number: _____

**Current Complaint:**

_____

Previous Complaints/Health Concerns:

_____



Any Additional information you would like the provider to know:

_____
_____
_____
_____

A = Ache
B = Burning
N = Numbness
P = Pins and Needles
S = Stabbing
O = Other

**AUTHORIZATION FOR BILLING INSURANCE COMPANY** **Initial** _____

*I understand and agree that health/accident Insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are m y personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable. There will be a $25 dollar missed appointment fee for any appointments missed and not rescheduled 24 hours before day of appointment.

**AUTHORIZATION TO TREAT** **Initial** _____

*Consent: I consent to the chiropractic treatment/treatments offered or recommended to me by Dr. Angell, DC, including joint adjustments or manipulations or mobilization to the joints of my spine (neck and back), pelvis and extremities (shoulders, upper limbs and lower limbs), including various modes of physical therapy, and if necessary, diagnostic x-rays. I intend this consent to apply to all my present and future treatments at Guardian Chiropractic, LLC.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION** **Initial** _____

*I hereby allow Dr. Angell's DC, approved staff or agents to obtain my Protected Health Information from Dr. David Benoit to provide for the transfer of care to Dr. Amanda DC Angell, DC, under new ownership of Guardian Chiropractic, LLC.

Patient Signature: _____
Printed Name: _____ Date: _____
Guardian/Authorized Representative Signature: _____ Date: _____

# Informed Consent to Chiropractic Treatment

Please read this consent form and discuss it, if you would like to, with Dr. Angell, and then sign where indicated at the bottom of the page. Clinicians who use spinal manual therapy techniques, such as joint manipulation, mobilization, or adjustment are required to inform their patients that there may be some risks associated with such treatment.

Treatments provided at Guardian Chiropractic, LLC, including the spinal adjustment, manipulation and/or mobilization, have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders/arms/legs, for headaches and other neuromusculoskeletal symptoms. Treatment provided at Guardian Chiropractic, LLC very possibly also contribute to your overall well-being. The risk of injury or complication from manual treatment is substantially lower than the risk associated with many standard medical treatments given for the same forms of musculoskeletal pain, such as muscle relaxing drugs, anti-inflammatory drugs such as aspirin, or pain pills. The most frequent risk that occurs in a chiropractic clinic is from burns associated with hot packs. Our office does NOT use hot packs. Rarely some patients have reported muscle or ligament sprains or strains or rib fractures following an adjustment, however, our low amplitude techniques make that extremely improbable. There have been some "reports" of disc injury following an adjustment, however, there is NO scientific study that has ever demonstrated that such injuries are caused, or may be caused, by adjustments or manipulative techniques. In fact there is much scientific evidence to the contrary. Chiropractic adjustments offer disc patients significant relief and a speedier recovery without the need to resort to surgery. There have also been "reports" of injuries to a vertebral artery following neck adjustments. Usually these patients have a predilection for vertebral artery dissection prior to their chiropractic visit. These patients are already at risk for stroke under many positional activities. They are already at risk for serious neurological injury and impairment, and are no more likely to have such an incident in a chiropractic office than they are in a medical clinic or a beauty salon. This form of complication is astronomically rare occurring about 1 in 12–50 million and has little or no correlation with the chiropractic adjustment.

Dr. Angell will evaluate your individual case, provide an explanation of care and a suggested treatment plan, or alternatively a referral for outside consultation and/or further medical evaluation if deemed necessary.

Acknowledgement: I acknowledge that I have read, discussed, or have been given the opportunity to discuss, with my clinician the nature of chiropractic treatment in general and my treatment in particular as well as the contents of this consent.

Consent: I consent to the chiropractic treatment/treatments offered or recommended to me by Dr. Angell, including joint adjustments or manipulations or mobilization to the joints of my spine (neck and back), pelvis and extremities (shoulders, upper limbs and lower limbs), including various modes of physical therapy, and if necessary, diagnostic x-rays. I intend this consent to apply to all my present and future treatments at Guardian Chiropractic, LLC.

Patient Signature: _____

Printed Name: _____

Date: _____

Guardian/Translator (print): _____

Guardian Chiropractic, LLC
Dr. Amanda Angell, DC
972 Western Avenue
Manchester, Maine 04351
Telephone: (207) 622-3900
Fax: (207) 622-1960

# Financial Policy

It is our office policy that all services rendered are charged directly to you the patient and that you are ultimately responsible for all payments regardless of whether or not this office accepts insurance assignment.

Once an appointment has been made, it is reserved specifically for you. If you are unable to keep your appointment, please give a 24-hour notice to allow us to accommodate waiting patients, there will be a $25 fee for missed appointments.

If you would like a call reminder the day before, our staff is happy to do so upon request.

# Insurance Policy

It is the policy of this office to extend our patients the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under chiropractic care.

- The privilege of insurance assignment begins when your insurance forms are received by our office.
- All deductible payments MUST be made prior to insurance submittal.
- All co-payments are payable when service is rendered. (Co-payment is that part of service that is not paid by your insurance) A $200 co-payment balance must not be exceeded by any patient or professional care may be terminated.
- Since we do not own your policy and since from time to time, we experience difficulty in collecting from your insurance company and since insurance assignment is a privilege it may be terminated at any time. Of course, we will give you ample notice and ask that you act in your own behalf with your insurance company.
- This office does not promise that an insurance company will pay for the usual and customary charges of this office, nor will this office enter into any dispute with an insurance company over reimbursement or the amount of reimbursement.
- When making a health care decision it is important to remember that you the patient are ultimately financially responsible for any services rendered.
- Lastly, it is our goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your healthcare or any of our policies, please let us know.

Signature _____

Printed Name _____ Date_____

**Exam Type:** New Patient  New Injury  Return to care

| Supine | L | R |
|---|---|---|
| Lindner | | |
| SLR | | |
| Braggards | | |
| WLR | | |
| Fabere Pat. | | |
| Psoas 4/5 | | |
| TFL 4/5 | | |
| Hip Flex (L1-3) | | |
| Ft. Eversion (S1) | | |
| Piriformis 4/5 | | |
| Leg Ext. (L2-4) | | |
| Hip Abduction (L4) | | |
| Hip Abduction (L5) | | |
| Hip Abd. w/ I/E Rot | | |
| Supraspinatus 4/5 | | |
| Triceps w/Ext. 4/5 | | |
| Triceps w/Flex 4/5 | | |
| Brachioradalis | | |

| Sitting | L | R |
|---|---|---|
| Val + Bech | | |
| Shoulder Dep | | |
| Wrights | | |
| Supraspin 4/5 | | |
| Infraspin 4/5 | | |
| Maximum Cervical Depression | | |
| Subcapularis 4/5 | | |
| Shldr Abd. (C5) | | |
| Wrist Ext (C6) | | |
| Wrist Flex (C7) | | |
| Finger Flex (C8) | | |
| Finger Abd (C7, T1) | | |
| Wrist Pron. 4/5 | | |
| Abd. Poll. Brev. 4/5 | | |

| Vitals | |
|---|---|
| Height | |
| Weight | |
| Wears Orthotics | |
| Heel Lift | |
| Blood Pressure | |
| Pulse | |
| Temperature | |

| Prone | L | R |
|---|---|---|
| Hibbs | | |
| Yeomans | | |
| Hip Ext 4/5 | | |

| Posture | L | R |
|---|---|---|
| Head Tilt | | |
| Head Rot. | | |
| Shoulder (high) | | |
| Shoulder (ant) | | |
| Iliac Crest (high) | | |
| Pronation | | |
| Foot Flare | | |
| Knee Huperext | | |
| Minors | | |
| Adams | | |
| Antalgia | | |
| Kemps | | |
| Toe Walk (S1) | | |
| Heel Walk (L5) | | |

| Reflexes | L | R |
|---|---|---|
| Biceps (C5) | | |
| Triceps (C7) | | |
| Brachialis (C6) | | |
| Patellar (L4) | | |
| Achilles (S1) | | |
| Plantar | | |

| Myospasms/Myofacitis | L | R |
|---|---|---|
| Subocc. | | |
| Trap | | |
| Scalenes | | |
| SCM | | |
| Lev. Scap | | |
| Rhom | | |
| Quad Lumb | | |
| Piriformis | | |
| TFL | | |
| Erector Sp. T/S | | |
| Erector Sp. L/S | | |
| Pects | | |
| Infraspinatus | | |
| Supraspinatus | | |

| Hip Motion | N | L | R | PN |
|---|---|---|---|---|
| Flex. | 120 | | | |
| Ext. | 30 | | | |
| Int. Rot. | 40 | | | |
| Ext. Rot. | 40 | | | |

| Shoulder Motion | N | L | R | PN |
|---|---|---|---|---|
| Flex | 180 | | | |
| Int. Rot. | 90 | | | |
| Ext. Rot. | 90 | | | |
| Abd. | 180 | | | |

| Cervical Motion | N | EX | PN |
|---|---|---|---|
| Flex | 60 | | |
| Ext | 50 | | |
| R Lat Flex | 40 | | |
| L Lat Flex | 40 | | |
| R Rot | 80 | | |
| L Rot | 80 | | |

| Dermatone | L | R |
|---|---|---|
| C5 | | |
| C6 | | |
| C7 | | |
| C8 | | |
| T1 | | |
| L1 | | |
| L2 | | |
| L3 | | |
| L4 | | |
| L5 | | |
| S1 | | |

| Extremity Subluxation | L | R | PN |
|---|---|---|---|
| TMJ | | | |
| SC/AC/GH | | | |
| Radius | | | |
| Ulna | | | |
| Carpals | | | |
| Thumb | | | |
| Talus | | | |
| Feet | | | |
| Med Tibia | | | |
| Lat Tibia | | | |

| Dorso-Lumbar Motion | N | EX | PN |
|---|---|---|---|
| Flex | 60 | | |
| Ext | 50 | | |
| R Lat Flex | 40 | | |
| L Lat Flex | 40 | | |
| R Rot | 80 | | |
| L Rot | 80 | | |

| Subluxations | L | R |
|---|---|---|
| OCC | | |
| C1 | | |
| C2 | | |
| C3 | | |
| C4 | | |
| C5 | | |
| C6 | | |
| C7 | | |
| T1 | | |
| T2 | | |
| T3 | | |
| T4 | | |
| T5 | | |
| T6 | | |
| T7 | | |
| T8 | | |
| T9 | | |
| T10 | | |
| T11 | | |
| T12 | | |
| L1 | | |
| L2 | | |
| L3 | | |
| L4 | | |
| L5 | | |
| SI Flex | | |
| SI Ext | | |
| PI Ilium | | |
| AS Ilium | | |
| PD | | |