WELCOME

Office: ______________________

Date: ______________________

Patient Information:

Name: ____ E-mail ______________________________
Last, First, MI

Home address: ____________________________________ City ______________ State _____ Zip __________

Home ph. _____________________ Cell ph. ____________________ SSN: ______________________________

Date of birth ____________ Age _______ Height ______ ft. ______ in. Weight ______ lbs. Male ____ Female ____

Single _____ Married _____ Divorced _____ # of children ______ Ages ________________

Your Occupation: __________________________ Employer: ____________________________

Employer Address: ____________________________________ Phone: ____________________

How did you hear about our practice? ____

Name of spouse (or parent) ______________ their best contact ___________________

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 ________

Were there other passengers were in the car with you? ____ If so, who? ______________________________

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: ___________ Office: ___________________

What is the name of your family physician?_____________________ City? ____________________
Have you ever had Chiropractic care before? ____ If yes, name: ________________ Last visit ______
If you are having pain (neck, back or extremities etc.), health problems, symptoms, and/or complaints, please list them in order of severity:

1. ____ For how long? _____________________
2. ____ For how long? _____________________
3. ____ For how long? _____________________

Has this problem been getting worse or staying the same? ____________________________________

Currently or in the past, have you noticed these symptoms while working? ____ If yes, what activities caused you to notice them?____
Are there any activities, incidents or events that may have caused these symptoms? ________________
____
Have you ever had a work related injury? ____ If yes, what was the date? ____________

Have you been involved in an auto accident in the last 12 months? ____ If yes, date? ___________

List any other doctors you've consulted for these conditions: _________________________________

Current Health History:

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

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

Past Health History:

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

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

Name: ______________________________ Date: ___________ Office: ____________________

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

Medication	Dosage	Frequency	Medication	Dosage	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): __________________________

____

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: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

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

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.

☐ There is a possibility that I 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

Name: ______________________________ Date: __________ Office: ____________________

Rating:

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR CURRENT TYPICAL LEVEL OF ACTIVITIES AS THEY ARE NOW.

0 meaning no disability at all, and 10 meaning that you cannot perform those activities at all.

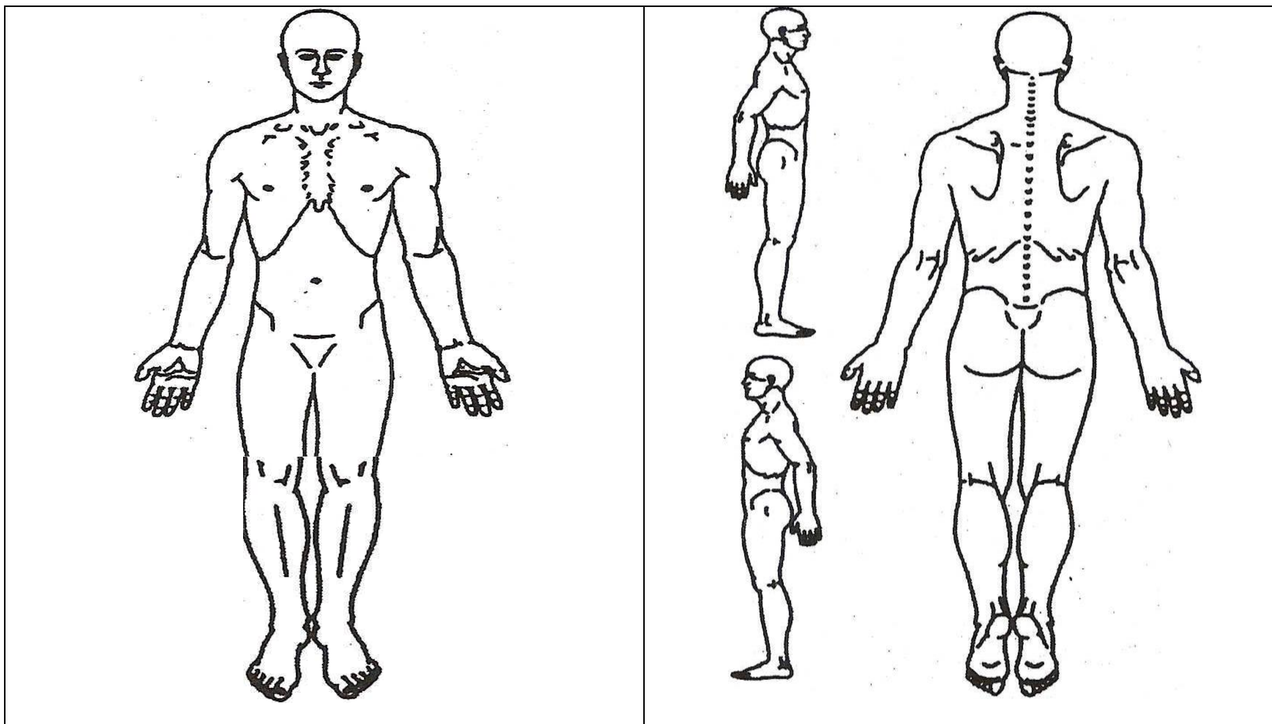
0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

Family/Home Responsibilities: yard work, doing the dishes, errands, favors for other family members, driving kids to school, etc.	
Recreation: hobbies sports, and other similar leisure time activities.	
Social Activity: involvement with friends, parties, theater, concerts, dining out, other social functions.	
Occupation: anything related to one's job or that of a homemaker or volunteer work.	
Self-Care: taking a shower, driving, getting dressed, etc.	
Life Supporting Activities: eating, sleeping and breathing.	

On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ACHE **B:** BURNING **C:** CRAMPING **D:** DULL PAIN **R:** THROBBING PAIN **N:** NUMBNESS **T:** TINGLING



AFC Inflammation Questionnaire

Name: **Date:**

The medical symptom screening questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after the first time, record your symptoms for the last 48 hours ONLY.

Point Scale:

0=Never or almost never have the symptom
1=Occasionally have it, effect is not severe
2=Occasionally have, effect is severe
3=Frequently have it, effect is not severe
4=Frequently have it, effect is severe

Skin:
___Acne
___Hives or rash
___Hair Loss
___Flushing or hot flashes
___Excessive Sweating
Total:_____

Ears:
___Itchy eyes
___Earaches, ear infections
___drainage from ear
___Ringing in ears
Total:_____

Eyes:
___Watery, itchy, or dry eyes
___Swollen, reddened or sticky
___Bags or dark circles under eyes
___Blurred or tunnel vision (does not include near-or-far-sightedness)
Total:_____

Head:
___Headache
___Faintness
___Dizziness
___Insomnia
Total:_____

Lungs:
___Chest congestion
___Asthma, bronchitis
___Shortness of breath
___Difficult breathing
Total:_____

Heart:
___Irregular or skipped heartbeat
___Rapid or pounding heartbeat
___Chest Pain
Total:_____

Energy/Activity:
___Fatigue, sluggishness
___Apathy, lethargy
___Hyperactivity
___Restlessness
Total:_____

DIGESTIVE TRACT:
___Nausea or vomiting
___Diarrhea
___Constipation
___Bloated Feeling
___Belching, or passing gas
___Heartburn
___Intestinal/Stomach Pain
Total:_____

Mouth/Throat:
___Chronic coughing
___Gagging, frequent need to clear throat
___Sore throat, hoarseness, loss of voice
___Swollen/discolored tongue, gums, lips
___Canker sores
Total:_____

Emotions:
___Mood swings
___Anxiety, fear or nervousness
___Depression
Total:_____

Nose:
___Stuffy nose
___Sinus problem
___Hay fever
___Sneezing attacks
___Excessive mucus formation
Total:_____

Weight:
___Binge eating/drinking
___Craving certain foods
___Excessive weight gain
___Compulsive eating
___Water retention
___Underweight
Total:_____

Mind:
___Poor memory
___Poor concentration
___Slurred Speech
___Stuttering or stammering
___Difficulty in making decisions
___Confusing, poor comprehension
___Learning disabilities
Total:_____

Joints/Muscles:
___Pain or aches in joints
___Arthritis
___Stiffness or limitation or movement
___Pain or aches in muscles
___Feeling of weakness or tiredness
Total:_____

Other:
___Frequent illness
___Frequent or urgent urination
___Genital itch or discharge
Total:_____

Grand Total:______

Key to questionnaire

Add individual scores and total each group. Add each groups score and give a grad total.

*Optimal is less than 10 *Mild us 10-20 *Moderate is 21-35 *Severe is over 36

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test(s), diagnosis and analysis.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies, may render the patient susceptible to injury. Of course, the doctor will not provide specific healthcare if s/he 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 if s/he may be suffering from conditions such as latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot and cold therapies (including but not limited to hot pack and ice), fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of the approaches already. These options may include, but are not limited to: self- administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office. 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.

Patient Name: ____________________________ Signature: ________________________________ Date: _______________

Parent or Guardian: _______________________ Signature: ________________________________ Date: _______________

Witness Name: ____________________________ Signature: ______________ Office: ___________ Date: _______________

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of AFC Physical Medicine and Chiropractic Centers.

Please initial below:

__________ 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.

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

__________ I wish to receive an electronic copy of Privacy Notice and my email address is: ____

Please initial below:

__________ I acknowledge that it is the policy of AFC 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, Diane Nelson, about my concerns.

Method of payment for today's charges: □ Cash □ Check □ Credit Card □ ________________________

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE AND LENGTH OF CARE.
IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. We're required to maintain your original x-rays. Films may be loaned to another health provider with your prior authorization only.

____ ________________________
Signature of Patient/Guardian Date

____ ________________________
Witness (Office Staff) Date

Office: __________________________________