



PATIENT INFORMATION	CONTACT INFO.												
Date: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F Name: _____ Birth Date: _____ Age: _____ <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced Spouse's Name: _____ DOB: _____ If under 18 years of age, list legal parents/guardians: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name</th> <th style="width: 20%;">DOB</th> <th style="width: 50%;">Phone</th> </tr> </thead> <tbody> <tr> <td>Father: _____</td> <td></td> <td></td> </tr> <tr> <td>Mother: _____</td> <td></td> <td></td> </tr> <tr> <td>Guardian: _____</td> <td></td> <td></td> </tr> </tbody> </table> Who do you normally live with? <input type="checkbox"/> Mother & Father <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> None	Name	DOB	Phone	Father: _____			Mother: _____			Guardian: _____			Cell: _____ Work: _____ Email: _____ Address: _____ _____ City: _____ State: _____ Zip: _____ EMERGENCY CONTACT: _____ Relationship: _____ Phone #: _____ <u>How did you hear about us?</u> <input type="checkbox"/> Friend/Family If so, who? _____ <input type="checkbox"/> Facebook <input type="checkbox"/> Instagram <input type="checkbox"/> Google <input type="checkbox"/> Other website: _____ <input type="checkbox"/> Other _____ Do we have your expressed permission to send monthly educational and promotional content to your email? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name	DOB	Phone											
Father: _____													
Mother: _____													
Guardian: _____													
EMPLOYMENT	ACCIDENT INFORMATION												
Past / Current Occupation: _____ Employer: _____ Employer Address: _____ Employed: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> Student (Full Time) <input type="checkbox"/> Student (Part Time) School: _____ If you are unemployed, is this due to your present pain condition: <input type="checkbox"/> Yes or <input type="checkbox"/> No Time off work: _____	Is this condition due to an accident: <input type="checkbox"/> YES <input type="checkbox"/> NO What was the date of the injury: (____/____/____) What type of accident was this? <input type="checkbox"/> Injury at work (Worker's Compensation) <input type="checkbox"/> Car Accident (Personal Injury/ Liability) <input type="checkbox"/> Other: _____ Attorney Name: _____ Phone: _____ To whom have you made a report of this accident: <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Worker's Compensation/ Labor and Industries <input type="checkbox"/> Other: _____												
PHYSICIAN INFORMATION	Cancellation/Late Policy												
Primary Care or Referring MD: _____ Clinic Name: _____ Phone #: _____ Other Physician's involved in care (Name and phone #): _____ _____	It is a professional courtesy to provide 24 hours' notice if you cannot keep an appointment. There will be a \$25 charge for all appointments cancelled LESS THAN 24 hours in advance. If the appointment is not cancelled, the no show fee is \$52 payable PRIOR to your next visit. If you are late to an appointment, please understand that you have a scheduled time and this may result in your appointment being later to accommodate you.												

Date: _____ **Name:** _____ **DOB:** _____

PRIMARY COMPLAINT: _____ When & how did this complaint start? _____

What makes the complaint worse? _____

What makes the complaint better? _____

What words would you use to describe this complaint? _____

Does your condition radiate anywhere? _____

What is the severity of your complaint 0-10 (0=best, 10=crippling/bedrest required) _____

What time of the day is your complaint the worst? _____

Before this complaint began, had you ever experienced this type of problem before? _____

What lifestyle changes have you had to make due to this complaint? _____

SECOND COMPLAINT: _____ When & how did this complaint start? _____

What makes the complaint worse? _____

What makes the complaint better? _____

What words would you use to describe this complaint? _____

Does your condition radiate anywhere? _____

What is the severity of your complaint 0-10 (0=best, 10=crippling/bedrest required) _____

What time of the day is your complaint the worst? _____

Before this complaint began, had you ever experienced this type of problem before? _____

What lifestyle changes have you had to make due to this complaint? _____

THIRD COMPLAINT: _____ When & how did this complaint start? _____

What makes the complaint worse? _____

What makes the complaint better? _____

What words would you use to describe this complaint? _____

Does your condition radiate anywhere? _____

What is the severity of your complaint 0-10 (0=best, 10=crippling/bedrest required) _____

What time of the day is your complaint the worst? _____

Before this complaint began, had you ever experienced this type of problem before? _____

What lifestyle changes have you had to make due to this complaint? _____

Date: _____ **Name:** _____ **DOB:** _____

DIAGNOSTIC STUDIES:

Which complaint have you had diagnostic studies for? _____ Primary _____ Secondary _____ Third

TYPE OF IMAGING	YES, (OF WHAT?)	NO	Where were the images taken?
X-RAYS			
MRI			
OTHER			

REVIEW OF CURRENT SYSTEMS: - [please READ CAREFULLY and check appropriate boxes]

- Recent or sudden weight loss, fever, chills, weakness or fatigue. Back problems, poor posture, arthritis.
- Recent or sudden difficulty concentrating or memory issues. Recent headache, dizziness or syncope.
- Recent or sudden change in smell, vision or hearing. Recent or current enlarged lymph nodes.
- Recent unexplained skin rash or itching. Recent sweating, cold or heat intolerance.
- Recent anemia, bleeding or sudden unexplained or excessive bruising.
- Recent or sudden shortness of breath, coughing, chest pain/pressure/discomfort or heart palpitations.
- Recent burning on urination, change in bowel / bladder control or recent increase in Erectile Dysfunction.

PAIN TREATMENTS: Please check your response to the treatments you have tried.

TREATMENT	NEVER TRIED	NO RELIEF	MILD RELIEF	MODERATE RELIEF	EXCELLENT RELIEF	DETAILS
SURGERY						
INJECTIONS/ RFA						
TRACTION						
PHYSICAL THERAPY						
ACUPUNCTURE						
CHIROPRACTIC						
ORTHOTICS						
OTHER THERAPY						

Please indicate any other healthcare providers who you've seen for this injury/condition:

Name: _____ Type of Practice: _____ Date of Last Visit: _____
 Name: _____ Type of Practice: _____ Date of Last Visit: _____
 Name: _____ Type of Practice: _____ Date of Last Visit: _____

Date of Last Physical Examination: _____

PAST SURGICAL HISTORY OR HOSPITALIZATIONS:

DATE	TYPE OF OPERATION AND OUTCOME OF THE SURGERY

WOMEN ONLY: Are you, or is there any possibility you may be pregnant? Yes No Unsure

ALLERGIES: _____

Date: _____ **Name:** _____ **DOB:** _____

CURRENT MEDICATIONS or SUPPLEMENTS:

Name	Dose/ Frequency	Reason

PAST MEDICAL HISTORY:

Have you had any of the following health problems (please check all that apply)?

- | | | |
|---|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Lyme’s Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Anxiety/Nervousness | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Neuritis |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Bleeding/Clotting Problems | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Cancer (Type): _____ | <input type="checkbox"/> Hernia | <input type="checkbox"/> Spine Trauma |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Weight Loss Resistance |

SOCIAL HISTORY:

Do you smoke/ chew / Vape nicotine ? Yes _____/day Yes - In the Past No - Never

Do you use Marijuana products? Yes _____/day Type: _____ No – Never

Do you drink alcohol? Yes _____ drinks /week Yes - In the Past No – Never

How much caffeine do you drink daily? _____

Your Height: _____ Current Weight: _____ Ideal Weight: _____ Recent Gain/Loss: _____#

Your Current Exercise Routine: _____

IMMEDIATE FAMILY HISTORY: I Decline to Disclose my family Health History

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your immediate blood relatives had any of the following: Disease Relationship to you	
Father					Arthritis, Rheumatoid, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer (List Type)	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes, Clotting	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	

DECLARATION

I declare under penalty of perjury (under the laws of the United States of America) that the foregoing is true and correct and that I am not attempting to investigate Chirobody Chiropractic Sports Medicine Clinic or any of its employees as a representative of any agent or entity, or any insurance company or other organizational entity or person.

Signature: _____ Date: _____ DOB: _____



Informed Consent -- Chiropractic Care

Instructions: *This document relates to your Informed Consent for care. Please read carefully before signing.*

General. I, the below-signed patient/individuals, have read this document and Care Plan in their entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that while the Care Plan lists you as the "Rendering Provider," at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of Care: Alternatives

Chiropractic manipulation / adjustment. As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

Other Potential Alternatives. I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; and surgery.

Contraindications to Manipulation / Adjustment. I understand that you will not give me an adjustment / manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Patient's/Legal Guardian Signature: _____ Date of Signature: ___ / ___ / ___

Patient's Name: _____

Name of Parent / Guardian / Authorized Representative (if applicable): _____



Thank you for choosing Chirobody!. We are honored by your choice and are committed to providing you with the highest quality care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities: (Please Initial)

_____The patient (or patient’s guardian, if a minor) is ultimately responsible for the payment for his/her treatment.

_____We are pleased to assist you by billing your insurance carrier. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.

_____Patients are responsible for the payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their Insurance Plan, P.I.P coverage or L&I claims.

_____Patients may incur, and are responsible for the payment of additional charges at the discretion of Chirobody Staff. These charges may include (but are not limited to):

- Charge for returned checks.
- Charge for missed appointments without 24 hours advance notice.
- Charge for the copying and distribution of patient medical records.
- Charge for extensive forms completion.
- Any costs associated with the collection of a patient account balances. (This also includes any cost that might be associated with collecting on an unpaid balance, attorney’s fees and court costs.)

Patient Authorizations:

By my signature below, I hereby authorize Chirobody and its Chiropractors and Staff, to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate in my care.

By my signature below, I hereby authorize Chirobody to bill my health insurance and/or any third party listed for services rendered in this office. I understand that I am financially responsible for charges not covered by my insurance carrier. (i.e. Health Insurance, Auto Insurance, L&I etc.). ***All payments are due at the time of service, no exceptions.**

By my signature below, I authorize Chirobody to communicate by mail, answering machine message, text, and/or email according to the information I have provided in my patient registration information.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Signature: _____ **Date:** _____

Printed Name: (please print) _____



Regarding the Use & Disclosure of Protected Health Information
HIPAA Notice of Privacy Practices
("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: **CHIROBODY Chiropractic**.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "HIPAA Notice of Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can obtain one in the Office or call the Office to request such copy be sent to me.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): _____

Signature: _____ Date: ____/____/____