Patient/Insurance Info

NAME: ____ DATE: ____________________

ADDRESS: ____

CITY: ______________________________ STATE: _____ ZIP: __________

MARITAL STATUS: S M D W AGE: _______ SEX: M F

HOME PHONE: _______________ WORK PHONE: _____________ EMAIL: ________________________

BIRTHDATE: ___________________________ SOCIAL SECURITY #:_____________________________

(SS# used to prevent insurance fraud)

OCCUPATION: ______________________________ EMPLOYER: _________________________________

EMERGENCY CONTACT: ____

Is your visit today due to:

☐ Auto Accident? Injury Date: ___________________ State in which accident occurred: ______

☐ Work Injury? Injury Date: ___________________

☐ Other Injury? Injury Date: ___________________

Primary Insurance Carrier: ____

Policy Holder: (person's name) ____

Your Relationship to Policy Holder: Self Spouse Child Other

Policy Holder Information (if other than "self")

Employer: ________________________ Birthdate: _______________ SS#: ______________________

Secondary Insurance Carrier: ____

Policy Holder: (person's name) ____

Your Relationship to Policy Holder: Self Spouse Child Other

Policy Holder Information (if other than "self")

Employer: ________________________ Birthdate: _______________ SS#: ______________________

CASE HISTORY

Patient Name____

LEFT RIGHT

SEVERITY OF PAIN
List region of pain and circle severity number. [1 = least, 10 = greatest]

example: neck
1 2 3 4 5 6 7 8 9 10

MARK PAIN AREA

++++	Burning
0000	Stabbing
xxxx	Sharp
||||	Constant

1. ______________________
1 2 3 4 5 6 7 8 9 10
2. ______________________
1 2 3 4 5 6 7 8 9 10
3. ______________________
1 2 3 4 5 6 7 8 9 10
4. ______________________
1 2 3 4 5 6 7 8 9 10
5. ______________________
1 2 3 4 5 6 7 8 9 10

RIGHT LEFT

Please mark area of pain on the drawing using the code listed above.

PLEASE GIVE MOST CURRENT DATE OF:

Spinal Exam ____________
Disc Exam ____________
X-ray Exam ____________
Lab Exam ____________
Last Physical ____________
FEMALE ONLY
Pap Smear ____________
Breast Exam ____________

DOCTOR'S USE ONLY

____
____
____
____
____
____
____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

____	541	Appendicitis	____	285.9	Anemia	____	429.9	Heart Disease	____	716.9	Arthritis
____	541	Pneumonia	____	285.9	Measles	____	429.9	Goiter	____	716.9	Epilepsy
____	541	Rheumatic Fever	____	285.9	Mumps	____	429.9	Influenza	____	716.9	Mental Disorder
____	541	Polio	____	285.9	Chicken Pox	____	429.9	Pleurisy	____	716.9	Lumbago
____	541	Tuberculosis	____	285.9	Diabetes	____	429.9	Alcoholism	____	716.9	Eczema
____	541	Whooping Cough	____	285.9	Cancer	____	429.9	Venereal Infection	____		AIDS

HABITS

☐ Smoking	Packs/Day ______
☐ Drinking	Alcohol ______
☐ Coffee	Cups/Day ______

EXERCISE

☐ None
☐ Moderate
☐ Daily

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother, No. of _____	☐	☐	☐	☐	☐
Sister, No. of _____	☐	☐	☐	☐	☐

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
____________	Vaccinations	____________	Tubes in Ears	____________	Sinus
____________	Tonsillectomy	____________	Appendectomy	____________	Hernia
____________	Gall Bladder	____________	Female Organs	____________	Thyroid
____________	Back Operation	____________	Rectal Surgery	____________	Stomach
____________	Other	____________	Other	____________	Other
	____________		____________		____________
	____________		____________		____________

Are you presently taking any medications – prescription or over-the-counter? ☐ No ☐ Yes

What drugs? ____

CASE HISTORY

(continued)

Patient Name_______________________________________

Please enter a “2” (for previously) or a “3” (for presently), in front of all the signs and symptoms below that you have/have been afflicted with. Leave blank if not applicable. A complete history and understanding of your health will facilitate care.

GENERAL SYMPTOMS

Code	Symptom
____784.0	Headache
____780.6	Fever
____780.9	Chills
____780.8	Night Sweats
____780.2	Fainting
____780.4	Dizziness
____780.3	Convulsions
____780.52	Loss of Sleep
____780.7	Fatigue
____799.2	Nervousness
____783	Loss of Weight
____782	Numbness or pain in arms/legs/hands
____995.3	Allergy (what)
____786.09	Wheezing
____729.2	Neuralgia

MUSCLES & JOINTS

Code	Symptom
____	Weakness
____	Twitching
____847	Stiff Neck
____722.10	Backache
____719	Swollen Joints
____781	Tremors
____729.5	Foot Trouble
____724.79	Painful Tail Bone
____724.5	Pain Between Shoulders
____563.3	Hernia
____737.3	Spinal Curvature

GASTRO-INTESTINAL

Code	Symptom
____783	Poor Appetite
____536.8	Poor Digestion
____994.2	Excessive Hunger
____787.3	Belching or Gas
____787	Nausea
____787	Vomiting
____578	Vomiting Blood
____536.8	Pain over Stomach
____564	Constipation
____558.9	Diarrhea
____789	Colon Trouble
____455.6	Hemorrhoids (Piles)
____785.1	Liver Trouble
____782.4	Jaundice
____575.9	Gall Bladder Trouble

CARDIO-VASCULAR

Code	Symptom
____783	Rapid Heart
____427.89	Slow Heart
____401.9	High Blood Pressure
____458.9	Low Blood Pressure
____786.51	Pain over Heart
____738	Previous Heart Trouble
____719.07	Swelling Ankles
____759.9	Poor Circulation
____	Varicose Veins
____436	Strokes

EYE/EAR/NOSE/THROAT

Code	Symptom
____368.9	Poor Vision
____378.9	Crossed Eyes
____379.91	Pain in Eyes
____389.9	Deafness
____388.70	Earache
____388.30	Ear Noises
____388.60	Ear Discharges
____478.1	Nasal Obstruction
____784.7	Nose Bleeds
____462	Sore Throats
____784.49	Hoarseness
____477.9	Hay Fever
____493.9	Asthma
____460	Frequent Colds
____240.9	Enlarged Thyroid
____463	Tonsillitis
____686.9	Sinus Trouble

SKIN OR ALLERGIES

Code	Symptom
____368.9	Skin Eruptions
____698.9	Itching
____278.8	Bruising Easily
____701.1	Dryness
____	Boils
____782	Sensitive Skin
____708.9	Hives or Allergy
____692.9	Eczema
____	Medicines
	____________
	____________

RESPIRATORY

Code	Symptom
____786.2	Chronic Cough
____786.3	Spitting Blood
____933.1	Spitting Phlegm
____786.50	Chest Pain
____786.09	Difficulty Breathing

GENITO-URINARY

Code	Symptom
____788.3	Frequent Urination
____788.1	Painful Urination
____599.7	Blood in Urine
____592	Kidney Infection
____788.3	Bed Wetting
____788.1	Inability to control urine
____601.9	Prostate Trouble

FOR WOMEN ONLY

Code	Symptom
____786.2	Painful Periods
____626.2	Excessive Flow
____626.4	Irregular Cycle
____627.2	Hot Flashes
____625.3	Cramps or Backaches
____634.9	Miscarriage
____623.5	Vaginal Discharge
____	Pregnant at this time
____	Last Pap
By Whom	____________
Other	____________

List accidents or falls, and dates: • Car ______________ • Recreational Vehicle ______________ • Sports ______________

• School ___________ • Other ____

List any broken bones (fractures) or dislocations: ____

Ever on crutches? • No • Yes Why? ____

Have you ever had any spinal taps or spinal injections? • No • Yes

Were you ever knocked unconscious? • No • Yes

Have you ever had a lapse of memory? • No • Yes

Have you ever had x-rays taken? • No • Yes When? ___________ By Whom? ______________________________

For what ailments were these x-rays made? ____

Do you suffer from any condition other than that for which you are now consulting us? ______________________________

____

It is understood and agreed that the amount paid to Downtown Chiropractic for x-rays is for examination only and the x-ray negatives will remain the property of the office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient Signature: ____ Date: ________________________

CHIROPRACTIC DOCTOR- PATIENT INFORMED CONSENT

CHIROPRACTIC
It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy, and Medicine. Chiropractic care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical, and spinal conditions.

ANALYSIS
A Doctor of Chiropractic (DC) conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers.

DIAGNOSIS
Although DC's are experts in Chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the DC, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic test, diagnosis, and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor will not give a Chiropractic adjustment, or health care, if he/she is in a state that such care may be contra-indicative. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the DC. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The DC is licensed in a special practice and is available to work with other types of providers/specialists in your health care regime.

INFORMATION ABOUT POSSIBLE RISKS OF TREATMENT
DC's, Medical Doctors, and Physical Therapists using manual therapy treatments for patients with headache and cervical spine (neck) complaints, are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The chances of this happening are estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments.

Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your DC.

As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, disk injuries, or physio-therapy burns. These are extremely rare occurrences.

RESULTS
The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond to Chiropractic care may come under the control or be helped by medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great power in alleviating pain and controlling disease.

TO THE PATIENT
I have read, and understand the foregoing.

____ Signature ____________________ Date

_________ *RADIOLOGY SERVICES* _________

PATIENT CONSENT FORM & PERSONAL INJURY SERVICE LIEN

As a patient seeking Chiropractic treatment, I have had x-rays taken for the diagnosis of my condition. My Chiropractor has requested a radiological consultation which utilizes the services of a Board Certified M.D. Radiologist.

I hereby authorize ____________________ to submit and collect their service fees from my Health Insurance, Workers Compensation, Employer, or Attorney as indicated. I further authorize ___________________ to furnish my Insurance Carrier, Employer, or Attorney with a full report of the x-ray interpretation or any other requested medical information.

I authorize my Insurance Carrier or Attorney to pay directly to _________________ all sums due for consultation services or to withhold such sums from settlement, claim judgement or verdict as may be necessary to protect ______________________for their services.

I hereby give a lien to ____________________ against any and all proceeds of any settlement, judgement, or verdict which may be paid to my attorney, myself or my successors as the result of injuries for which I have been treated or injuries in connection therewith.

I direct my Attorney to issue a LETTER OF PROTECTION which states all amounts are protected from settlement proceeds.

I understand _________________________ may not be a provider in my PPO or managed care network and ______________________ claims may be processed as out of network with higher patient deductibles and coinsurance percentages applicable.

I understand I am directly and fully responsible to ___________________________***:***

- for all consultation fees submitted for the interpretation of my x-rays.
- for any deductible, copayment, and coinsurance amounts not paid by my managed care provider (PPO, POS, or HMO).
- to remit payment in full within ten (10) days of payment or settlement of this claim if I receive payment directly.
- to pay statement account balances timely and understand a service charge will be added to any patient account which becomes past due and is sent to collection.

I understand and agree that if I do not recover sufficient monies on my case, I am still personally responsible for paying said provider and will be held responsible for any attorney's fees, collection agency costs, court costs, or any other expense incurred in order to collect the amount owed to ________________________***.***

I agree that a photocopy of this original authorization shall be considered equally as authentic as the original.

I authorize _________________________ to sign my name to any check written in both our names, where such a check is in payment for its services regarding my injury.

I authorize my examination films to be released to ________________________ for a radiological interpretation.

Patient Signature: ______________________________ **Date:** __________________

Referring D.C.: _______________________________

Name of Clinic: _______________________________

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ACKNOWLEDGEMENT OF ATTORNEY

The undersigned being attorney of record for the patient above agrees to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect said provider above named.

Attorney Signature: _________________________________ **Date:** _____________