

Chiropractic Information Form

Please answer **ALL** questions below. When completed, please return to the front desk.

Patient Information

| | | | | | |
|---|--|----------------|--------------|---|------|
| Date: | | | | | |
| Name: | | Nickname: | | Email | |
| Home Phone: | | Cell Phone: | | Work Phone: | |
| Address: | | | City, State: | | Zip: |
| Social Security #: | | | Birth Date: | | Age: |
| Marital Status: Single: <input type="checkbox"/> Married: <input type="checkbox"/> Divorced: <input type="checkbox"/> Widowed: <input type="checkbox"/> | | | | Occupation: | |
| Employer: | | | | Employer Phone: | |
| Names and Ages of Children: | | | | | |
| Spouse: | | Occupation: | | Employer: | |
| Emergency Contact: | | | | Number: | |
| How where you referred to our office: | | | | | |
| Family Medical Doctor: | | | | May We Update Your Doctor: Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Do you have Facebook: Yes <input type="checkbox"/> No <input type="checkbox"/> | | Facebook Name: | | | |
| Would you like text message appointment reminders: Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | How In advance: 2hrs <input type="checkbox"/> 4hrs <input type="checkbox"/> 1day <input type="checkbox"/> | |
| Provider: AT&T/Cingular <input type="checkbox"/> Cricket <input type="checkbox"/> Verizon <input type="checkbox"/> T-Mobile <input type="checkbox"/> Nextel <input type="checkbox"/> Sprint <input type="checkbox"/> Virgin Mobile <input type="checkbox"/> | | | | | |

Insurance Information

*If we **do not** have a copy of your insurance card, please fill out the information below.*

| | | | |
|---|--|------------------|--|
| Insurance Company: | | Subscriber Name: | |
| Subscriber #: | | Group #: | |
| Provider Phone (Located on back of insurance card): | | | |

Reason for Visit

| Reason For Visit | Pain Scale 1-10 (1 Mild, 10 Worst) | When did this Start? | Did the issue start with injury? | Type of Injury |
|----------------------|---------------------------------------|----------------------|----------------------------------|----------------|
| 1. (Primary Concern) | | | | |
| 2. | | | | |

| | |
|--|--------|
| What is your major symptom? | |
| What does this prevent you from doing? | |
| How frequent is the problem? <input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Intermittent <input type="checkbox"/> Nightly | |
| How long does it last? <input type="checkbox"/> All Day <input type="checkbox"/> A Few Hours <input type="checkbox"/> Minutes | |
| Are there any other conditions/symptoms that are related to this problem? | |
| Is the pain? <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Stabbing | Other? |
| What helps relieve the problem? | |
| What makes the problem worse? <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Lying <input type="checkbox"/> Bending <input type="checkbox"/> Lifting <input type="checkbox"/> Twisting | Other? |
| Women: Are you pregnant or may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Additional Information that we should know: | |

Pain Scale- Check the box that most adequately describes your pain level

| | |
|--|------------------|
| No Symptoms | Extreme Symptoms |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | |
| 0 | 10 |

Other doctors you have seen for this condition?

| Type | Name/Office | Date of Visit | Diagnosis | Treatment | Help? Y/N |
|--------------|-------------|---------------|-----------|-----------|-----------|
| Chiropractor | | | | | |
| Physician | | | | | |
| Orthopedist | | | | | |
| Other | | | | | |

Do these conditions interfere with any part of the following?

| | | | | |
|-------------------------------|--------------------------------|--|--|--------|
| <input type="checkbox"/> Work | <input type="checkbox"/> Sleep | <input type="checkbox"/> Daily Routine | <input type="checkbox"/> Sports/Exercise | Other: |
|-------------------------------|--------------------------------|--|--|--------|

Past Medical History

Please click the box indicating the conditions you have had or have now.

| | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Circulatory Issues | <input type="checkbox"/> Strokes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ruptures | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Low Blood Sugar |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Coughed Up Blood | <input type="checkbox"/> Depression | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Congenital Disease | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Mumps | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Plantar Fasciitis |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Malaria | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Ringing in Ears | | <input type="checkbox"/> Asthma | <input type="checkbox"/> Sinus Problems |

Fractured/Broken Bones

| Type | Region | Year |
|-----------------|--------|------|
| Arm/Hand | | |
| Leg/Foot | | |
| Pelvis | | |
| Collar | | |
| Ribs | | |
| Spinal Vertebra | | |
| Other | | |

Head-Please check all that apply

| | | | | |
|--------------------------------------|------------------------------------|--|--------------------------------------|---------------------------------------|
| Headaches: How many per week? | <input type="checkbox"/> Front | <input type="checkbox"/> Side of Head | <input type="checkbox"/> Behind Eyes | <input type="checkbox"/> Back of Head |
| <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evening | <input type="checkbox"/> Faintness | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Whiplash | <input type="checkbox"/> Sluggish | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Indecisive | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Face Twitch | | | | |
| <input type="checkbox"/> Hair Loss | | | | |
| <input type="checkbox"/> Concussion | | | | |
| Other: (Please Explain) | | | | |

Nose-Please check all that apply

| | | | | | | | |
|---|-----------------------------------|--|--|--|--|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Stuffy | <input type="checkbox"/> Congested | <input type="checkbox"/> Runny | Drainage: | <input type="checkbox"/> Yellow | <input type="checkbox"/> Green | <input type="checkbox"/> Clear |
| <input type="checkbox"/> Sinus Infection | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Deviated Septum | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Post Nasal Drip | <input type="checkbox"/> Acute Smell | |
| Does change of seasons make symptoms worse? <input type="checkbox"/> Y <input type="checkbox"/> N | | | | What season? <input type="checkbox"/> Spring <input type="checkbox"/> Summer <input type="checkbox"/> Fall <input type="checkbox"/> Winter | | | |
| Other: (Please explain) | | | | | | | |

Ears-Please check all that apply

| | | | | | |
|--|-----------------------------------|---------------------------------------|--|--|---|
| <input type="checkbox"/> Hearing Changes | <input type="checkbox"/> Deafness | <input type="checkbox"/> Hearing Aids | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Increased Ear Wax | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Swimmers Ear | <input type="checkbox"/> Drainage | <input type="checkbox"/> Aches | <input type="checkbox"/> Itches | <input type="checkbox"/> Pressure | <input type="checkbox"/> Tubes in Ears |
| Other: | | | | | |

Neck-Please check all that apply

| | | | | | | |
|--------------------------------|------------------------------------|--|---|--|---|---|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Whiplash | <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Bruit | <input type="checkbox"/> Carotid Stenosis | <input type="checkbox"/> Trouble Swallowing |
| <input type="checkbox"/> Lumps | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling in Hands | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Change in Range of Motion | | |

| |
|---|
| Have you had any major illnesses, injuries, falls, or auto accidents? |
| Have you been treated for any health condition by a physician in the last year? |
| What medication, supplements, or drugs are you currently taking? |
| Are you interested in learning more about nutrition and supplements: <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Do you have any allergies of any kind? <input type="checkbox"/> NO <input type="checkbox"/> YES (Please explain): |
| Please list any other health problem you have, no matter how insignificant: |

Surgeries

| Type | Body Part | Year |
|------|-----------|------|
| | | |
| | | |
| | | |

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 a 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 at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. 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.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. 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.
5. 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.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

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

Name of Patient

Signature of Patient or Guardian

Date

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, diagnostic x-rays, physical therapy techniques, on me (or on the patient named below for which I am legally responsible) by the licensed doctors of chiropractic at this office.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (a one in three million chance). We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known, are in the best interest.

I have had an opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having being informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

Printed name of patient

Signature of Patient

Date

Signature of patient's representative (if minor)

Date