

WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone # (H) _____ (W) _____ (C) _____

Date of Birth: _____ Age: _____ Sex: Male Female SS#: _____

Marital Status: Single Married Divorced Widowed Separated Minor

Occupation: _____ Employer: _____

How did you hear about our practice? (Check one) Internet? Which search engine did you use? _____

Referral from family or friend? Name: _____ Other (specify): _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer Preferred Language: _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)

Native Hawaiian or Pacific Islander / Other _____ / I Decline to Answer

Is this visit due to an accident? Yes No if yes, what type? Auto Work Other _____

Insurance Information

Do you have health insurance? Yes No Name of Carrier: _____

Member ID: _____

Do you have secondary insurance? Yes No Name of Carrier: _____

Member ID: _____

Policy Holder Name: _____ D.O.B.: _____ Relationship to patient (if other than self): _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ DATE _____

Health History

Who is your primary care physician? (Doctor and/or practice) _____

Primary Health Condition(s) (Concern): _____

Other Doctors Seen For This Condition: _____ Type of Treatment: _____

Results: _____ When did this condition begin? _____

Please check to indicate if you are currently experiencing any of the following conditions:

- | | | | | |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Bowel/Bladder Changes | |

Please check to indicate if you have ever had any of the following:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | |
| | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other _____ | |

Are you currently taking any medications or under any medical care? Yes No If yes, explain _____

Please list any medications you are currently taking (**Be sure to include dosage and frequency**) _____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ | |

Do you exercise: Never Daily Weekly Walk Run Swim

Do your work activities mostly involve: Sitting Standing Light Labor Heavy Labor Full Time Part Time

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

REVIEW OF SYSTEMS

Please mark if you have experienced any of these symptoms within the last month:

Neurological

- Migraines
- Headaches
- Slurring of speech
- Ringing in ear
- Nose bleeds

Ear/Nose/Throat

- Altered taste/smell
- Night blindness
- Sore throat
- Gingivitis

Cardiovascular

- Chest pain
- Palpitations/
racing heart beat
- Swelling in hands/feet
- Anemia

Respiratory

- Recurrent respiratory infections
- Asthma
- Chest congestion
- Wheezing
- Frequent sneezing

GI

- Stomach pains/
cramping
- Constipation
- Reflux/Heartburn
- Bloating
- Gas
- Nausea/Vomiting
- Increased bleeding

Musculoskeletal

- Joint pain
- Arthritis
- Chronic pain
- Muscle aches
- Numbness/tingling

Skin

- Eczema
- Dermatitis
- Excessive sweating
- Rashes
- Brittle nails
- Hair loss
- Easy bruising

Genitourinary

- Uterine fibroids
- Ovarian cysts
- Cancer (breast, ovarian, prostate, uterine)
- Prostate problems

Emotional/Mental

- Depression
- Anxiety
- Mood swings
- Irritability
- Memory Loss
- Confusion

Energy

- Fatigue
- Hyperactivity
- Restlessness
- Insomnia
- Decreased Libido
- Stress

Weight

- Decreased appetite
- Weight gain
- Inability to lose weight
- Food cravings
- Binge eating
- Water Retention

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

For any YES answer, please include details.

- | | | |
|---|----|-----|
| 1. Do you suffer from neck pain, with pain in your shoulder, arms, or hands? | NO | YES |
| Comment: _____ | | |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands? | NO | YES |
| Comment: _____ | | |
| 3. Do you have reduced feeling (sensation) or swelling in your hands or arms? | NO | YES |
| Comment: _____ | | |
| 4. Do you suffer from a loss of handgrip strength? | NO | YES |
| Comment: _____ | | |
| 5. Do you suffer from back pain with pain in your buttocks, legs or feet? | NO | YES |
| Comment: _____ | | |
| 6. Do you have weakness, numbness or burning in your buttocks, legs or feet? | NO | YES |
| Comment: _____ | | |
| 7. Do you have reduced feeling (sensation) or swelling in your legs, feet? | NO | YES |
| Comment: _____ | | |
| 8. Do you suffer from cold hands or feet? | NO | YES |
| Comment: _____ | | |

9. Do you have frequent falls or find that you trip over your feet while walking? NO YES
 Comment: _____
10. Do you suffer from headaches? If yes, how often, how severe, what has been tried? NO YES
 Comment: _____
11. Have you tried any medications such as anti-inflammatory? NO YES
 If yes, what kind of medication?
 Comment: _____
12. Have you ever tried any Physical Therapy or Chiropractic treatments before? NO YES
 If yes: When? How long? What kind?
 Comment: _____
13. Have you had an MRI? NO YES
 If yes: When? Who ordered it? What was it ordered for?
 Comment: _____

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come to simply ease their pain or discomfort (Relief Care). Others are interested in having the cause of the problem, as well as the symptoms corrected (Corrective care). Our team of Doctors will weigh your needs and desires when recommending your treatment plan.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care ___ Corrective Care ___ Check here if you want the Doctor to select your care ___

SIGNATURE (X) _____ DATE _____

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

There is a possibility that I may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because: _____

Date of last menstrual period: _____

 Patient's Signature

 Date

INFORMED CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Signature of Patient/Guardian

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices.
(Please initial one of the following options and sign below)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

Please call my home: _____

my work: _____

my cell number: _____

If unable to reach me:

You may leave a detailed message

Please leave a message asking me to return your call

Text you with appointment reminders (cell number & provider: _____)

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

Signature of Patient/Guardian

Date

MEDICAL INFORMATION RELEASE FORM
(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____ Child(ren) _____

Other _____ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signature of Patient/Guardian

Date

Witness (Office Staff)

Date

Chiropractic Consent to Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care from this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your musculoskeletal health. These procedures will assist us in determining what care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with physical medicine and give consent to the examinations that the doctor deems necessary, to include chiropractic care involving spinal adjustments, as reported following my assessment.

This notice is effective as of the date it is signed and will expire seven years after the date on which you last received services from us.

Patient Signature

Date