Hamburg Natural Health

*****PLEASE PRINT*****

Name:______________________ Address:____________________________

City, State, Zip:_______________ Home Phone:________________________

Cell Phone:__________________ Email Address:_______________________

***Would you like to receive our complementary monthly E-Newsletter?_______

Social Security #:___________Birth date:_______Age:_______M/F________

Please check one: Married__Single__Divorced__Widowed__

Spouses name:____________________

Patient Occupation________________Employer:_________________________

Work Phone #:_________Work Address:_______________________________

How were you referred to our office?__________________________________

Have you ever had chiropractic care before?____If yes, when_______________

List your chief complaints in order of severity:

1.________________________________For how long?__________________

2.________________________________For how long?__________________

3.________________________________For how long?__________________

List other Doctors consulted for this condition:

1._____________________________Address:__________________________

2._____________________________Address:__________________________

Is this injury or illness work related?_____

Is this injury or illness related to an automobile accident?_____

All first visit charges are payable when services are rendered.

Patients Signature:________________________ Date:______________________________

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NAME:____DATE:______________________

Please indicate any symptoms/problems you experience from the following list:
****Please check any that apply to you and check the severity and frequency****

SYMPTOM	CHECK	SEVERITY (1-10)	FREQUENCY
Headaches			
Dizziness			
Blurred Vision			
Lack of Concentration			
Depression			
Nervousness			
Sleeplessness			
Lack of Energy			
Buzzing/ringing in ears			
Fainting			
Heart Palpitations			
Sinusitis			
Neck/Shoulderpain			
Back Pain			
High BloodPressure			
Lung/ Respiratory issues			
Indigestion			
Bladder issues			
Kidney/Liver issues			
Urinaryissues			
Colon issues			
Hip pain			
Leg pain			
Poor circulation			
Thyroid issues			

Any other disorders not listed above:____

Please list any accidents (car or other) that you may have been in along with the approximate date:____

Please list any medications including over the counter medicines being taken:____________________

____

____

____

HAMBURG NATURAL HEALTH

Noah Hoy, DC
44 Union Street
Hamburg, NY 14075

Telephone (716) 648-3418
Fax (716) 649-8002

I hereby authorize Dr. Noah Hoy and staff to discuss my personal medical condition, treatment options, and future care with the following people:

Name______________________________ (Relationship)____________________________________

Name______________________________ (Relationship)____________________________________

Name______________________________ (Relationship)____________________________________

Signature____Date______________________________________

Patient or Person Authorized to give consent for Patient

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: ______________________ Signature: ______________________ Date: __________

Parent or Guardian: ______________________ Signature: ______________________ Date: __________

Witness Name: ______________________ Signature: ______________________ Date: __________

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TERMS OF ACCEPTANCE

WHEN A PATIENT SEEKS CHIROPRACTIC HEALTHCARE 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. OUR CHIROPRACTIC METHOD OF CORRECTION IS 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 FINDINGS, WE WILL ADVISE YOU. IF YOU DESIRE ADVICE, DIAGNOSIS OR TREATMENT FOR THOSE FINDINGS, WE WILL RECOMMEND THAT YOU SEEK THE SERVICES OF A HEALTH CARE PROVIDER WHO SPECIALIZES IN THAT AREA.

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 SUBLUXATIONS.

PRINT NAME________________________________, 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:______________

Hamburg Natural Health

We schedule our appointments so that each patient receives the right amount of time to be seen by Dr. Hoy and staff. That's why it is very important that you keep your scheduled appointment time with us and arrive on time.

If your schedule changes and you cannot keep your appointment, please contact us so that we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with Dr. Hoy, please give us at least 24 hours advance notice.

If you do not cancel or reschedule your appointment with at least 24 hours advance notice, we may assess a $25.00 "no-show" service charge to your account. You will be billed directly for it.

I understand the "no-show" policy of Hamburg Natural Health and agree to pay $25.00 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance, in order to avoid a potential no-show charge to my account.

Name:____

Date:____