Dr. Tyler Baker, D.C.
10815 Prairie Brook Rd
Omaha, NE 68144
Phone: 402-397-1800 Fax: 1-888-210-5034

Today's Date _____/_____/_____

Name _____ Age _____ Birthdate _____ Sex M F

Address _____

City_____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone_____

Email Address: _____Occupation_____

Marital Status: S M W D Spouses Name (insurance purposes) _____

Females Only: Are you currently pregnant? Yes No

How Did You Hear About Us? _____

1. Please list your main symptoms that you would like to discuss with the doctor?

_____

_____

_____

2. How long have you had your current symptoms?_____

3. What originally caused your symtpoms?_____

4. What actions can you take that temporarily decrease the pain?_____

5. What activities increase your pain (circle all that apply): Sitting Standing Walking Sleeping Exercising Driving

Others_____

6. How Do You View Your Problem (circle one)...
   A. MINIMAL (Annoying but causing NO limitations)
   B. SLIGHT (Tolerable but causing a little limitation)
   C. MODERATE (Sometimes tolerable but definitely causing limitations
   D. SEVERE (Causing Significant limitations)
   E. EXTREME (Causing near constant (>80% of the time) limitations)

7. What does the pain feel like (circle all that apply): Sharp Dull Achy Throbbing Shooting Stabbing Numb Tingling

8. Does the pain travel down your legs or arms? If so, please describe where_____

9. On a scale of 1 to 10, 10 being the worst, how would you rate your level of discomfort right now? _____

10. What percentage of time are you aware of your main problem? (circle one)
   A. Occasionally (25% of the time)
   B. Intermittently (50% of the time)
   C. Frequently (75% of the time)
   D. Constant (90-100% of the time)

11. Is it worse in the morning or the evening?_____

12. What kinds of treatments have you received?

Spinal Surgeries:	How Many_____	Approx Date _____	
Other Surgeries:	How Many _____	Approx Date _____	
Injections:	How Long _____	Approx Date _____	How Long _____
Drugs/Pharmaceuticals: _____		Approx Date _____	How Long _____
Physical Therapy		Approx Date _____	How Long _____
Chiropractic		Approx Date _____	How Long _____
Other_____			

15. How did the previous treatments(s) work out for you? (circle all the apply)

a. Bad results
b. Some results
c. Great results
d. Nothing changed
e. Did not get worse
f. Did not work very long
g. Still trying
h. Confused

Please check all of the following symptoms and signs which you now have or have had within the last 6 months.

O Allergies
O Alcoholism
O Anemia
O Arteriosclerosis
O Arthritis
O Asthma
O Autoimmune Disease
O Back Pain
O Bleeding Disorder
O Breast Lump
O Bronchitis
O Bruise Easily
O Cancer
O Cataracts
O Chest Pain
O Congestive heart disease
O Cold Extremities
O Constipation
O COPD/ Emphysema
O Cramps
O CVA (stroke/TIA)
O Dementia/Alzheimer's
O Depression
O Diabetes
O Digestion Problems
O Dizziness
O Emotional/mental disorders
O Epilepsy
O Excessive Menstruation
O Eye Pain or Difficulties
O Fatigue
O Frequent Urination
O Gallbladder disease/stones
O Glaucoma
O Gout
O Headache
O Hemorrhoids
O High Blood Pressure
O HIV
O Hot Flashes
O Irregular Heart Beat
O Kidney Infection
O Kidney Stones
O Liver disease/cirrhosis
O Loss of Memory
O Loss of Balance
O Loss of Smell
O Loss of Taste
O Lung disease
O Macular Degeneration
O Migraines
O Nosebleeds
O Pacemaker
O Parkinson's
O Polio
O Poor Posture
O Prostate Trouble
O Retinal Disease
O Sciatica
O Seizures
O Shortness of Breath
O Sinus Infection
O Sleep Problems
O Skin Sensitivity
O Spinal Curvatures
O Stroke
O Swelling of Ankles
O Thyroid Condition
O Tuberculosis
O Tobacco Usage
O Varicose Veins
O Venereal Disease
O Other_____

***Patient/Guardian Signature_____ DATE _____/_____/_____**

Doctor's Notes: _____

_____

_____

_____

_____

_____

_____

_____

***ADL: 1. Limitations: Time:**
2. Limiations: Time:
*** ROM for _____ is _____ & ROM for _____ is _____.**

DOCTOR-PATIENT RELATIONSHIP INFORMED CONSENT

RESULTS
Although we do see great improvements with our patients, there are many factors such as (age, health status, degeneration, etc) that go into whether a patient will receive benefit from our services. As with any health condition, we cannot guarantee any results. In most cases there is a more gradual but satisfactory response. Two or more similar conditions may respond differently to the same care.

The availability and nature of other treatment options.
Other treatment options for your condition not offered here may include:
- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-reducers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

INFORMED CONSENT FOR CARE
A patient, in coming to the Doctor of Chiropractic, gives the Doctor Permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. Chiropractic care or other clinical procedures are usually beneficial and seldom cause any problem. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

For patients with Fibromyalgia or are in Severe pain we often use very gentle procedures.
In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a Chiropractic adjustment, or health care, if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

It is important to acknowledge the difference between the health care specialties of Chiropractic, and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, and physical conditions. It is important to understand what to expect from Chiropractic health care services.

TO THE PATIENT
Please discuss any questions or problems with the Doctor **before** signing this statement of policy.
I have read, and understand the foregoing.

MEDICAL RELEASE
I authorize Dr. Tyler Baker, DC/or Dr. Scott Sizenbach, DC for the release of any medical or other information necessary to process claims. I also request payment of medical or government benefits either to myself or the party who accepts assignment.

SIGNED_____**DATE**_____

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 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 the front desk before signing this consent.

- The patient understands and agrees to allow this chiropractic office to use their Patient Health information for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment.
- The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. (A copy fee may apply) 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
- A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
- 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.
- 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.
- Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, this office has the right to refuse to give care.

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

Signature of Patient or Guardian Date