Patient Information

Name: ____

Email address: ____

Mailing Address: ____

City_______________________________ State________Zip__________________

Phone # (Cell)____________________ (Other) ____________________

Date of Birth:__________________ Sex: Male Female

Marital Status: Single Married Divorced Widowed Separated Minor

Race: Caucasian African American Asian Native American Latin American Other

Emergency contact:

Name____________________________ Relationship:_______________________

Phone #: _______________________________

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? ____________________________

How did you hear about our practice? ____

What is the main reason for seeking treatment?
____

VAS: (0-10)________

How long have you had it?
____

How often does it occur?
____

What does it feel like? (describe)
____

What have you done that has helped this problem?
____

What activities would you like to do if this was not a problem?
____

What, if anything has made the problem worse?❑driving ❑walking ❑ working ❑bending ❑sports ❑sleeping

What, if anything, has made the problem better? ❑rest ❑ice ❑ heat ❑elevation ❑NSAIDS ❑pain meds

What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)

- □ Medications Helped: Little Some Much
- □ Exercise Helped: Little Some Much
- □ Physical Therapy Helped: Little Some Much
- □ Nutrition Helped: Little Some Much
- □ Chiropractic Helped: Little Some Much
- □ Stretching Helped: Little Some Much

Does it cause you to be (check applicable boxes):

- □ Moody
- □ Irritable
- □ Exhausted at the end of the day
- □ Other____

Does it affect your work (check applicable boxes):

- □ Decision making
- □ Unable to work long hours
- □ Decreased productivity
- □ Poor attitude
- □ Other____

Does it affect your general life conditions (check applicable boxes):

- □ Lose patience with spouse/children
- □ Restricted in your daily activities
- □ Hinders ability to exercise or do sports
- □ Interferes with ability to do hobbies
- □ Restricted household duties
- □ Interrupt sleep
- □ Other____

History of Present Injury/Illness:

❑ 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

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Medical History:

❑ Hypertenstion ❑ Heart Disease ❑ Migraines ❑ Liver Disease ❑ Rheumatoid Arthritis

❑ Diabetes ❑ Pinched nerve ❑ Cancer ❑ Kidney Disease ❑ Fibromyalgia
❑ High cholesterol ❑ Herniated disc ❑ Ulcers ❑ Osteoporosis ❑ Thyroid problems

❑ Pacemaker ❑ Stroke ❑ Arthritis ❑ Bleeding Disorders

____

____

OTHER (explain)

____

Are you currently under drug and/or medical care? Yes No
Primary care physician
____

Please all medications: (**Be sure to include dosage and frequency**)
____
____
____
____
____

Supplements (vitamins/herbs/minerals):
____
____
____
____
____

Allergies:
____
____
____
____
____

WOMEN ONLY: Date of LMP:_______ ***Any possibility of pregnancy: YES or NO***

Surgeries and/or hospitalizations (**type & date**): **(Please note ALL joint replacement surgeries!)**

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____
____
____

Family History: Is there a family history of any of the following conditions? (Indicate parents, grandparents, children, & siblings)

Heart Disease _________ Diabetes_________ Cancer________ Arthritis________ Other_________

Social History:
Intake of following:
Cigarettes _________packs/day
Alcohol _________drinks/week
Caffeine _________cups/day

Exercise frequency: Never Daily Weekly

Type:____

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate tests, 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 your family physician, gynecologist, and/or dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. 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 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.

Sign here: X______________________________I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices. (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. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves a notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages via text, email, and/or phone (with or without voicemail). I may make a request of an alternative means of communication (within reason) in writing.

X____

Signature of Patient/Guardian Date

X____

Witness (Office Staff) Date