Patient Information

Patients Name: First: _____ MI: _____ Last: _____

Birthday: ___/___/_____ Age: ____ Gender: Male Female Patient's SSN: _____

Address: _____ Apt. _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Email: _____

Employer: _____ Occupation: _____

Referred by: _____ Marital Status: _____

Emergency Contact – Name: _____ Phone #: _____

Relationship: _____

Parent/Spouse Information

Name: _____ SSN: _____ Birthday: ___/____/_____

Employer: _____ Occupation: _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize ChiroSport, PC to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such chiropractic care to third-party payers and/or health practitioners. I authorize and request my insurance company to pay directly to ChiroSport, PC insurance benefits that would otherwise be payable to me. I understand that my chiropractic insurance carrier may pay less than the full fee for services. I agree to be responsible for payment for all services rendered for myself and/or my dependents.

Patient Signature (or parent if a minor) _____ Date: _____

Consent for Treatment

I, _____ hereby authorize the doctors at ChiroSport P.C. (and whomever they may designate as their assistant(s) to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I will permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient Signature (or parent if a minor) _____ Date: _____

Acknowledgement & Receipt of Privacy Practices

I have received a copy of ChiroSport P.C.'s Notice of Privacy Practices with an effective date of January 1, 2004.

Patient Signature (or parent if a minor) _____ Date: _____

ChiroSport, P.C. Financial Policy

Dear Patient:
Thank you for choosing us as your health care provider. The following is our financial policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. If you have any questions or concerns about our payment policies, please do not hesitate to contact our office manager.
We ask that you read and sign our Financial Policy prior to seeing the doctor.
In special circumstances, we may accept an assignment of insurance benefits. However, you must understand that:

1. **Your insurance policy is a contract between you, your employer, and the insurance company. ChiroSport, PC is NOT a party to that contract. ChiroSport, PC's relationship is strictly with you, not the insurance company.**
2. **All charges will be the patient's responsibility whether the insurance company remits payment or not. Certain services may not be covered. Fees for these services will then become the patient's responsibility. We will attempt to make you aware of these situations as soon as possible.**
3. **Co-payments and co-insurance are due at the time of service. We accept cash, checks, Visa, MasterCard, and Discover. If you would like your claim processed through insurance, please make sure to provide proper insurance information.**
4. **If the insurance company has not paid your balance in full within 30 days, we will ask that you contact the carrier to help speed up the process.**
5. **If the insurance company has not paid in full within 45 days, you may be responsible for the balance due.**
6. **A 1.5% monthly interest charge may be applied to all balances exceeding 90 days.**

If a financial hardship occurs, we encourage you to communicate with us so that we may assist you in the management of your account.
Thank you for choosing ChiroSport, PC as your health care provider. We know you had many providers to choose from and we appreciate your trust in us and the opportunity to serve you.

Patient Signature (or parent if a minor) _____ Date: _____

Consent Form

To the patient: please read the entire document prior to signing it. It is crucial that you understand the information contained within this document and we address any questions or concerns prior to signing.

The material risk inherent in chiropractic adjustment:

As with any healthcare procedure, certain complications may arise during chiropractic manipulation and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costal vertebral strains and separations, and burns. 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. We will make every reasonable effort during the examination to screen for contraindications to care. However, if you have a condition that would otherwise not come to the doctor's attention, it is your responsibility to inform them.

The probability of those risks occurring:

Fractures are rare occurrences and generally results from an underlying weakness of the bone. Screening for this will occur during the examination, health history check, and/or x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The remaining complications are also generally described as rare.
Do not sign until you have read and understand the above. Please check the appropriate block and sign below
I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I discussed it with Dr. _____ and have had my questions answered to my satisfaction. By signing below, I state that I weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risk, I hereby give my consent to treatment.

_____ _____ _____ _____
Patient Signature (or parent if a minor) Date Doctor's Signature Date

Current Patient Condition

Reason for visit and/or area of concern:

1. _____
2. _____
3. _____

When did symptoms appear?

1. _____
2. _____
3. _____

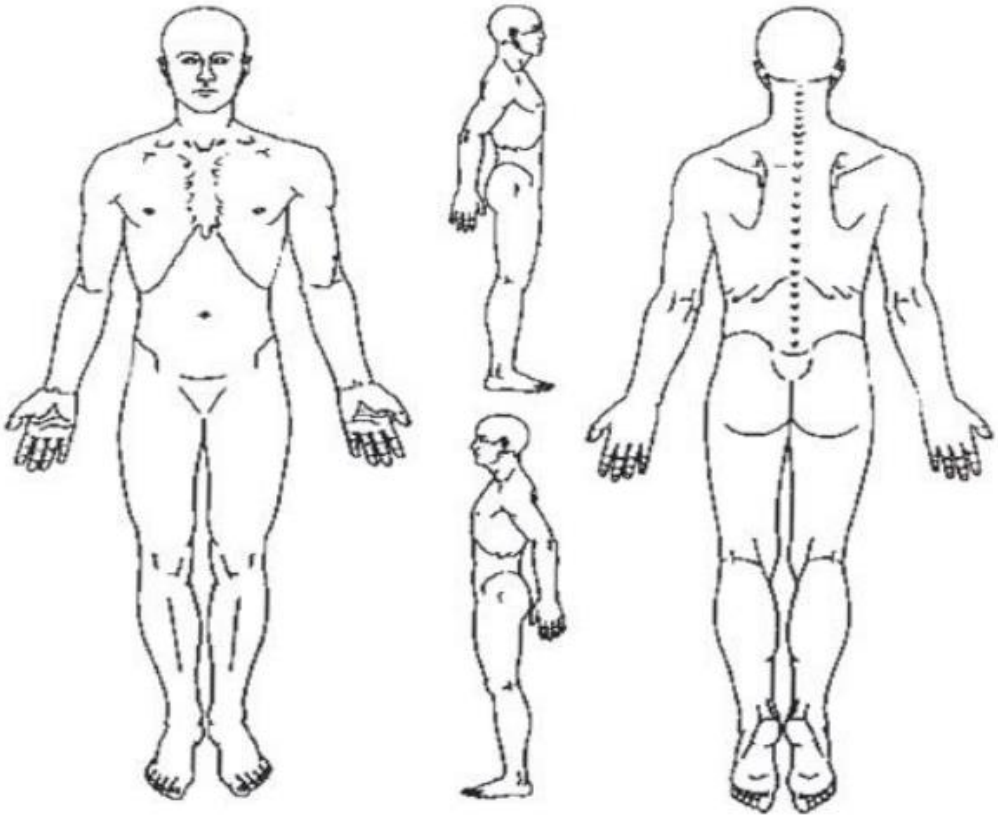
Circle all that apply for the following questions:

1. Progression of pain? Getting better Getting worse Unchanging Unknown
2. Type of pain? Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Other: _____
3. Frequency of pain? Constant (100%) Frequent (75%) Occasional (25%) Intermittent (<25%)
4. What does it interfere with? Work Sleep Daily Routine Recreation
5. Movements that are painful? Sitting Standing Walking Bending Laying Other: _____
6. Rate your pain (10 being the worst): 1 2 3 4 5 6 7 8 9 10

Pain Diagram

Use the following letters to mark the characteristics of your pain:

S=sharp A=aching B=burning N=numbness/tingling T=tight/stiff



Health Information

Height: _____ Weight: _____ Pregnant? _____ Recovering from cold/flu? _____

Laboratory procedures performed (e.g., stool analysis, blood/urine chemistries, bone density, saliva):

_____

_____

Outcomes: _____

What type of medical treatment have you tried for this problem(s)? – circle all that apply:

PCP/Internist Orthopedist Neurologist Neurosurgeon Physiatrist Podiatrist Chiropractic

Physical Therapy Acupuncture Homeopathy Vitamins/Minerals Diet Modification

Conventional Drugs Herbs Other: _____

Date of exam: _____ Practitioner Name/Clinic: _____

_____ _____

_____ _____

Current health issues for which you are being treated: _____

_____

_____

Current medications: _____

_____

Major hospitalizations, surgeries, and injuries, including any complications and dates:

_____

_____

Stress level 1-10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify major causes of stress (e.g., work, family, finances, etc.) _____

Do you consider yourself – circle one: Underweight Overweight Just Right

Have you had an unintentional weight loss/gain for 10 pounds or more in the last 3 months? Yes No

Is your job associated with potentially harmful chemicals (pesticides, radioactivity, solvents, etc) or health and/or life-threatening activities (fireman, farmer, etc.)? Please list: _____

_____

Do you experience any of these general symptoms EVERYDAY? – circle all that apply:

Shortness of Breath	Low Grade Fever	Diarrhea	Bleeding	Nausea
Fecal Incontinence	Constipation	Headaches	Discharge	Vomiting
Urinary Incontinence	Itching/Rash	Chronic Pain/Inflammation	Insomnia	Dizziness

Medical History

- [ ] Arthritis
- [ ] Allergies/hay fever
- [ ] Alcoholism
- [ ] Alzheimer's disease
- [ ] Autoimmune disease
- [ ] Blood pressure issues
- [ ] Bronchitis
- [ ] Cancer
- [ ] Chronic fatigue syndrome
- [ ] Carpal tunnel syndrome
- [ ] Cholesterol issues
- [ ] Circulatory issues
- [ ] Colitis
- [ ] Dental issues
- [ ] Diverticular disease
- [ ] Drug addiction
- [ ] Depression
- [ ] Diabetes
- [ ] Eating disorder
- [ ] Epilepsy
- [ ] Emphysema
- [ ] Ear/eye/nose/throat issues
- [ ] Environmental sensitivities
- [ ] Fibromyalgia
- [ ] Food intolerance
- [ ] Gastroesophageal reflux disease
- [ ] Genetic disorder
- [ ] Glaucoma
- [ ] Gout
- [ ] Heart disease
- [ ] Irritable bowel syndrome
- [ ] Kidney/bladder disease/stones
- [ ] Mental illness
- [ ] Migraine headaches
- [ ] Neurological disorders
- [ ] Thyroid issues
- [ ] Obesity
- [ ] Osteoporosis
- [ ] Pneumonia
- [ ] Sexually transmitted infection
- [ ] Seasonal affective disorder
- [ ] Skin issues
- [ ] Sinus issues
- [ ] Tuberculosis
- [ ] Ulcer
- [ ] Urinary tract infection
- [ ] Varicose veins
- [ ] Other: _____

Medical (Men)

- [ ] Benign prostatic hyperplasia
- [ ] Decreased sex drive
- [ ] Infertility
- [ ] Prostate Cancer

Medical (Women)

- [ ] Breast Cancer
- [ ] Decreased sex drive
- [ ] Endometriosis
- [ ] Fibrocystic breasts
- [ ] Fibroid/ovarian cysts
- [ ] Infertility
- [ ] Menstrual irregularities
- [ ] Premenstrual syndrome
- [ ] Vaginal infections
- [ ] Birth control (form: _____)
- [ ] Number of children: _____
- [ ] Number of pregnancies: _____
- [ ] C-section
- [ ] Surgical menopause
- [ ] Menopause

Information on Cycle

- [ ] Changes in normal flow

Date of last menstrual period: _____

Length of cycle: _____

Interval between cycles: _____

Family Health History

- [ ] Alcoholism/drug addiction
- [ ] Alzheimer's disease
- [ ] Arthritis
- [ ] Asthma
- [ ] Cancer
- [ ] Depression
- [ ] Diabetes
- [ ] Glaucoma
- [ ] Heart disease
- [ ] Infertility
- [ ] Learning disabilities
- [ ] Mental illness/suicide
- [ ] Migraine headaches
- [ ] Neurological disorders
- [ ] Obesity
- [ ] Stroke

Health Habits

- [ ] Beer: # glasses / day/week: _____
- [ ] Coffee: # 6oz. cup/day: _____
- [ ] Liquor: # oz. / day/week: _____
- [ ] Soda: # can/day: _____
- [ ] Tea: # 6oz. cup/day: _____
- [ ] Tobacco: # / day: _____
- [ ] Water: # oz. / day: _____
- [ ] Wine: # glasses / day/week: _____
- [ ] Other: _____

Exercise

- [ ] 5-7 days per week
- [ ] 3-4 days per week
- [ ] 1-2 days per week
- [ ] 45+ minute workouts
- [ ] 30-45 minute workouts
- [ ] <30 minute workouts
- [ ] Walking
- [ ] Running, jogging, jumping rope
- [ ] Weightlifting
- [ ] Swimming
- [ ] Boxing
- [ ] Other: _____

Nutrition & Diet

- [ ] Mixed food diet (meat & vegetables)
- [ ] Vegetarian
- [ ] Vegan
- [ ] Salt restriction
- [ ] Fat restriction
- [ ] Starch/carbohydrate restriction

Food Frequency (servings/day)

Fruit: _____

Dark green veggies: _____

Grains (unprocessed): _____

Beans, peas, legumes: _____

Dairy, eggs: _____

Meat, poultry, fish: _____

Eating Habits

- [ ] Skip breakfast
- [ ] 2 meals per day
- [ ] 1 meal per day
- [ ] Graze (small frequency meals)
- [ ] Eat on the go
- [ ] Add salt to food

Supplements

- [ ] Multivitamin
- [ ] Vitamin C
- [ ] Vitamin E
- [ ] EPA/DHA
- [ ] Calcium (source: _____)
- [ ] Magnesium
- [ ] Zinc
- [ ] Minerals (list: _____)
- [ ] Friendly flora (acidophilus)
- [ ] Digestive enzymes
- [ ] Amino acids
- [ ] CoQ10
- [ ] Antioxidants (lutein, resveratrol, etc.)
- [ ] Herbs
- [ ] Protein shakes
- [ ] Super foods
- [ ] Liquid meals
- [ ] Other: _____

Would you like to:

- [ ] Have more energy
- [ ] Sleep better
- [ ] Be stronger
- [ ] Have more endurance
- [ ] Increase your sex drive
- [ ] Be thinner
- [ ] Be more muscular
- [ ] Improve your complexion
- [ ] Have stronger nails
- [ ] Have healthier hair
- [ ] Feel more motivated
- [ ] Be less moody
- [ ] Be more organized
- [ ] Think more clearly / be more focused
- [ ] Improve memory
- [ ] Do better on tests
- [ ] No use of over-the-counter drugs
- [ ] Be free of pain
- [ ] Stop using laxatives/stool softeners
- [ ] Have stronger teeth
- [ ] Have agreeable body odor
- [ ] Get rid of allergies
- [ ] Have less colds and flus
- [ ] Reduce risk of inherited disease tendencies
- [ ] Other: _____
- [ ] Other: _____