Welcome

We are pleased to welcome you to our Chiropractic practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you. We look forward to working with you in maintaining your health.

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip code: _____

Cell phone: _____Email:_____

Sex: [ ] M, [ ] F Age: _____ Birthdate: _____ [ ] Single, [ ] Married, [ ] Divorced, [ ] Widowed [ ] Separated

Employer's Name: _____ Occupation: _____

Whom may we thank for referring you? _____

Emergency contact: _____ phone: _____

Reason for Visit:

Location:	Intensity: 0-10 0= no pain, 10= worst pain	How long with pain?	Type of pain: Sharp, dull, aching, stiffness, throbbing?	Frequency: Constant, frequent, occasional?	Better with: ice, heat, rest, lying, ointment, medication, etc.	Worse with: walking, sitting, standing, lying, lifting
Neck						
Upper back						
Mid back						
Lower back						
Shoulder						
Knee						
Other:						
Other:						

Does the pain radiate? [ ] no, [ ] yes; _____

How is the pain interfering with your life? [ ] can't work, [ ] can't sleep well, [ ] can't exercise, [ ] _____

Due to trauma: (fall, car accident, work)? [ ] no, [ ] yes; _____

Have you seen another doctor for this condition? [ ] no, [ ] yes;_____

Are you taking any medication? [ ] no, [ ] yes; _____

Have you had any surgeries? _____

Please list any serious injuries you have had in the last 10 years:

Falls: _____

Head injuries: _____ Broken bones: _____

Car Accidents: _____ Work injuries: _____

Medical History:

[ ] high blood pressure, [ ] Diabetes, [ ] Cancer, [ ] Thyroid, [ ] Stroke, [ ] Arthritis, [ ] Psychiatric Illness. [ ] Ulcers, [ ] Heart disease, [ ] Vascular illness, [ ] Kidney disease, [ ] other: _____

Any allergies to medications or other? [ ] no, [ ] yes: _____

Please list the medications you currently take: [ ] no medication, [ ] _____

_____

Social History:

[ ] Working, [ ] Unemployed, [ ] Retired, [ ] Student,

[ ] Smoker, [ ] Non-Smoker, [ ] Ex-smoker, how long?_____,

[ ] consume alcoholic drinks [ ] yes, [ ] no, [ ] on social occasions only.

Family History:

Mother: [ ] alive, [ ] deceased, [ ] Medical condition: _____

Father: [ ] alive, [ ] deceased, [ ] Medical condition: _____

Brother/Sister: [ ] alive, [ ] deceased, [ ] Medical condition: _____

Brother/Sister: [ ] alive, [ ] deceased, [ ] Medical condition: _____

Primary Insurance

Ins. Co:_____ ID#_____ Phone:_____

Authorization: I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the chiropractor to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Signature: _____ Date:_____

Witness: _____ Date: _____

Are you the primary insured? [ ] yes, [ ] no, If not, who is the primary insured?_____

What is your relationship to the primary insured? [ ]spouse, [ ] child, [ ] other:_____

Date of Birth and address of primary insured:_____

Informed Consent for Chiropractic Care

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As Chiropractors we understand that health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

A disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by chiropractic adjustments. An adjustment is the specific application of force to correct and/or reduce vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine. The doctor primarily uses the Zone Technique and Diversified Technique. Adjustments are done by hand or by instrument where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare, it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, and dizziness.

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

_____

Print Name: Signature: Date:

HIPPA Privacy Notice

By subscribing my name below, I acknowledge receipt of a copy of this HIPPA privacy notice, and my understanding and my agreement to its terms.

_____

Patient Signature: Date:

Cancellation Policy

Your appointment is reserved especially for you. Kindly give at least 24 hours notice if you cannot keep your scheduled appointment. Beginning on January 1st, 2025, patients who do not give at least 24 hours notice will be automatically charged a $25 missed appointment fee to the card on file.

I have read and understand the Cancellation Policy and the automatic charge.

_____

Print Name: Signature: Date: