PATIENT INTRODUCTION CARD

Date _____ Home Phone _____ Cell Phone _____

Name _____

Address _____ City _____ State _____ Zip_____

Date of Birth _____/_____/_____ Age _____ **Circle One:** Married Single Other

Email address _____

Occupation _____ Employer _____

Office Address _____ Office Phone _____

Previous chiropractic care? **Circle One:** Yes No If yes, Doctor's name _____

Major Complaint _____

How did you hear about our office? _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged.

New Patient History

Current Condition

1. Do you have a main complaint? If yes, what is it?

_____

2. When did you first notice your symptoms? What happened?

_____

3. What helps your condition?

_____

4. What aggravates your condition?

_____

5. Is your pain sharp or dull?

_____

6. Do you have any numbness, pins and needles, or tingling in your arms or legs?

_____

7. Where is your pain located?

_____

8. Is your pain constant or does it come and go?

_____

9. Have you seen another doctor for this condition in the past 3 years?

_____

10. Do you have any pain or problems with your: jaw, hands, wrists, elbows, shoulders, hips, knees, ankles, and/or feet?

_____

11. Please list any prescriptions or supplements you have taken in the past six months.

_____

Past Medical History

1. When was your last car accident?

_____

2. Have you been hospitalized or had any injuries in the past 3 years?

_____

Social and Family History

1. Do you smoke, use recreational drugs, or alcohol?

_____

2. Do you have a family history of: arthritis, diabetes, hypertension, stroke, heart disease, cancer, and/or any other disease or condition?

_____

REVIEW OF SYSTEMS
HEALTH QUESTIONNAIRE

Please check each of the conditions below that you are currently experiencing.

Date: _____

Patient: _____ **File No:** _____

MUSCULO SKELETAL SYSTEM

- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Broken bones
- ☐ Shoulder pain
- ☐ Head Ache

GENITO-URINARY SYSTEM

- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

FEMALE

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on the breast

ARE YOU PREGNANT?

_____YES _____ NO

GASTRO-INTESTINAL SYSTEM

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble

CARDIO-VASCULAR RESPIRATORY

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficult breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

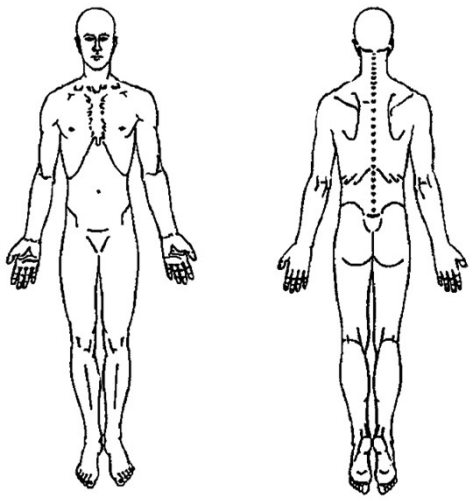
EYE, EAR, NOSE AND THROAT

- ☐ Eye strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Difficult breathing through nose
- ☐ Sore gums
- ☐ Dental problems
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Sinus problems
- ☐ Allergy
- ☐ Jaw pain

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscles jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

SYMPTOM LOCALIZATION



P _____ **Pain**
N _____ **Numbness**
S _____ **Spasm**

T _____ **Tender**
H _____ **Hypoesthesia**

Pain Index:

LEAST 1 2 3 4 5 6 7 8 9 10 **WORST**

Patient's Signature: _____

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing the Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operation. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____

Printed Name-Patient or Representative

_____ ___/___/___

Signature **Date**

Relationship to Patient
(If other than patient) _____

Is there someone you give permission to share information with: _____

Relationship:_____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Wellness Office will prepare any and necessary reports and forms to assist me in a making collections from the insurance company and that any amount to be paid directly to this Wellness Office will be credited to my account upon receipt. 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. I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered to me will be immediately due and payable.

_____ _____

Signature Date

DISCOUNTED SERVICES

Some services today are being provided to you at a discounted rate.

Your evaluation may consist of a: consultation, complete case history, and chiropractic, orthopedic, neurological assessment and examination.

The chiropractic and orthopedic evaluation may include, but is not limited to: visual inspection, motion palpation, active, passive, and resisted range of motion, and orthopedic tests specific to the localized area. The cervical, thoracic, lumbar, and sacroiliac regions will be assessed.

The neurological evaluation may consist of: muscle testing, deep tendon reflexes, and bilateral sensory assessment.

Even if insurance coverage exists, your insurance will <u>not be billed</u> for today's visit or your follow-up visit.

Signature _____ Date _____