CHIROPRACTIC
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CONFIDENTIAL PATIENT INFORMATION

Today's Date: _____

Name: _____

Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Age: _____ □ Male □ Female

Marital Status: □ Married □Single □Divorced □Separated □Other _____

Name of Spouse/Nearest Relative: _____Phone: _____

Your Occupation_____ Your Employer: _____

Who may we thank for referring you to this office? _____

Payment for Services will be: □Cash □Check □Credit Card □Worker's Compensation □Automobile Insurance □Health Insurance

Name of Insurance Co.: _____

Insured's Employer: _____

Are you covered by more than one insurance company? □Yes □No

If Yes, Name of other insurance company _____

ACCIDENT HISTORY:

□Job □Auto □Other 1_____ Date:_____

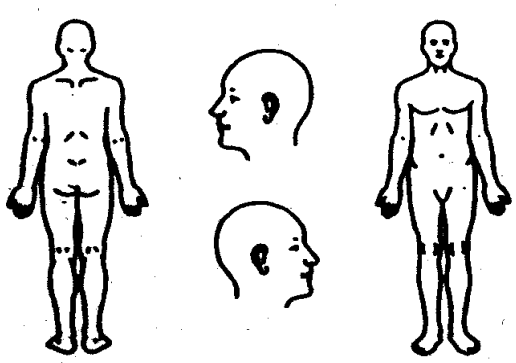
□Job □Auto □Other 2._____Date:_____

□Job □Auto □Other 3._____Date:_____

Name _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Circle areas of complaint below



PLEASE RATE YOUR SYMPTOMS (1-10, 1 being the least serious)

	DESCRIPTION	RATING
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____

SYMPTOMS ARE WORSE IN □**MORNING** □**AFTERNOON** □**NIGHT**

SYMPTOMS DEVELOPED FROM: □**JOB RELATED INJURY** □**AUTO ACCIDENT** □**OTHER** □**ACCIDENT** □**ILLNESS** □**UNKNOWN CAUSE** □**GRADUAL ONSET**

DATE OCCURRED: _____

SYMPTOMS HAVE LASTED____HOUR(S) ___DAY(S) ___WEEK(S) ___MONTH(S)__YEAR(S)

SYMPTOMS/COMPLAINTS: □**COME & GO** □**ARE CONSTANT**

HAVE YOU EVER HAD THIS BEFORE: □**NO** □**YES WHEN?** _____

ARE YOU PREGNANT □**NO** □**YES** **DATE OF LAST MENSTRUAL PERIOD**_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION: □BENDING □REACHING □STRAINING AT STOOL □COUGHING □SITTING □TURNING HEAD □LIFTING □SNEEZING □WALKING □LYING DOWN □STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION: □BENDING □SITTING □LIFTING □STANDING □LYING DOWN □TURNING HEAD □REACHING □WALKING

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING: □blurred vision □buzzing in ears □cold feet □cold hands □cold sweats □concentration loss/confusion □constipation □depression/weeping spells □diarrhea □dizziness □face flushed □fainting □fatigue □fever □head seems too heavy □headaches □insomnia □light bothers eyes □loss of balance □loss of smell □loss of taste □low resistance to colds □muscle jerking □numbness in fingers □numbness in toes □pins and needles in arms □pins and needles in legs □ringing in ears □shortness of breath □stiff neck □stomach upset

Name _____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING: (CIRCLE YES OR NO FOR EACH)

Y	N	Broken or fractured bones	Y	N	Osteoarthritis	Y	N	Eating disorder
Y	N	Circulatory Problems	Y	N	Epilepsy	Y	N	Alcoholism
Y	N	Rheumatoid Arthritis	Y	N	Heart Condition	Y	N	Drug Addiction
Y	N	Seizures/Convulsions	Y	N	Stroke	Y	N	HIV Positive
Y	N	A congenital disease	Y	N	Cancer	Y	N	Gall bladder condition
Y	N	Excessive bleeding	Y	N	Stomach Condition	Y	N	Head problems
Y	N	High/Low blood pressure	Y	N	Depression	Y	N	Tumor
Y	N	Diabetes	Y	N	Lung condition	Y	N	Bowel condition

Explanation _____

_____

_____

OTHER DOCTORS SEEN RECENTLY:_____ **FOR:**_____

MEDICATIONS:_____

SURGERIES/HOSPITALIZATIONS:_____

MAJOR ILLNESS IN YOUR FAMILY:_____

WHAT ARE YOUR HEALTH CARE GOALS?

_____ Temporary Relief (Help the symptom but do not fix the cause of the problem)
_____ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

WHAT ARE YOUR FAVORITE HOBBIES OR ACTIVITIES?_____

ARE YOUR CURRENT PROBLEMS AFFECTING THESE HOBBIES OR ACTIVITIES? □NO □YES

ON A SCALE OF 1-10 (1 being the least, 10 being the most)

_____ How committed are you at being at your maximum health potential?
_____ How important is it for your family to be at their optimum health potential?
_____ How committed are you to preventing arthritis and maximizing your health potential?

DISCLAIMER:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all moneys will be credited to my account upon receipt. I, also authorize the release of any health information necessary to process this claim. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, the fees for professional services rendered me will be immediately due and payable. In the event of default I agree to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection. I authorize the use of this signature on all insurance submissions.

Patient's Signature: _____ **Date:** _____
Guardian Signature: _____ **Date:** _____

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INFORMED CONSENT & TERMS OF ACCEPTANCE FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working for the same goals. It is important that each patient understand both the objective and the method that will be used to attain it. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives. Chiropractic is a separate and distinct science, art, and practice. Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. One disturbance to the nervous system is called vertebral subluxations. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. The purpose of the nervous system is to control and coordinate all bodily function. This may result in pain and dysfunction or may be entirely asymptomatic.

The primary method for removing subluxations is through specific chiropractic adjustments (manual -by hand, hand held instrument, or drop table). There are times when the adjustment is supplemented with other methods such as traction, exercise, hot or cold packs, or other non-invasive modalities which your doctor considers necessary. These modalities are used in order to properly correct subluxations, or help the patient hold adjustments. In addition, nutritional supplements, orthotics or lifestyle counseling may be included if it is specifically for the purpose of helping the patient to be subluxations-free. With subluxations reduced, the body can begin the process of repair leading to better health. In some patients this happens quickly; in others, more slowly. In some patients the repair and maintenance is complete; in others, only partial.

We do not diagnose diseases nor claim to cure disease. However, if during the course of a chiropractic examination, we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

- **There is a chance for soreness following your adjustments and rehabilitation. There is a possibility of symptoms worsening before noticeable improvement.**
- **There is also a chance (1/ 400,000** Dvorak J., Orelli F: Man Med 1985; 2:1-4**) of serious adverse complication (Vertebrobasilar Stroke) as a result of cervical spinal adjustments. Other possible complications include: sprain / strains, disc injury, fractures, rib fractures, dislocation**

PATIENT TREATMENT OPTIONS & ALTERNATIVES TO CHIROPRACTIC CARE:

- **Chiropractic Care:** Short Term Relief, Stabilization / Structural Correction, Wellness / Maintenance
- **Alternatives to chiropractic:** Do nothing, Physical Therapy, Medical Treatment (PCP), Specialist Referral by PCP, or other alternative healing arts

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____
Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

FEMALES: Pregnancy Release
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation, if necessary. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____/ _____ _____
Signature Date