PATIENT HEALTH RECORD

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Birth date: _____ Age: _____ Male ❑ Female ❑ Email: _____

Cell phone: _____ Home phone: _____

Work phone: _____ Emergency Contact Name & Phone: _____

Occupation: _____ Employer: _____

Primary care physician: _____ City: _____

Marital Status: ❑ M ❑ S ❑ W ❑ D Number of children: _____ Spouse's/Partner's name: _____

Are you insured? ❑ Y ❑ N Insurance Company: _____

Is this visit the result of a work or auto injury? ❑ Y ❑ N

REASON FOR THIS VISIT

* Describe the reason for this visit: _____

* How did this condition begin? _____

* When did this condition begin? _____

* What makes it Better? (rest, ice, heat, positioning, etc.) _____

* What makes it Worse? (sitting, standing, walking, bending, lifting, etc.) _____

* Does the pain

❑ Stay in one spot ❑ Travel to other areas

* Type of Pain

❑ Sharp/Shooting ❑ Ache ❑ Pins and needles

❑ Burning ❑ Numbness ❑ _____

* In the past week on average how often have your symptoms been present?

(Intermittent) ❑ 0-25% ❑ 26-50% ❑ 51-75% ❑ 76-100% (Constant)

* In the past week how often has your pain interfered with your daily activities [e.g. work, social activities, or household chores?]

0 1 2 3 4 5 6 7 8 9 10

No interference **Unable to carry on activities**

* Please rate your pain (10 being the worst)

1 2 3 4 5 6 7 8 9 10

* Has this condition occurred before? ❑ Yes ❑ No Please explain: _____

* Have you ever seen other doctors for this condition? ❑ Yes ❑ No

Doctor's Name(s): _____

Types of treatment: _____

Did it help? ❑ Yes ❑ No ❑ Temporary relief

Any other recent health concerns? _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

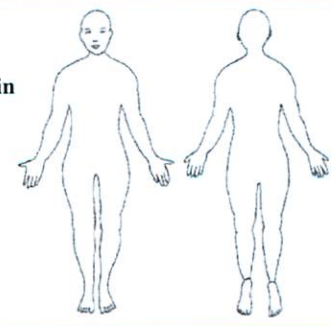
Have you been adjusted by a Chiropractor before? ❑ Yes ❑ No

Reason for those visits? _____

Doctor's name _____

Approximate date of last visit _____

Mark the location of your pain



HEALTH CONDITIONS

Please check each of the diseases or conditions you have now or have had in the past.

- ❑ Dizziness
- ❑ Headache
- ❑ Neck pain
- ❑ Numbness in arms/legs/hands
- ❑ Lower back pain
- ❑ Pain in arms/legs/hands
- ❑ HIV/AIDS
- ❑ Heart surgery/pacemaker
- ❑ Heart attack/stroke
- ❑ High/Low blood pressure
- ❑ Arthritis
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Cancer/Chemotherapy
- ❑ Joint replacement_____

Are you pregnant? ❑ Y ❑ N

Are you taking birth control pills? ❑ Y ❑ N

Date of last menstrual cycle: _____

❑ Other(s): _____

❑ Please list surgeries and dates: _____

_____

_____

_____

_____

DEMOGRAPHICS

Preferred Language: _____

Do you smoke?

- ❑ Never
- ❑ Past
- ❑ Present:
  - ❑ Occasionally ❑ Daily

Nicotine Replacement Use?

- ❑ Never
- ❑ Past
- ❑ Present:
  - ❑ Occasionally ❑ Daily

Are you taking any medications? ❑ Yes ❑ No

Medication	Dosage

Are you allergic to any medications? ❑ Yes ❑ No

Medication	Reaction	Onset Date	Comments

Height: _____ Weight: _____

❑ I do ❑ I do not

Give my permission to disclose my information to my primary care physician.

Our Privacy Policy

While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.
There are several circumstances in which we may have to use or disclose your health insurance information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for operational purposes.
- At times, we offer spinal adjustments in an open room setting, with other patients in the same room. Comments about your symptoms and/or progress may be discussed at your office visits. If you have something private that you would like to discuss with the doctor, let the front desk know and you will be put in to a closed room.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to certain individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information please let us know in writing. We are not required to agree to your restrictions.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing.

I have read your consent policy and agree to its terms. Initial _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will perform an examination and x-rays, if necessary, to determine a diagnosis and make treatment recommendations. If treatment is initiated, the doctor will use his/her hands or a mechanical device in an attempt to restore normal function to your joints and muscles. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or other soft tissue techniques may also be used.
Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation and/or ancillary procedures. Extremely rare complications could include muscle strain, ligamentous sprain, injury to intervertebral discs, rib fracture, or nerve injury. A small minority of patients may notice stiffness or soreness with the first few treatments. The ancillary procedures/hot packs could produce skin irritation, burns, or minor complications.
Other treatment options which could be considered may include the following:

- Over-the-counter analgesics. The risks of these medications include irritation or damage to the stomach, liver, kidneys, ulcers or other side effects in a significant number of cases.
- Medical care prescription anti-inflammatory drugs, muscle relaxers and analgesics. Risks of these drugs include the above mentioned side effects and patient dependence on narcotics.
- Surgery, in conjuction with medical care, adds the risks of adverse reaction to anesthesia, death, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and cause chronic pain cycles. It is quite probable that a delay of treatment will complicate your condition and make future rehabilitation more difficult.
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

Initial _____

I understand that all services are to be paid in full at the time of service. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable. I authorize the use of this signature on any insurance submissions.

Signature: _____ Date: _____