EXAM PATIENT HISTORY

Incident: PI WC Group Cash

MC Insurance:_____

_____
Today's Date

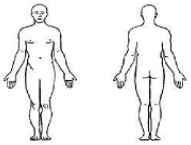
_____ _____ _____
Last Name First Name Middle Name (Initial)

1. What symptoms prompted you to seek care today?_____

LOCATION & QUALITY OF PAIN

Neck & Upper Back

Neck L R
Upper Back L R
Thoracic L R



Quality
Aching Dull Sharp Burning
Constant Intermittent Throbbing
Cramping Tightness
Numbness Swelling Shooting
Radiating Headaches

Sensations
Burning Numbness
Pins & Needles Tingling
Throbbing

Severity
Normal Lifestyle School
Sleeping Work Eating

Pain Scale
1 2 3 4 5 6 7 8 9 10
(Circle multiple numbers if pain ranges)

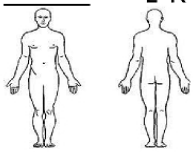
How long have symptoms been present?
_____

Pain is Exacerbated by:
Driving Joint use Movement
Sitting Standing Bending Rest Twisting
Walking Physical Activity

(If it applies) Mechanism of Injury
Bending Jogging Lifting
Lifting and Turning,
Motor Vehicle Accident
(Driver, Passenger, Pedestrian)
Repetitive injury Running Sports Turning
Twisting Walking Working

Low Back &Other

Lower back L R
Hip L R
_____ L R
_____ L R



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Prior Interventions (What have you done to relieve the symptoms?)

◯ Prescription medication ◯ Ice
◯ Over-the-counter drugs ◯ Heat
◯ Chiropractic Other_____

Review of systems :

		Current	Past	None
a.	**Musculoskeletal System-**osteoporosis, arthritis, neck pain, back problems, poor posture	◯	◯	◯
b.	**Neurological System-**anxiety, depression, headache, dizziness, pins & needles, numbness	◯	◯	◯
c.	**Cardiovascular System**-high blood pressure, low blood pressure, high cholesterol, chest pain	◯	◯	◯
d.	**Integumentary System**-skin cancer, psoriasis, eczema, acne, hair loss, rash	◯	◯	◯
e.	**Genitourinary System**-kidney stones, infertility, bedwetting, prostate issues, PMS symptoms	◯	◯	◯
f.	**Constitutional System**-fainting, low libido, poor appetite, fatigue, sudden weight, weakness	◯	◯	◯
g.	**Lymphatic System**-swelling or pain in lymph nodes of neck, axillae, groin & other areas	◯	◯	◯

Prior illnesses, operation, injuries or treatments:

_____

_____

Social History (Tell us about your health habits)

Allergies:_____
(203)Tobacco Use:_____

Medications/Supplements:_____

_____

Goals/Problems:

_____

Do you have a pacemaker?
YES / NO

Have you had or do you have cancer?
YES / NO

Are you pregnant?
YES / NO

INTAKE FORM

Today's Date (MM/DD/YY)

Gender
◯ Male ◯ Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (Or Initial)

Birth Date (MM/DD/YYYY)

Height

Address

Marital Status
◯ Single ◯ Married
◯ Divorced
◯ Widowed ◯ Separated

Weight

City

State

ZIP/Postal Code

Home Phone

Cell Phone

Spouse's Name

Spouse's Birth Date

E-Mail Address

Child's Name & Age

Emergency Contact

Phone

Child's Name & Age

Primary insurance holder's name

Primary holder's phone #

Child's Name & Age

Primary insurance holder's address

Your Employer/ Occupation

Primary Physician

Who can we thank for referring you?

How can we help you today?

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **Would you like an appointment reminder? YES NO**

Initials _____ **If yes: Circle which you prefer for future appointments: TEXT REMINDERS EMAILS NONE**

Initials _____ **If text: Circle your cell phone provider: Verizon AT&T T-Mobile Sprint Other:_____**

Initials _____ **I grant permission to be called or text to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials _____ **I acknowledge that insurance verification is NOT a guarantee of benefits. Benefits are based off my contract plan that my insurance is provided thru. I agree to pay according to my contract plan as my charges are processed.**

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature

Date (MM/DD/YYYY)

CONFIDENTIAL HEALTH INFORMATION

INFORMED CONSENT TO TREAT/ HIPPA

You make the decisions regarding your health care. Our role is to provide you with information to aid you in making informed decisions. This is referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the associated benefits and risks, as well as the potential effect on your health should you choose not to receive care.

If indicated, diagnostic exams may be conducted. These exams will be performed carefully, but may cause discomfort.

Chiropractic care mainly involves the chiropractic adjustment; however there may be additional procedures or recommendations. To complete a chiropractic adjustment, the doctor uses their hands or assistive instruments to influence anatomical structures, such as vertebrae. Potential benefits of a chiropractic adjustment include restoring normal joint motion, reducing joint swelling, inflammation, and pain, and improving neurological function.

It is important to understand, as with all health care approaches, that results are not guaranteed and there is no promise of a cure. There exists some risks to care, including, but not limited to: muscle spasm, aggravating and/or temporarily increasing symptoms, lack of improvement of symptoms, burns/scarring from electrical stimulation and hot/cold therapies, fractures, disc injuries, strokes, dislocations, strains, and sprains. In regard to strokes, there is a rare, but serious condition known as an arterial dissection that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustments do not cause a dissection on a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificated. I have read and understand your Notice of Privacy Practices. A more completed description can be requested. I understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

It is also important that you understand there are more treatment options available for your condition other than chiropractic procedures. These options may include: self-administered care, over-the-counter pain relievers, physical measures and rest, prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendations to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future conditions for which I seek chiropractic care from this office.

Name of Patient:_____ Date: _____

Signature of Patient:_____

Name Printed of Guardian/Parental and Relationship to Patient:_____

Guardian/Parental Signature:_____ Date: _____