

# 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 \_\_\_\_\_ Widowed \_\_\_\_\_ # 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 #: (H) \_\_\_\_\_ (W) \_\_\_\_\_

## Accident Information:

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

Were there other passengers 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:**

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

## Past Health History:

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

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

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

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

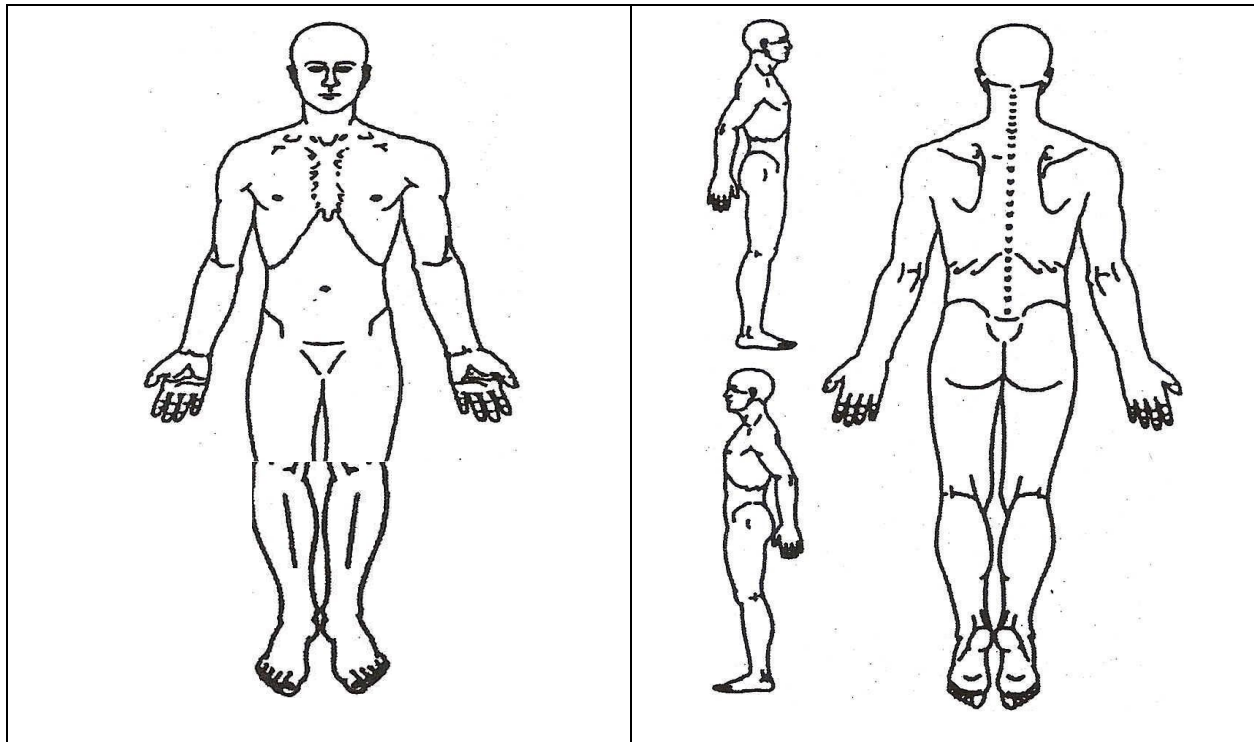
Totally unable to function

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Office: \_\_\_\_\_

Please rate activities on a 0-10 scale (1-3 mild discomfort, 4-6 moderate discomfort, 7-9 severe discomfort)

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



### 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

## 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: \_\_\_\_\_