Patient Name: _____ **Date:** _____

Date of Birth_____ Age_____

Address_____ City_____ State _____ Zip Code _____

H. Phone _____Cell Phone_____ W. Phone _____

Email Address: _____

Sex M F Marital Status M S D W

Occupation _____

Employer _____

Emergency Contact and Phone Number: _____

Referred by: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor: _____

1. **Past Health History:**

   A. **Surgeries:**

Date	Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

   B. **Previous Injury or Trauma:** _____

   Have you ever broken any bones? Which? _____

   C. **Allergies:** _____

2. **Family Health History:**

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Heart disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease
□ Diabetes □ Other _____ □ None of the above

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Patient Name: _____ **Date:** _____

A. **Deaths in immediate family:**

Cause of parents' or siblings' death Age at death

_____

_____

_____

_____

3. **Social and Occupational History:**

A. **Job description:** _____

B. **Work schedule:** _____

C. **Recreational activities:** _____

D. **Lifestyle:**

Hobbies: _____

Level of Exercise: _____

Alcohol Use: _____

Tobacco Use: _____

Drug Use: _____

Diet: _____

Would you be open to some free family Health & Wellness information? YES NO

4. **Medications:**

Medication Reason for taking

_____

_____

_____

_____

_____

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Patient Name: _____ **Date:** _____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes □ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia □ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use □ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Dr. Tara Finkstein/Titan Chiropractic** for services performed.

Patient or Guardian Signature _____ Date _____

412 E. Oskaloosa St Pella IA 50219 **641-820-0151**

Patient Name: _____ **Date:** _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

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Patient Name: _____ **Date:** _____

NEW PATIENT HISTORY FORM

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other _____

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Patient Name: _____ **Date:** _____

NEW PATIENT HISTORY FORM

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other _____

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Patient Name: _____ **Date:** _____

NEW PATIENT HISTORY FORM

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other _____

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TITAN CHIROPRACTIC & SPORTS PERFORMANCE

412 E OSKALOOSA STREET PELLA IA 50219
641-820-0151 FAX 641-204-0218
TITANSPORTSCLINIC.COM

Financial Policies

Payment is due for services rendered **at the time of appointment**, following appointment, unless previous arrangements have been made. **Initial:** _____

I am financially responsible for any applicable deductibles or co-pays. I also understand that I am financially responsible for any charges not covered by this assignment; including any denials for any reason. I understand that I will be held responsible for any costs incurred regarding collection of payment for services rendered. In this clinic, we will provide you a receipt upon request to submit for reimbursement to your insurance company based on your benefits. This is not a guarantee of your benefits. Plans for Chiropractic care vary based on each individuals insurance policy.

Circle which pertains to you: Private Insurance (such as Blue Cross) No Insurance Medicare

Initial:_____

Minors: (if applicable)

Minors are welcome to come without their parents for their visits. However, if a parent is not going to accompany the child we do require a credit card on file that will be charged after each visit or purchase of a punch card. The front desk can assist you in any questions you may have. **Initial:** _____

Missed Appointment: No Call/No Show

We reserve the right to charge a **$35.00** missed appointment fee. We have voicemail available 24 hours a day, 7 days a week should you need to cancel during non-office hours. We are aware that unforeseen events result in a missed appointment and can be discussed on an individual basis. **Initial:** _____

By signing below, I acknowledge, and have been advised of how health information about me may not be used or disclosed by Titan Chiropractic & Sports Performance.

Patient -or- Guardian Signature _____ Date _____

TITAN CHIROPRACTIC & SPORTS PERFORMANCE

About Cupping Therapy

This ancient therapy utilizes negative pressure, rather than tissue compression, for superior results in a wide array of bodywork techniques. Fire cup therapy is a traditional, time-honored treatment that remains favored by millions of people worldwide because it is safe, comfortable and delivers remarkable results.

Why Cupping is so effective in bodywork

By creating suction and negative pressure, cupping therapy lifts connective tissue, releases rigid tissue and loosens adhesions. Cupping pulls stagnation, waste and toxins to the skin level where it can be easily flushed out by the lymphatic and circulatory system.

Cupping techniques bring blood flow and nutrition to stagnant areas. The pulling action engages the parasympathetic nervous system, thus allowing deep relaxation throughout the entire body.

What are the marks that can occur from cupping?

They are not bruises. They are metabolic waste, toxins and other stagnant material that have been freed from the underlying tissue and brought to the surface where they can more easily by flushed away. These marks can last anywhere from a few hours to a few weeks and are not tender to the touch.

Suggested after care recommendations:

Drink plenty of water to help eliminate toxins out of the body. (Your body weight / 1/2) Avoid showers, steam, sauna and exercise immediately following bodywork. Light stretching and range of motion exercises are beneficial.

Contraindications:

People who are on blood thinners should not experience Massage Cupping. If you start taking such medication please inform the therapist so your treatment plan can be adjusted.

INFORMED CONSENT

* I understand that all treatments at this facility are therapeutic in nature. I agree to communicate any physical discomfort or draping issues during the session to the therapist.
* Information has been provided to me about Cupping Therapy. If I choose to experience these therapies during treatments, I understand the potential effects and after-care recommendations
* It has been explained to me that there are contraindications for Cupping Therapy. I have fully disclosed all health factors to my therapist, including those not mentioned on my Massage Health Intake Form, to avoid any complications.
* It has been explained to me that there is a possibility of discoloration that can occur from the release and clearing of stagnation and toxins from the body.
* I also understand that this reaction is not bruising, but due to cellular debris, pathogenic factors and toxins being drawn to the surface to be cleared away by my circulatory systems.
* I further understand that the discoloration will dissipate from a few hours to as long as 2 weeks in some cases and in relation to my after-care activities.
* I understand that the first time I experience Cupping, my body's immune system can temporarily react to this release as it might with the flu-producing flu-like effects such as nausea and headache. These symptoms will subside in time with rest and water. Water helps to dilute the intensity of the releases.
* I understand that Cupping Therapy modalities should not be combined with aggressive exfoliation, be performed within 4 hours of shaving, after sunburn or when I'm hungry or thirsty.
* I understand I should avoid exposure to cold, wet and/or dry windy weather conditions, hot showers, baths, saunas, hot tubs and aggressive exercise for 4-6 hours. I understand that exposure to such extremes can produce undesirable side effects and I should avoid such situations.

I agree to allow the Cupping Practitioner to perform Massage Cupping. I also agree that I have read, understand and will follow all of the information above and will not hold the practitioner responsible.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

TITAN CHIROPRACTIC & SPORTS PERFORMANCE

412 E OSKALOOSA STREET PELLA IA 50219
641-820-0151 FAX 641-204-0218
TITANSPORTSCLINIC.COM

I authorize and consent to the performance of Chiropractic, Physical Rehabilitation, Myofascial Decompression, Sports Performance, Nutrition and all other services conducted by or under the direction of Dr. Tara Finkstein, DC and Dr. Parker Schenk, DC, to include all contractors. I understand the objective of this practice is to facilitate health through the reduction of the vertebral subluxation complex and its related components. I will not hold Dr. Tara Finkstein, DC and or Dr. Parker Schenk, DC or any associates or contractors responsible for any pre-existing medically diagnosed or undiagnosed conditions or for any medical diagnosis such as cancer, heart disease, strokes or other problems. The Doctor will make every reasonable effort during the examination to screen for contraindications for care. However if a condition that would otherwise not come to the attention of the doctor it is your responsibility to inform such Doctor.

I authorize the Doctors and staff to release any information deemed appropriate concerning my physical condition to an insurance company, claims adjuster, case nurse, claims reviewer, health care provider, or attorney, or coaching staff, in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered, and hereby release any one of any consequences thereof. I agree that a photo static copy of this agreement will serve as the original.

_____ _____

Patient Signature Date

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain 0 1 (2) 3 4 (5) 6 7 (8) 9 10 **worst possible pain**

---

1 – What is your pain RIGHT NOW?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

2 – What is your TYPICAL or AVERAGE pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.