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 of Patient/Guardian_____ **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:

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

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

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

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

_____

_____

Please list any allergies: _____

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

❑ Heart Disease_____❑ Diabetes _____
❑ Cancer _____❑ Arthritis_____❑ Other _____

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 of Patient/Guardian_____ **Date**_____

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

_____

Please list any and all medications, supplements/vitamins, herbs etc. you are currently taking:

Name	Strength/Dosage	Frequency	What are you taking it for?

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

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**

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

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 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**

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 instances 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.

SIGNATURE (X)_____**DATE** _____