ATKINSON CHIROPRACTIC

PATIENT # _____

DATE _____

OFFICE USE ONLY

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need any help, please ask the receptionist.

PATIENT DATA

email: _____

(First name, middle initial, last name) SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____

NAME _____ HOME PHONE _____ EMERGENCY PHONE _____

HOME ADDRESS _____ CITY _____ ZIP CODE _____

MAILING ADDRESS _____ CITY _____ ZIP CODE _____

AGE _____ BIRTHDATE _____ MARITAL: M S W D HOW MANY CHILDREN? _____

OCCUPATION _____ EMPLOYER _____

EMPLOYERS' ADDRESS _____ OFFICE PHONE _____

NAME OF SPOUSE OR PARENT (circle one) _____ OCCUPATION _____

SPOUSE OR PARENTS' EMPLOYER _____ OFFICE PHONE _____

PATIENT'S NEAREST RELATIVE (other than spouse) _____ RELATIONSHIP _____

RELATIVE'S ADDRESS _____ CITY _____ ZIP CODE _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

DATE OF LAST PHYSICAL EXAM _____ X-RAYS: _____

WHAT OPERATIONS HAVE YOU HAD & WHEN? _____

SERIOUS ILLNESSES _____

WHAT MEDICATIONS OR DRUGS ARE YOU TAKING? _____

PREVIOUS CHIROPRACTOR _____

DATE OF LAST VISIT _____

INSURANCE DATA:

Name of person(s) responsible for payment _____

Do you have insurance? ☐ No ☐ Yes Company's Name _____

PLEASE LIST ALL SOURCES OF INSURANCE

•PRIMARY HEALTH INSURANCE _____ S.S.# / EMPLOYEE I.D. NO. _____
NAME

INSURANCE ADDRESS _____ PHONE NUMBER _____ GROUP NO. _____

•SECONDARY HEALTH INSURANCE _____ S.S.# / EMPLOYEE I.D. NO. _____
NAME

INSURANCE ADDRESS _____ PHONE NUMBER _____ GROUP NO. _____

I hereby instruct and direct my insurance company to pay by check made out and mailed to Atkinson Chiropractic. If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it to Atkinson Chiropractic, the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Patient's Signature _____ Date: _____

Guardian or Spouse's Signature Authorizing Care _____ Date: _____

Information Taken By: _____ Date: _____

—PLEASE COMPLETE THE INFORMATION ON THE REVERSE SIDE ALSO—

HEALTH QUESTIONNAIRE: CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE YOUR ACCIDENT/INJURY

SYMPTOMS:

HEAD:
- ☐ Headache
- ☐ entire head
- ☐ forehead
- ☐ migraine
- ☐ back of head
- ☐ temples
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Ringing in ears

NECK:
- ☐ Stiff neck
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Pain in neck
- ☐ Neck pain with movement

SHOULDERS:
- ☐ Pain in shoulder joint (R-L)
- ☐ Pain across shoulders
- ☐ Bursitis (R-L)
- ☐ Arthritis (R-L)
- ☐ Can't raise arm
- ☐ above shoulder level
- ☐ over head
- ☐ Tension in shoulders

ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Fingers hurt or go to sleep
- ☐ Pins and needles in arms
- ☐ Pins and needles in fingers
- ☐ Hands cold
- Loss of grip strength

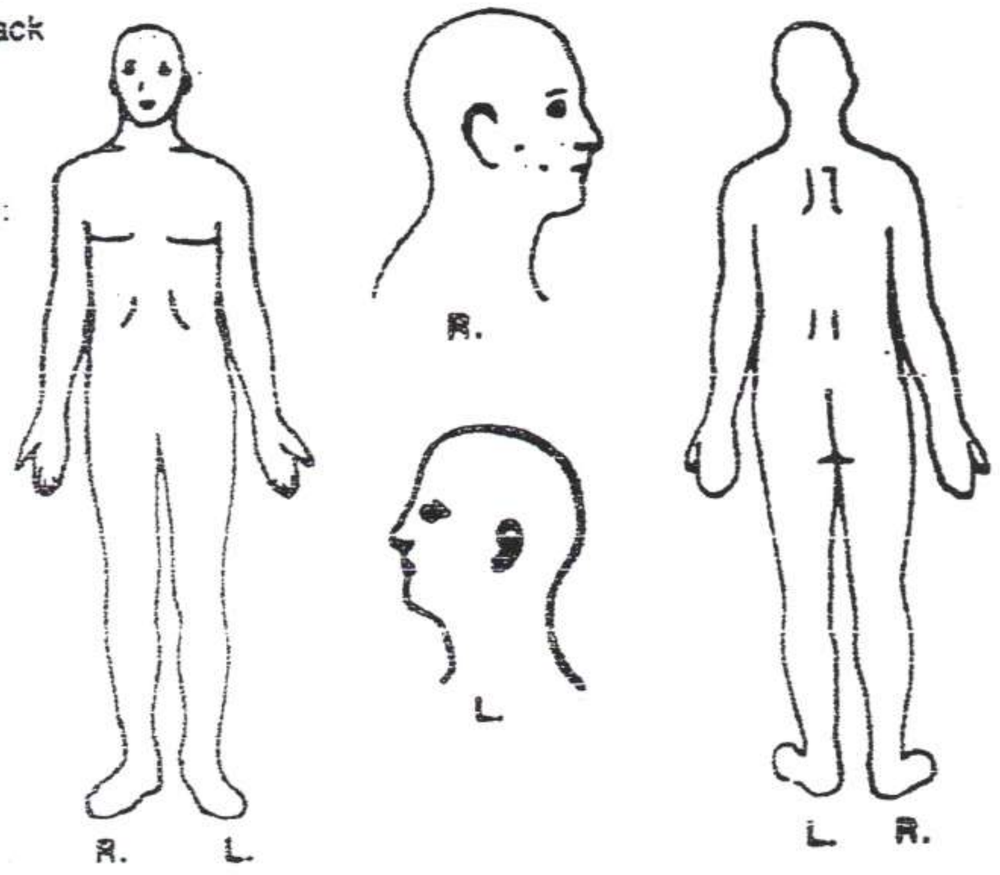
MID-BACK:
- ☐ Mid-back pain
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing pain in mid-back
- ☐ Muscle spasms

LOW BACK:
- ☐ Low back pain
- ☐ Low back pain is worse when:
- ☐ working
- ☐ lifting
- ☐ stooping
- ☐ standing
- ☐ sitting
- ☐ bending
- ☐ coughing
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

HIPS, LEGS & FEET:
- ☐ Pain in buttocks (R-L)
- ☐ Pain in hip joint (R-L)
- ☐ Pain down leg (R-L)
- ☐ Pain down both legs
- ☐ Leg cramps
- ☐ Pins & needles in legs (R-L)
- ☐ Numbness of legs (R-L)
- ☐ Numbness of feet (R-L)
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Cramps in feet (R-L)
- ☐ Swollen ankles (R-L)

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs

Mark Areas of Pain in Red
Mark Areas of Tingling/Numbness in Blue



ABDOMEN:
- ☐ Ulcer
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Loss of sleep

PAST OR PRESENT CONDITION:
- ☐ High blood pressure
- ☐ Heart problem
- ☐ Stroke
- ☐ Asthma
- ☐ Prostate problems
- ☐ Arthritis
- ☐ Diabetes
- ☐ Bladder infection
- ☐ Kidney disorders
- ☐ Depression
- ☐ Other _____

Had you ever had cancer?	☐ Yes	☐ No	Do you have any unusual bleeding or discharges?	☐ Yes	☐ No
Are you losing weight without trying?	☐ Yes	☐ No	Do you have a thickening or lump on the body?	☐ Yes	☐ No
Does the pain wake you up at night?	☐ Yes	☐ No	Do you have indigestion or difficulty swallowing?	☐ Yes	☐ No
Have you had a change in bowel or bladder problems?	☐ Yes	☐ No	Have you had any obvious changes in a wart or mole?	☐ Yes	☐ No
Do you have a sore that doesn't heal?	☐ Yes	☐ No	Do you have a nagging cough or horseness?	☐ Yes	☐ No

Present complaint(s): _____

_____

How often are the complaints present ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (25% of less)

Since your problem began is the pain: ☐ Increasing ☐ Decreasing ☐ Not changing

When did your problem begin: Specific date if possible? _____ Have you lost any days from work? From _____ to _____

Describe how your problem began: _____

Were you previously treated for a different occurance of this condition? ☐ Yes ☐ No If yes by ☐ Chiropractor ☐ M.D. ☐ Other

Physical activity at work ☐ Sedentary more than 50% of the day ☐ Light manual labor ☐ Manual labor ☐ Heavy manual labor

General physical activity: ☐ No regular exercise program ☐ Light exercise program ☐ Strenuous exercise program

Patient accepted? ☐ Yes ☐ No Doctor's Signature _____

ATKINSON CHIROPRACTIC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, [patient's name] acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Atkinson Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created received or maintained by the Practice.

_____ _____

Patient Signature (or Legal Guardian) Authorized Signer for Chiropractor

_____ _____

Name (please print) Date

ATKINSON CHIROPRACTIC

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctor's of chiropractic who use manual therapy techniques such as spinal adjustments are required to advise patients that there are many risks associated with such treatment. In particular you should note:

A. While rare, some patients may experience short term aggravation of symptoms fractures or muscle ligament sprains or strains as a result of manual therapy techniques:
B. There have been reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of the possible association because stroke sometimes causes serious neurological impairment and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from cervical spinal adjustments is extremely remotes;
C. There are rare reported cases of disc injuries following cervical and lumbar spine adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment including spinal adjustment has been subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be a highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed or will have the opportunity to discuss with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the content of this consent.

I consent to the chiropractic treatment offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Patient Signature (or Legal Guardian)	Authorized Signer for Chiropractor
Name (please print)	Date