

PATIENT INFORMATION

File#: _____

Name _____ Today's Date _____

Address _____ City _____ Zip _____

Phone 1 _____ Phone 2 _____ Status: S M D W

Date of Birth _____ SSN: _____ DL# _____

Email _____ Referred by? _____

Occupation _____ How long? _____

Employer: _____

Address _____ City _____ Zip _____

Finances [] I have no insurance and will pay by Cash, Check or Credit Card today [] I have insurance
(Please note that by law we MUST collect co-pays and deductibles at time of service if you have insurance)

Primary Insurance _____ Memb ID#: _____

Secondary Insurance _____ Memb ID#: _____

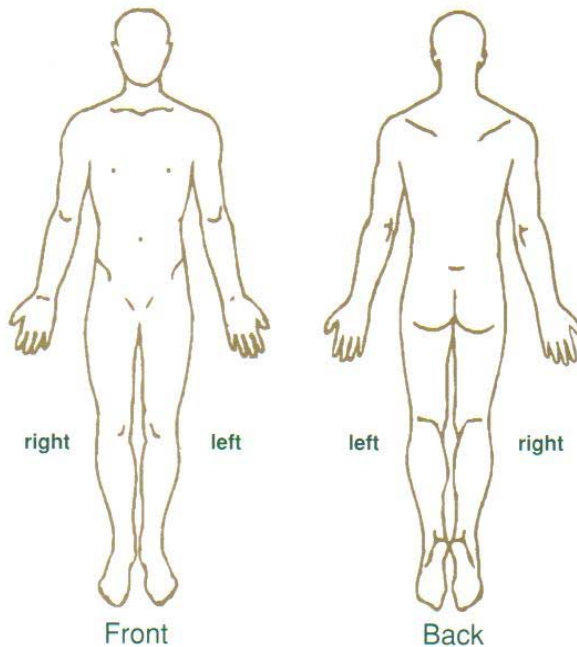
Tell us about your condition:

Height _____ Weight _____ Dominant Hand? R L

Please mark area(s) of pain or discomfort on the figures below. Mark all areas with a descriptive symbol and a number for severity of pain or distress on a 1 (minimal discomfort) to 10 (excruciating pain) scale.

Description: Numbness NNN, Pins & Needles PPP, Burning BBB, Aching AAA, Stabbing SSS, Electric EEE

Other: _____



When did it start? _____ How did it start? _____

Have you had similar problems in the past? When? _____

Have you seen a Doctor of Chiropractic in the past? _____

Name and last visit: _____

Health History

Are you taking any of these medications?

Nerve pills Pain killers Aspirin/Ibuprofen/Tylenol/Aleve Muscle Relaxers Stimulants Blood Thinners Insulin
 Tranquilizers Other: _____

Do you now or have you ever had any of these conditions?

Y N Heart attack/stroke	Y N Heart surgery/Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral valve prolapse	Y N Artificial valves
Y N Alcohol/Drug abuse	Y N Venereal disease	Y N Hepatitis
Y N HIV+/AIDS	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes/TB	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back problems	Y N Artificial Bones/Joints	Y N Arthritis

List any previous accidents/injuries:

List any other serious medical conditions you may have or ever had:

List any allergies you may have:

List previous surgeries with dates:

Take Vitamin/Nutritional supplements? List:

Significant Family Medical History:

Are you pregnant? Y N LMP: _____ Taking Birth control pills? Y N Type/How Long? _____

Are you on any special diet? Y N How long? _____ wks/mos/yrs Describe: _____

Do you smoke? Cigarettes? Y N Cigars? Y N Pipe? Y N How many/How Often? _____

Authorization for Treatment: *"I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information provided."*

Signature _____ Date: _____

Assignment of Benefits/Direct Payment to Provider: *"I hereby authorize assignment of my insurance rights and benefits and order any insurance company making payments on my behalf to do so directly to the provider."*

Signature _____ Date: _____

Informed Consent for Chiropractic Treatment of your Pain

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device to manipulate the area treated. You may feel or hear a “click” or “pop” and may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment he/she determines is most appropriate for your condition.

Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one’s health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. *Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.*

Other options for the treatment of pain include: Do nothing – live with it, over-the-counter medications, physical therapy, medical care, injections, or surgery. There are hundreds of other treatments for pain. Most treatments that have potential benefits also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose.

My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused me pain in the past.

Patient Name

Signature

Date

Witness Name

Signature

Date