

Welcome to Rzepa Family Chiropractic

Patient Information

Thank you for choosing Rzepa Family Chiropractic for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

(please print clearly)

Name: _____ SS/HIC/Patient ID #: _____
First _____ Middle Initial _____ Last _____

Address: _____ City: _____ State: _____ Zip Code: _____

Sex: Female Male Birthdate: _____ E-mail: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Do you prefer to receive calls at: Home Work Cell No Preference

Married Widowed Single Minor Separated Divorced Partnered for _____ years

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ City: _____ State: _____ Zip Code: _____

Spouse or parent's name: _____ Employer: _____ Work Phone: (____) _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency: _____ Phone: (____) _____

Responsible Party

Name of person responsible for this account: _____

Relationship to patient: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip Code: _____

Name of employer: _____ Work Phone: (____) _____

Symptoms

Reason for visit: _____ When did you first notice the symptoms? _____

Is the condition getting progressively worse? _____ Where specifically is the problem(s) located? _____

Which activities are difficult to perform? Sitting Standing Walking Bending Lying down Other

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

Rate the severity of your pain. (1 = mild pain or discomfort, to 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you received for your condition?

Medication Surgery Physical Therapy Other _____

Name and address of other doctor(s) who have treated you for your condition:

Health History Check only those conditions which are applicable: _____

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Allergy Shots	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Herniated Disc	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Herpes	<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tumors, Growths
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Polio	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fractures	<input type="checkbox"/> Measles	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Scarlet Fever	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Stroke	

Dates of last exams: _____

(Woman) Are you pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

List any types of surgeries which you have had and the dates which they occurred: _____

Please list all medications you are currently taking: _____

Allergies: _____

Daily Habits _____

What type of exercise do you perform on a daily basis? None Moderate Heavy

What do your daily work habits include? _____

What vitamins do you currently take? _____ Nutritional supplements (if any)? _____

Do you smoke? Yes No How much per day? _____

How much liquor do you consume weekly? _____ How many caffeinated beverages do you consume daily? _____

Certification and Assignment _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Rzepa all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Rzepa may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Rzepa Family Chiropractic

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ (signature)

_____ (date)

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle: _____

_____ (signature)

_____ (date)