



## PATIENT INFORMATION

Name: \_\_\_\_\_  
Last First MI

Email address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone # (Cell) \_\_\_\_\_ (Home) \_\_\_\_\_ (Other) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  Male  Female SS#: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor

Race  Caucasian  African American  Asian  Native American  Latin American  Other \_\_\_\_\_

Occupation: \_\_\_\_\_

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

How did you hear about our practice? \_\_\_\_\_

Emergency contact: Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

## ACCIDENT INFORMATION

Is this visit due to an accident?  Yes  No If yes, what type?  Auto  Work  Other \_\_\_\_\_

Has it been reported?  Yes  No If yes, to whom? \_\_\_\_\_

Claim #: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

## HEALTH OR AUTO INSURANCE INFORMATION

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

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

Policy Holder Name: \_\_\_\_\_ D.O.B. : \_\_\_\_\_

Relationship to patient (if other than self): \_\_\_\_\_ Phone # \_\_\_\_\_

**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR DRIVER'S LICENSE AND 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 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:** \_\_\_\_\_ **DATE** \_\_\_\_\_

## HEALTH HISTORY

Who is your primary care physician? (doctor and/or practice) \_\_\_\_\_

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

- |                                              |                                              |                                         |                                                |
|----------------------------------------------|----------------------------------------------|-----------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Low Back Pain (L/R) | <input type="checkbox"/> Elbow Pain (L/R)    | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Sudden Weight Loss    |
| <input type="checkbox"/> Mid Back Pain (L/R) | <input type="checkbox"/> Hip Pain (L/R)      | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Pins/Needles in Legs  |
| <input type="checkbox"/> Neck Pain (L/R)     | <input type="checkbox"/> Leg/Knee Pain (L/R) | <input type="checkbox"/> Nervousness    | <input type="checkbox"/> Pins/Needles in Arms  |
| <input type="checkbox"/> Wrist Pain (L/R)    | <input type="checkbox"/> Ankle Pain (L/R)    | <input type="checkbox"/> Tension/Stress | <input type="checkbox"/> Pins/Needles in Hands |
| <input type="checkbox"/> Hand Pain (L/R)     | <input type="checkbox"/> Foot Pain (L/R)     | <input type="checkbox"/> Night Pain     | <input type="checkbox"/> Cold Feet             |
| <input type="checkbox"/> Arm Pain (L/R)      | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Allergies      | <input type="checkbox"/> Fever                 |
| <input type="checkbox"/> Shoulder Pain (L/R) | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Jaw Problems   | <input type="checkbox"/> Sleeping Difficulties |

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

- |                                             |                                                 |                                           |                                               |                                           |
|---------------------------------------------|-------------------------------------------------|-------------------------------------------|-----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Aids/HIV           | <input type="checkbox"/> Cataracts              | <input type="checkbox"/> Gout             | <input type="checkbox"/> Migraines            | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Chemical Dependency    | <input type="checkbox"/> Hair Loss        | <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Hernia           | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Difficulty Weight Loss | <input type="checkbox"/> Herniated Disc   | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Water Retention  |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Food Cravings          | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Polio                | <input type="checkbox"/> Weight Gain      |
| <input type="checkbox"/> Brittle Nails      | <input type="checkbox"/> Fractures              | <input type="checkbox"/> Hyperactivity    | <input type="checkbox"/> Prosthesis           |                                           |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Glaucoma               | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Restlessness         |                                           |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Goiter                 | <input type="checkbox"/> Liver Disease    | <input type="checkbox"/> Rheumatoid Arthritis |                                           |
| <input type="checkbox"/> Other _____        |                                                 |                                           |                                               |                                           |

Are you currently under 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 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  Walks  Runs  Swims

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

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** \_\_\_\_\_

**Reviewed by 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
Date



## INFORMED CONSENT TO MEDICAL/CHIROPRACTIC TREATMENT

As with any medical or chiropractic procedure there are certain complications which may arise. Medical Doctors, Nurse Practitioners and Chiropractors are required to advise patients that there are risks associated with such treatment. Adverse reactions or potential side effects are listed below:

### Chiropractic

1. Some patients may experience some stiffness or soreness following the first few days after a chiropractic treatment.
2. Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
3. We will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.
4. Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

### Medical

1. Following an injection (trigger point injections, PRP, Stem Cell therapy, cortisone, HA, Vit.B12, facial or cosmetic procedures, etc.), patients may experience soreness, redness, inflammation, bruising, rash, or an infection.
2. Potential adverse reactions from **IV therapy** include: hypernatremia (high levels of sodium), fluid retention, high blood pressure, heart failure, injection site reactions, kidney damage, electrolyte abnormalities, or infection.
3. Potential adverse reactions for **Hair Restoration Therapy** include: pain at the injection site, edema, facial swelling, discoloration of the skin, rash, or infection.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which we check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with one of the chiropractors and/or nurse practitioner.

I consent to the medical/chiropractic treatments offered or recommended to me by the doctor, including spinal manipulation, any injections, diagnostic testing, etc. I intend this consent to apply to all my present and future medical/chiropractic care.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Witness Signature

## Patient Quality of Life Survey

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

Please circle any that apply:

1. How have you taken care of your health in the past?
 

a. Medications	e. Nutrition/Diet
b. ER	f. Vitamins
c. Routine medical	g. Chiropractic
d. Exercise	
2. How did the previous method(s) work out for you?
 

a. Bad results	c. Great results
b. Some results	d. No change
3. How have others been affected by your health condition?
 

a. No one is affected	c. They tell me to do something
b. Have not noticed any problem	d. People avoid me
4. What are you afraid this might be (or beginning) to affect (or will affect)?
 

a. Job	f. Sleep
b. Kids	g. Time
c. Future ability	h. Finances
d. Marriage	i. Freedom
e. Self-esteem	
5. Has your health condition affected your job, relationships, finances, family, or other activities? \_\_\_\_\_
6. What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc)  
\_\_\_\_\_
7. What are you most concerned with regarding your problem?  
\_\_\_\_\_
8. Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? \_\_\_\_\_
9. What would be different/better without this problem?  
\_\_\_\_\_