**Top of Form**



|  |  |
| --- | --- |
| **PATIENT INFORMATION** | **CONTACT INFO.** |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Single Married Widowed Separated Divorced  Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If under 18 years of age, list legal parents/guardians:  Name DOB Phone  Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Who do you normally live with?  Mother & Father Father Mother Guardian None | Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How did you hear about us?  Friend/Family If so, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Facebook Instagram Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do we have your expressed permission to send monthly educational and promotional content to your email?  Yes  No |
| **EMPLOYMENT** | **INSURANCE** |
| Past / Current Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employed: Full-Time Part-Time Retired  Student (Full Time) Student (Part Time)  School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If you are unemployed, is this due to your present pain condition: Yes or No Time off work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance Co.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insured through Employer? Yes or No |
| **ACCIDENT INFO.** | **Cancelation/Late Policy** |
| Is this condition due to an accident: YES NO  If known, what was the date of the injury: (\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_)   * Worker’s Compensation * Personal Injury/ Liability * Other   Attorney Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 pregnant 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)?

Arthritis

Asthma

Anxiety/Nervousness

Backaches

Bleeding/Clotting Problems

Cancer (Type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression

Diabetes

Digestive Disorders

Dizziness

Epilepsy or Seizures

Fibromyalgia

Headaches

Heart Trouble

Hernia

High Blood Pressure

High Cholesterol

Kidney Disease

Lyme’s Disease

Multiple Sclerosis

Neuritis

Numbness

Sinus Trouble

Spine Trauma

Stroke

Thyroid Disease

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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):

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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: \_\_\_ \_/\_\_\_ \_/\_\_\_ \_