



## PATIENT INFORMATION

PLEASE PRINT LEGIBLY

Patient Name: \_\_\_\_\_  
Last Name First Name Middle Initial

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Sex (circle one): Male Female E-Mail Address: \_\_\_\_\_

Marital Status (circle one): Single Married Separated Divorced Widow

Race (circle one): Asian Black Caucasian Other Pacific Islander Decline

Ethnicity (circle one): Hispanic Non-Hispanic Decline

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Present MD's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## PAST MEDICAL HISTORY

*Please check the appropriate box for any of the following symptoms that you currently have or have had previously.*

- | YES                      | NO                       | YES                            | NO                       | YES                      | NO                  |                          |                          |                    |
|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS/HIV                       | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes            | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems    |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia/Bleeding Disorders      | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness           | <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Arteriosclerosis/Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia        | <input type="checkbox"/> | <input type="checkbox"/> | Neuralgia          |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis                      | <input type="checkbox"/> | <input type="checkbox"/> | Fractures           | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis       |
| <input type="checkbox"/> | <input type="checkbox"/> | Bowel or Bladder Problems      | <input type="checkbox"/> | <input type="checkbox"/> | Gout                | <input type="checkbox"/> | <input type="checkbox"/> | Sciatica           |
| <input type="checkbox"/> | <input type="checkbox"/> | Bursitis                       | <input type="checkbox"/> | <input type="checkbox"/> | Headaches           | <input type="checkbox"/> | <input type="checkbox"/> | Stroke             |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer                         | <input type="checkbox"/> | <input type="checkbox"/> | Hernia              | <input type="checkbox"/> | <input type="checkbox"/> | Swollen Joints     |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pain                     | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis       |
| <input type="checkbox"/> | <input type="checkbox"/> | Circulation Problem            | <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure  | <input type="checkbox"/> | <input type="checkbox"/> | Are You Pregnant?  |

- YES NO
- Have you received care at our office in the past?
- Have you ever had Surgery?

Explain: \_\_\_\_\_

- Have you ever had a Sports Injury?

Explain: \_\_\_\_\_

- Have you ever been in an Auto Accident?

Explain: \_\_\_\_\_

- Have you ever had a Work Related Injury?

Explain: \_\_\_\_\_

- Are you taking any medications or supplements (include over-the-counter medications)?

List: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_



## PRESENT COMPLAINT

What is your present complaint? \_\_\_\_\_

When did you first notice this? \_\_\_\_\_

How did it happen? \_\_\_\_\_

Is your present complaint is the result of (circle one):    AUTOMOBILE ACCIDENT    WORK INJURY    OTHER

How frequent is the condition? (circle one):    CONSTANT    COMES AND GOES

Is the pain (circle one):    MILD    MODERATE    SEVERE

How would you describe your pain? (circle one):    SHARP    DULL    BURNING    NUMBNESS    TINGLING    ACHY    OTHER

On a scale of 1-10, with 10 representing the most pain you ever experienced, what number would you give your pain? \_\_\_\_\_

Since the pain began, has your condition become (circle one):    WORSE    BETTER    REMAINS UNCHANGED

Do you have any arm, leg or head pain? (circle one):    YES    NO    If YES, where? \_\_\_\_\_

What makes your pain WORSE? \_\_\_\_\_

What RELIEVES your pain? \_\_\_\_\_

Have you had any sexual dysfunction, bowel or bladder problems (problems going to the bathroom)? (circle one):    YES    NO

If YES, describe: \_\_\_\_\_

Have you received other treatment from another healthcare provider for this condition? (circle one):    YES    NO

If YES, describe: \_\_\_\_\_

Have you ever had a similar condition in the past? (circle one):    YES    NO

If YES, when was the first time you noticed this problem? \_\_\_\_\_

Are there any other conditions or symptoms that may be related to your major symptom? (circle one):    YES    NO

If YES, describe: \_\_\_\_\_

Are you taking any medication or supplements? (circle one):    YES    NO    If YES, list: \_\_\_\_\_

Do you have a Primary Care Physician (PCP)? (circle one):    YES NO    If YES, list: \_\_\_\_\_

Sign Name: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

## PAIN DIAGRAM

Using the letters below, mark all areas of your body where you currently feel pain on the diagrams below.

**A** = Ache

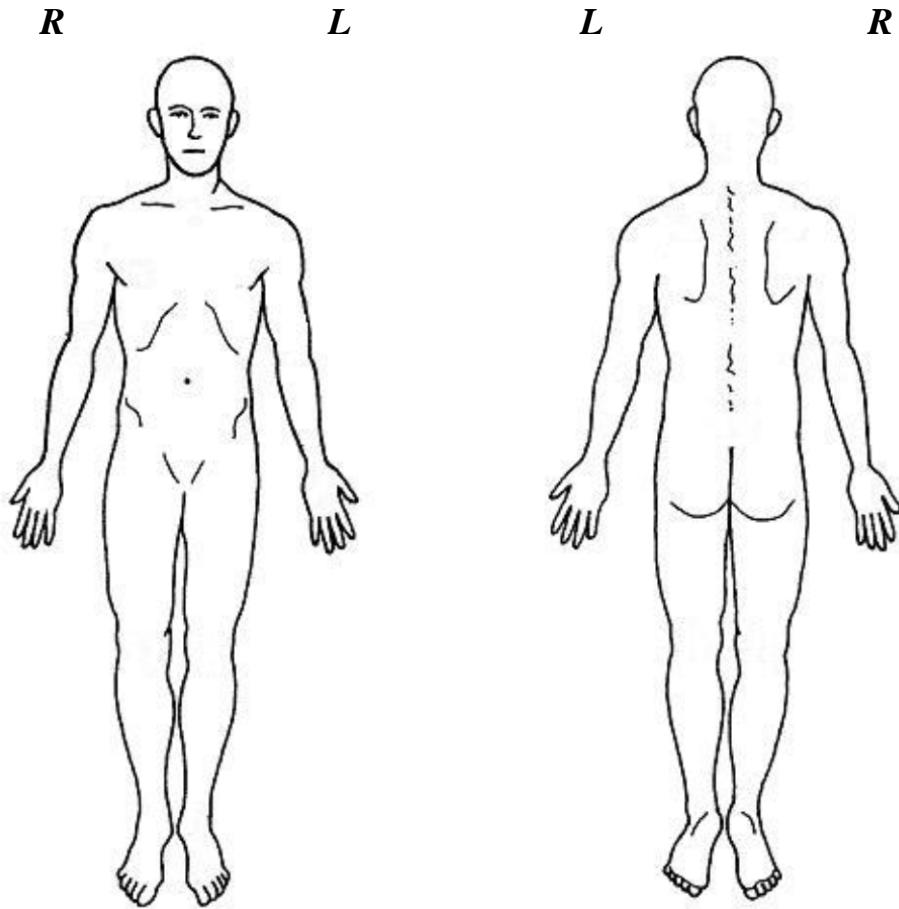
**B** = Burning

**N** = Numbness

**P** = Pins/Needles

**S** = Stabbing

**O** = Other



PRINT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_



## **MISSED APPOINTMENT POLICY**

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time.

Since our office does not charge for broken or cancelled appointments, please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

## **AUTHORIZATION AND RELEASE**

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 18%.

SIGNATURE: \_\_\_\_\_

## **REFERRAL ACCEPTANCE OF RESPONSIBILITY**

I understand that I am responsible for obtaining the appropriate referral forms for my services. I am aware that if I do not obtain a referral, I will be responsible for the balance of any services not paid by my insurance company requiring a referral or pre-authorization requiring a referral. I am also aware that many Primary Care offices require 2-4 days notice before issuing a referral.

SIGNATURE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_



## **INFORMED CONSENT TO CHIROPRACTIC TREATMENT**

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named below and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare." I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) named below and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments. By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

### **SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE**

PRINT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

WITNESS SIGNATURE \_\_\_\_\_



## 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 obligated to agree to those restrictions only to the extent they coincide with state and federal law.
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. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. 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.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. 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.**

PRINT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

*For further information regarding this notice, please contact our Doctor at (301)-620-8566*