

EXAM PATIENT HISTORY

Incident: PI WC Group Cash

MC Insurance: _____

Today's Date _____

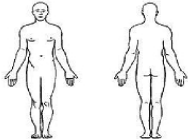
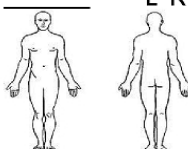
Last Name _____

First Name _____

Middle Name (Initial) _____

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

LOCATION & QUALITY OF PAIN

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<p>Neck & Upper Back</p> <p>Neck L R Upper Back L R Thoracic L R</p> 	<p>Quality</p> <p>Aching Dull Sharp Burning Constant Intermittent Throbbing Cramping Tightness Numbness Swelling Shooting Radiating Headaches</p> <p>Sensations</p> <p>Burning Numbness Pins & Needles Tingling Throbbing</p>	<p>Severity</p> <p>Normal Lifestyle School Sleeping Work Eating</p> <p>Pain Scale</p> <p>1 2 3 4 5 6 7 8 9 10 (Circle multiple numbers if pain ranges)</p> <p>How long have symptoms been present? _____</p>	<p>Pain is Exacerbated by:</p> <p>Driving Joint use Movement Sitting Standing Bending Rest Twisting Walking Physical Activity</p> <p>(If it applies) Mechanism of Injury</p> <p>Bending Jogging Lifting Lifting and Turning, Motor Vehicle Accident (Driver, Passenger, Pedestrian) Repetitive injury Running Sports Turning Twisting Walking Working</p>
<p>Low Back & Other</p> <p>Lower back L R Hip L R _____ L R _____ L R</p> 	<p>Quality</p> <p>Aching Dull Sharp Burning Constant Intermittent Throbbing Cramping Tightness Numbness Swelling Shooting Radiating</p> <p>Sensations</p> <p>Burning Numbness Pins & Needles Tingling Throbbing</p>	<p>Severity</p> <p>Normal Lifestyle School Sleeping Work Eating</p> <p>Pain Scale</p> <p>1 2 3 4 5 6 7 8 9 10 (Circle multiple numbers if pain ranges)</p> <p>How long have symptoms been present? _____</p>	<p>Pain is Exacerbated by:</p> <p>Driving Joint use Movement Sitting Standing Bending Rest Twisting Walking Physical Activity</p> <p>(If it applies) Mechanism of Injury</p> <p>Bending Jogging Lifting Lifting and Turning, Motor Vehicle Accident (Driver, Passenger, Pedestrian) Repetitive injury Running Sports Turning Twisting Walking Working</p>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Neurological System -anxiety, depression, headache, dizziness, pins & needles, numbness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Cardiovascular System -high blood pressure, low blood pressure, high cholesterol, chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Integumentary System -skin cancer, psoriasis, eczema, acne, hair loss, rash	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Genitourinary System -kidney stones, infertility, bedwetting, prostate issues, PMS symptoms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Constitutional System -fainting, low libido, poor appetite, fatigue, sudden weight, weakness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Lymphatic System -swelling or pain in lymph nodes of neck, axillae, groin & other areas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Prior illnesses, operation, injuries or treatments:

Do you have a pacemaker?

YES / NO

Social History (Tell us about your health habits)

Allergies: _____
(203) Tobacco Use: _____

Have you had or do you have cancer?

YES / NO

Medications/Supplements: _____

Are you pregnant?

YES / NO

Goals/Problems:



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: _____