

BACK & NECK CARE CHIROPRACTIC

Confidential Patient Information

Patient Information

Name _____
 Address _____

 City _____ State _____ Zip Code _____
 Home Phone (____) _____
 Cell (____) _____
 Social Security Number _____
 Birthdate _____ Age _____ Sex: M F
 Married Single Widowed Separated Divorced
 Occupation _____
 Employer _____
 Employer Address _____
 Work Phone (____) _____
 Spouse's Name _____
 Spouse's Occupation _____
 Number of Children: _____

Who may we thank for referring you? Yellow Page /
 Advertisement / Insurance / Web / Friend or Family?
 NAME: _____

Accident Information

Is condition due to an Accident? Yes No
 Date of Accident _____
 Type of Accident Auto Work Home Other
 To whom have you reported the Accident?
 Auto Insurance Employer Worker's Comp Other
 Attorney Name (if applicable) _____
 Attorney phone number _____

Insurance Information

Insurance Company _____
 Phone Number _____
 Policy/Claim # _____
 Group # _____

Emergency Contact

In case of an emergency, whom may we contact?

Name _____ Phone _____
 Relationship _____ Work Phone _____

To better inform your medical doctor of the status of your health, we would like to personally report your condition to them. Please provide their contact information.

Doctors name: _____ MD / DC / DO
 Clinic/Group _____
 Address: _____
 City, State, Zip: _____
 Phone: _____

Are you Pregnant? Yes No
 Due Date _____
 Do You Have:
 High Blood Pressure Yes No
 Pacemaker Yes No
 Cardiac or Circulatory Problems Yes No
 Do you bruise easily Yes No
 Infectious Disease Yes No

Consent To Treat

I hereby authorize the doctor(s) or other providers of this clinic and whomever they may designate as their assistants to administer treatment as they so deem necessary.

I, also authorize the release of information about my physical condition to my insurance company and/or attorney in order to process my bills for payment. I give permission to share private and medical information with my Medical Doctor as well as his/her staff. They have permission to share private and medical information with this office as it pertains to my health care. I certify that the above information is true and correct.

I understand that I am ultimately responsible for all bills occurred. When/If Insurance benefits are quoted, it is not a guarantee of payment, claims will be reviewed at the time they are received. As a courtesy to our patients we provide complimentary insurance billing. However, we are not responsible for claim status and processing.



Signature of Patient (or Patient's Guardian):
 Name: _____ Date: _____

PATIENT CHIEF COMPLAINT'S

Patient's Name: _____

DOB: _____

Date: _____

 <p>Left Right</p>	<p>Please Mark your Areas of Pain</p> <p>A=Aching / B=Burning / S=Stabbing / P=Pain N = Numbness / T = Tingling / W = Weakness</p>	 <p>Right Left</p>	<p>Please take the time to answer these questions to the best of your ability. If you are not sure of how to answer, please ask. The more information we have, the better we can serve you.</p> <p style="font-size: 1.2em; font-weight: bold;">Thank You</p>
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WHERE DOES IT HURT? (Please Circle)	NECK ↓ JAW	Upper Back ↓ Mid Back	Low Back ↓	Headache ↓	Shoulder L/R Elbow L/R Wrist L/R ↓	Hip L/R Thigh L/R Knee L/R Ankle L/R ↓
QUALITY Overall Status of Complaint	No Change, Worse, Better, Need more Medication	No Change, Worse, Better, Need more Medication	No Change, Worse, Better, Need more Medication	No Change, Worse, Better, Need more Medication	No Change, Worse, Better, Need more Medication	No Change, Worse, Better, Need more Medication
SIMILAR OR RECURRENT?	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
PAIN QUALITY: DESCRIBE your PAIN:	Aching, Burning, Cramp, Dull, Severe, Sharp, Shooting, Stabbing, Throbbing	Aching, Burning, Cramp, Dull, Severe, Sharp, Shooting, Stabbing, Throbbing	Aching, Burning, Cramp, Dull, Severe, Sharp, Shooting, Stabbing, Throbbing	Aching, Burning, Cramp, Dull, Severe, Sharp, Shooting, Stabbing, Throbbing	Aching, Burning, Cramp, Dull, Severe, Sharp, Shooting, Stabbing, Throbbing	Aching, Burning, Cramp, Dull, Severe, Sharp, Shooting, Stabbing, Throbbing
SEVERITY	Mild/Moderate/Severe	Mild/Moderate/Severe	Mild/Moderate/Severe	Mild/Moderate/Severe	Mild/Moderate/Severe	Mild/Moderate/Severe
PAIN SCALE 1 - 10 = WORST	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
DURATION Date it Started						
TIMING / PAIN: Improves with:	Improves with: Bending/Stooping, Getting off feet, Heat, Ice, Manipulation of joint/spine, Massage, Movement, OTC, Prescription Meds, Physical activity, Pressure, Rest., Sitting, Soaking, Walking	Improves with: Bending/Stooping, Getting off feet, Heat, Ice, Manipulation of joint/spine, Massage, Movement, OTC, Prescription Meds, Physical activity, Pressure, Rest., Sitting, Soaking, Walking	Improves with: Bending/Stooping, Getting off feet, Heat, Ice, Manipulation of joint/spine, Massage, Movement, OTC, Prescription Meds, Physical activity, Pressure, Rest., Sitting, Soaking, Walking	Improves with: Bending/Stooping, Getting off feet, Heat, Ice, Manipulation of joint/spine, Massage, Movement, OTC, Prescription Meds, Physical activity, Pressure, Rest., Sitting, Soaking, Walking	Improves with: Bending/Stooping, Getting off feet, Heat, Ice, Manipulation of joint/spine, Massage, Movement, OTC, Prescription Meds, Physical activity, Pressure, Rest., Sitting, Soaking, Walking	Improves with: Bending/Stooping, Getting off feet, Heat, Ice, Manipulation of joint/spine, Massage, Movement, OTC, Prescription Meds, Physical activity, Pressure, Rest., Sitting, Soaking, Walking
Exacerbation (worse) with	Exacerbation (worse) with Bend/Stoop, Cough, Lifting, On Feet, Movement, Physical activity, Pressure, Rest, Sitting, Sneeze, Walking	Exacerbation (worse) with Bend/Stoop, Cough, Lifting, On Feet, Movement, Physical activity, Pressure, Rest, Sitting, Sneeze, Walking	Exacerbation (worse) with Bend/Stoop, Cough, Lifting, On Feet, Movement, Physical activity, Pressure, Rest, Sitting, Sneeze, Walking	Exacerbation (worse) with Bend/Stoop, Cough, Lifting, On Feet, Movement, Physical activity, Pressure, Rest, Sitting, Sneeze, Walking	Exacerbation (worse) with Bend/Stoop, Cough, Lifting, On Feet, Movement, Physical activity, Pressure, Rest, Sitting, Sneeze, Walking	Exacerbation (worse) with Bend/Stoop, Cough, Lifting, On Feet, Movement, Physical activity, Pressure, Rest, Sitting, Sneeze, Walking
TIMING/ SYMPTOM ONSET HOW DID IT START? WHAT HAPPENED? Please Describe Is your pain:	Fall, Sport Injury, Unsure, Etc. Constant, Frequent Intermittent, Occasional	Fall, Sport Injury, Unsure, Etc. Constant, Frequent Intermittent Occasional	Fall, Sport Injury, Unsure, Etc. Constant, Frequent Intermittent Occasional	Fall, Sport Injury, Unsure, Etc. Constant, Frequent Intermittent Occasional	Fall, Sport Injury, Unsure, Etc. Constant, Frequent Intermittent Occasional	Fall, Sport Injury, Unsure, Etc. Constant, Frequent Intermittent Occasional

Previously Treated By: MODIFYING FACTORS By: Acupuncture, Chiropractor, Massage, ER, Urgent Care, Medical Physician, Physical Therapy, This office

ASSOCIATED SYMPTOMS: None. Ache, Fatigue, Swelling, **Headache, Dizziness, Memory, Bowel / Bladder/Sexual Dysfunction, Knee Pop, Click, Snap, Lock**

This issue is affecting my **Activities of Daily Living:** Job, Childcare, Marriage, Sex, Golf, Finances, Playing with Kids, Bowels, Urine

What is your Goal for Treatment? i.e. Be able to do a Specific Task? Pain Free? What would you like to do that you can't do now? _____

If this is a long term problem; why are you treating now? _____

PAST HEALTH HISTORY

Patient's Name: _____ DOB: _____ Date: _____

All information will be kept strictly confidential. Your responses will help determine if chiropractic, acupuncture or massage will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment.

Please check any of the following conditions you currently have or have had.

<u>SURGERIES</u>	<u>DATE</u>
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- Cardiovascular
- Gastrointestinal
- Spinal / Back / Neck
- Shoulder L/R
- Knee L/R
- Hip L/R
- Breast
- Other: _____

<u>ILLNESSES</u>	<u>DATE</u>
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ARTERIAL

- Atherosclerosis
- Peripheral Vascular Disease
- Reynaud's
- Varicose Veins
- Other: _____
- Aneurysms
 - Aortic
 - Abdominal
 - Thoracic

CEREBROVASCULAR

- Transient Ischemic Attack
- Aneurysms
- Carotid Artery Disease
- Cerebral vascular Accident (CVA)
- Stroke
- Other: _____

CONGENITAL ANOMALIES

CONNECTIVE TISSUE

- Arthritis (Type): _____
- Lupus
- Other: _____

ENDOCRINE

- Diabetes
- Gout
- Hyperthyroidism (Graves disease)
- Hypothyroidism
- Other: _____

EAR/MOUTH/NOSE/THROAT

- Hearing Loss L/R
- Menieres
- Otagia (Ear Ache)
- Otitis Media
- Tinnitus (Ringing)
- TMJ
- Teeth Grinding
- Sinusitis

EYE

- Anisocoria
- Dry Eye (Keratoconjunctivitis)
- Teary Eyes

GASTROINTESTINAL

- Colon
- Esophagitis-GERD
- Hernia
- Liver
- Gall Bladder (Cholecystitis)
- Pancreas
- Stomach
 - Chrons
 - Diverticulitis
 - IBS

GENITOURINARY

- Amenorrhea
- Dysmenorrhea
- Ectopic Pregnancy
- Impotence
- Infertility
- Endometriosis
- Menopause
- Menorrhagia (excess bleeding)
- Proctitis
- Urinary Tract Infection

HEART DISEASE

- Hypertension
- Varicose Veins
- Other: _____

HEMATOLOGY

- Anemia
- Coagulation Defect
- Other: _____

INFECTIOUS DISEASE

SKIN/INTEGUMENT

LUNG

- Asthma
- Breathing Difficulty
- Bronchitis
- Emphysema
- Influenza
- Pneumonia
- Other: _____

MUSCULOSKELETAL

- Adhesive Capsulitis of the shoulder
- Ankylosing Spondylitis
- Back Pain
- Bursitis
- Dislocation

- Epicondylitis
- Fracture (What)
- Herniated disc
- Knee
- Muscle spasm
- Osteochondritis Dessicans
- Osteoporosis
- Plantar Fasciitis
- Radicular Neuropathy
- Rotator Cuff Syndrome
- Sciatica
- Scoliosis
- Spinal Stenosis
- Spondylolithesis
- Tendonitis
- Torticollis
- Other: _____

NEOPLASM'S

- Cancer/Chemotherapy/ Radiation

NEUROLOGY

- Bell's Palsy
- Carpal Tunnel
- Epilepsy
- Headache – Cluster – Migraine
- Infantile Cerebral Palsy
- Parkinson's
- Seizure-grand mal
- Tremor-Benign essential
- Other: _____

PREGNANCY COMPLICATION

- Caesarian Section
- Pregnancy Ectopic

PSYCHIATRY

- Alcoholism
- Anorexia
- Attention Deficit Disorder
- Bulimia
- Drug dependency
- Manic Depressive
- Mental Retardation
- Neurotic Depression
- Other: _____

SIGNS & SYMPTOMS

- Abdominal; Pain
- Allergies _____
- Cough
- Edema (Swelling of Feet)
- Headache / Dizziness
- Insomnia
- Malaise (Fatigue)
- Swelling of the Ankle
- Syncope (Fainting)
- Other: _____

PAST HEALTH HISTORY

Patient's Name: _____ DOB: _____ Date: _____

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<u>INJURIES</u>					
None	Back Injury	Disability	Falls/Fracture (What)	Head Injury	Joint Injury
Motor Vehicle Accident (When)	Soft Tissue Injury	Other _____			

<u>TREATMENTS</u>	<u>For what reason(s)</u>	<u>How long ago</u>
Chiropractic Doctor		
Physical Therapy		
Acupuncture		
Massage		
Medical Doctor		
Urgent Care		
Other: _____		

<u>CURRENT MEDICATIONS (for?)</u>	<u>Vitamins / Herb / Minerals</u>	<u>Allergies</u>

<u>HAVE YOU HAD VACCINATIONS FOR:</u>	<u>Year</u>
Influenza	
Pneumonia	
Hepatitis A	
Hepatitis B	
Other:	

<u>AUTO or WORK INJURIES</u>	<u>When?</u>

<u>FAMILY HEALTH HISTORY</u>	<u>Age</u>	<u>Health Issues</u>
Father		
Mother		
Sibling		
Grandparents		

SOCIAL HISTORY (PLEASE CIRCLE ANSWERS THAT APPLY)

Exercise: None / Frequent / Infrequent / Limited / Occasional / Regular / Other:

Family Status: Children # : _____ / Divorced / Married / Single / Widowed

History given by: Child / Guardian / Parent / Self / Spouse

Medical Care:

Physical (date): _____ / Never had one Dental Exam (date): _____ Eye Exam (date): _____

Spinal Exam (date): _____ / Never had one For Women:

X-rays of: body area: _____ Mammogram (date): _____

CT of: body area: _____ Pap (date): _____

MRI of: body area: _____

Other _____

OCCUPATION:

SUBSTANCE USE

Caffeine: Yes / No Cups a day: _____ Tobacco: Yes / No Pack a day: _____ Chew: Y / N

Alcohol: Yes / No Drinks a week: _____ Drugs: Yes / No

WORK ENVIRONMENT: Repetitive injury / Extreme Temp / No problems / Constant sitting / Constant Standing
Heavy Data Entry / Lifting / Stressful

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, and traction may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me:

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Printed Name Signature Date

(Guardian) Printed Name Signature Date Doctor Initial