# WELCOME

Date: ____________________________

## Patient Information

Name: ________________________________________________________________________________
Last First MI

Email address: ____________________________Cell phone Carrier: VZW:___ AT&T:_____Tmobile:_____Other:_______

Mailing Address: ________________________________________________________________________________

Phone #(C)________________________________ (W)________________________(Other)____________________

Can we call you at work? ❑ Yes ❑ No

Date of Birth: ________________ Sex: ❑ Male ❑ Female SS#: ___________________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other _____

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: _________________________________ Employer: ____________________________________

Employer Address: _______________________________________________ Phone: _________________________

How did you hear about our practice? _______________________________________________________________

Emergency contact: Name: ___________________ Relation: ______________ Phone #: ____________________

Phone #: (H) ______________________ (W) ______________________

## Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other ___________

Has it been reported? ❑ Yes ❑ No If yes, to whom? ____________________________________

## Insurance Information

Policy Holder Name: ____________________________________________ D.O.B. :___________________________

Relationship to patient (if other than self): ___________________________ Phone # ____________________________

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _________________________________

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _________________________________

**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)**

## Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _______________________ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

**SIGNATURE (X)** _____________________________________________ **DATE** ___________________________

NAME ___________________________ DATE__________

# Health History

What is your primary complaint today?__________________________________________________

Who is your primary care physician? (doctor and/or practice) ________________________________________

**Please check to indicate if you are currently experiencing any of the following conditions:**

| | | | | |
|---|---|---|---|---|
| ❑ Neck Pain/Stiffness | ❑ Pins/Needles in Arms | ❑ Light Bothers Eyes | ❑ Sudden Weight Loss | ❑ Nausea |
| ❑ Back Pain/Stiffness | ❑ Pins/Needles in Legs | ❑ Depression | ❑ Loss of Taste | ❑ Cold Feet |
| ❑ Arm/Hand Pain | ❑ Fatigue | ❑ Nervousness | ❑ Loss of Memory | ❑ Chest Pain |
| ❑ Leg/Knee Pain | ❑ Sleeping Difficulties | ❑ Tension | ❑ Jaw Problems | ❑ Fever |
| ❑ Headaches | ❑ Loss of Smell | ❑ Cold Sweats | ❑ Constipation | ❑ Fainting |
| ❑ Dizziness | ❑ Allergies | ❑ Stomach Problems | ❑ Shortness of Breath | |
| ❑ Asthma | ❑ Blurred Vision | ❑ Night Pain | ❑ Bowel/Bladder Changes | |

**Please check to indicate if you have ever had any of the following:**

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

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain ____________________

Please list any medications you are currently taking (**Be sure to include dosage and frequency**)______________

______________________________________________________________

Please list any surgeries and/or hospitalizations you have had (**type & date**): ______________________

______________________________________________________________

______________________________________________________________

Please list any allergies: ______________________________________________________

Please list any supplements you are currently taking (vitamins/herbs/minerals): ______________________

Last Flu Vaccine:______________ Women only: LMP_________________ Any possibility of pregnancy: Yes or No

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

❑ Heart Disease ___________________ ❑ Diabetes ___________________

❑ Cancer ___________________ ❑ Arthritis ___________________ ❑ Other _____________________

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following:

Caffeine ___________ cups/day Alcohol _________ drinks/week Cigarettes _______ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

**SIGNATURE (X)** ______________________________________ **DATE** ____________________

Reviewed by Provider:_______(initials)

NAME ___________________________ DATE__________

**What are your conditions that you have *present* with you to be seen today?**
**Please list in order of importance to you.**
**Rate each 0-10 for pain. 0= no pain 10= being worst pain you have ever felt.**

**1.____________________ Pain Scale 0 1 2 3 4 5 6 7 8 9 10 Onset Date: __________________**

**2.____________________ Pain Scale 0 1 2 3 4 5 6 7 8 9 10 Onset Date: __________________**

**3.____________________ Pain Scale 0 1 2 3 4 5 6 7 8 9 10 Onset Date: __________________**

**4.____________________ Pain Scale 0 1 2 3 4 5 6 7 8 9 10 Onset Date: __________________**

**5.____________________ Pain Scale 0 1 2 3 4 5 6 7 8 9 10 Onset Date: __________________**

**6.____________________ Pain Scale 0 1 2 3 4 5 6 7 8 9 10 Onset Date: __________________**

**What do you struggle with in daily life because it hurts?**

**1.** ____________________________________ / ___________________________

**2.** ____________________________________ / ___________________________

**3.** ____________________________________ / ___________________________

**4.** ____________________________________ / ___________________________

**Please mark the corresponding issue with the number above**

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

**NAME** ____________________________ **DATE**___________

For any YES answer, please include details.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: ________________________________________________________________________

2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: ________________________________________________________________________

3. Do your hands or arms fall asleep regularly? NO YES
   Comment: ________________________________________________________________________

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: ________________________________________________________________________

5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: ________________________________________________________________________

6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: ________________________________________________________________________

7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: ________________________________________________________________________

8. Do our legs or feet fall asleep regularly? NO YES
   Comment: ________________________________________________________________________

9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: ________________________________________________________________________

10. Do you suffer from cold hands or feet? NO YES
    Comment: ________________________________________________________________________

11. Do have frequent falls or find that you trip over your feet while walking? NO YES
    Comment: ________________________________________________________________________

12. Do you suffer from frequent headaches? If yes, how often? NO YES
    ________________________________________________________________________________

13. Have you ever been diagnosed by any physician with having peripheral neuropathy? NO YES
    If yes, when and what treatment has been tried?
    ________________________________________________________________________________

14. Have you tried any medications for your pain such as anti-inflammatory? NO YES
    If yes, what kind of medication (Aleve, Motrin, Tylenol, steroids, flexeril)?
    ________________________________________________________________________________

15. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
    If yes: When? For how long? What kind?
    ________________________________________________________________________________

16. Have you had an MRI? NO YES
    If yes: When? Who ordered it? What was it ordered for?
    ________________________________________________________________________________

17. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    If yes: When? What kind? Who ordered it?
    ________________________________________________________________________________

# Review of Systems

**Name**________________________________________ **Date**____________________

| Y | N | **Neurological** |
|---|---|---|
| ___ | ___ | Migraines |
| ___ | ___ | Headaches |
| ___ | ___ | Slurring of speech |
| ___ | ___ | Ringing in Ear |
| | | **Ear/Nose/Throat** |
| ___ | ___ | Altered taste/smell |
| ___ | ___ | Night Blindness |
| ___ | ___ | Sore Throat |
| ___ | ___ | Gingivitis |
| ___ | ___ | Nose bleeds |
| | | **Cardiovascular** |
| ___ | ___ | Chest pain |
| ___ | ___ | Palpitations-racing heart beat |
| ___ | ___ | Swelling in hands/feet |
| ___ | ___ | Anemia |
| | | **Respiratory** |
| ___ | ___ | Recurrent Respiratory Infections |
| ___ | ___ | Asthma |
| ___ | ___ | Chest Congestion |
| ___ | ___ | Wheezing |
| ___ | ___ | Frequent Sneezing |
| | | **GI** |
| ___ | ___ | Stomach Pains or Cramping |
| ___ | ___ | Constipation |
| ___ | ___ | Reflux or Heartburn |
| ___ | ___ | Bloating |
| ___ | ___ | Gas |
| ___ | ___ | Nausea or Vomiting |
| | | **Musculoskeletal** |
| ___ | ___ | Joint Pain |
| ___ | ___ | Arthritis |
| ___ | ___ | Chronic pain |
| ___ | ___ | Muscle Aches |

| Y | N | **Skin** |
|---|---|---|
| ___ | ___ | Eczema |
| ___ | ___ | Dermatitis |
| ___ | ___ | Excessive Sweating |
| ___ | ___ | Rashes |
| ___ | ___ | Brittle Nails |
| ___ | ___ | Hair Loss |
| ___ | ___ | Easy Bruising |
| ___ | ___ | Increased Bleeding |
| ___ | ___ | Numbness/tingling |
| | | **Genitourinary** |
| ___ | ___ | Uterine fibroids |
| ___ | ___ | Ovarian cysts |
| ___ | ___ | Cancer (breast, ovarian, prostate, uterine) |
| ___ | ___ | Prostate problems |
| | | **Emotional/Mental** |
| ___ | ___ | Depression |
| ___ | ___ | Anxiety |
| ___ | ___ | Mood Swings |
| ___ | ___ | Irritability |
| ___ | ___ | Memory Loss |
| ___ | ___ | Confusion |
| | | **Energy** |
| ___ | ___ | Fatigue |
| ___ | ___ | Hyperactivity |
| ___ | ___ | Restlessness |
| ___ | ___ | Insomnia |
| ___ | ___ | Decreased Libido |
| ___ | ___ | Stress |
| | | **Weight** |
| ___ | ___ | Decreased Appetite |
| ___ | ___ | Weight Gain |
| ___ | ___ | Inability to Lose Weight |
| ___ | ___ | Food Cravings |
| ___ | ___ | Binge Eating |
| ___ | ___ | Water Retention |

**X-ray Questionnaire: For women only**

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: ____________________________________

☐ There is a possibility that I a may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because: ______________________________
________________________________________________________________________

Date of last menstrual period: ___________________

______________________________ ______________________
Patient’s Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _______________________________ DOB: ___________________

I acknowledge that I have reviewed the Notice of Privacy Practices of _________________.
(Please initial one of the following options and sign below.)

__________ I wish to receive a paper copy of Privacy Notice.

__________ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

__________ I acknowledge that it is the policy of _____________ to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

__________ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

_______________________________________ ________________________

Signature of Patient/Guardian Date

# Informed Consent to Care

Informed Consent to Care. A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate testing, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by that appropriate specialty provider. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider. The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies. I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Medical, chiropractic, massage, sunetics hair laser and acupuncture care, like all forms of health care, offer considerable benefits, at the same time these treatments may produce some level of risk. Although the level of risk for these types of treatments are most often very minimal, in rare cases injury has been associated with medical, chiropractic, massage and acupuncture care. Medical treatment complications are based on the procedure type and any risks associated with treatment will be explained prior to treatment being received. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke. The risks are extremely low for acupuncture as well, however possible side effects or complications include: soreness, organ injury and infection. Not everyone makes for a good candidate for acupuncture. Conditions which may increase the risk of complications include bleeding disorders, patients with pacemakers and those who are pregnant.

Prior to receiving medical, chiropractic, massage, sunetics hair laser and/or acupuncture care from this clinic, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and particularly your spine health. These procedures will assist us in determining if chiropractic or acupuncture care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan as care begins. I understand and accept that there are risks associated with medical, chiropractic, massage and acupuncture care and give consent to the examinations that the doctor or provider deems necessary, and to the medical, chiropractic, massage and or acupuncture care including spinal adjustments, as reported following my assessment.
This notice is effective as of today's date and will expire seven years after the date of which you last received services from this clinic.

______________________________ ____________________

Signature Date

______________________________ ____________________

Witness Date