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PATIENT INFORMATION CARD

TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU, PLEASE COMPLETE ALL QUESTIONS.

ABOUT YOU

FIRST NAME	MIDDLE NAME	LAST NAME	TODAY'S DATE

STREET ADDRESS	CITY	STATE	ZIP

MOBILE PHONE #	MOBILE PHONE PROVIDER	ALTERNATE NUMBER (Select Type) ☐ Home ☐ Work	EMAIL ADDRESS

PREFERED LANGUAGE	RACE	ETHNICITY	SOCIAL SECURITY #	HOW DID YOU HEAR ABOUT US

DATE OF BIRTH	GENDER ☐ Male ☐ Female	HEIGHT	WEIGHT	MARITAL STATUS ☐ Single ☐ Married ☐ Widowed ☐ Divorced	# OF CHILDREN	SPOUSE'S NAME

EMPLOYMENT AND/OR SCHOOL STATUS (Check all that apply)	OCCUPATION	EMPLOYER/SCHOOL NAME
☐ Full Time Employee ☐ Full Time Student ☐ Homemaker ☐ Unemployed ☐ Part Time Employee ☐ Part Time Student ☐ Retired ☐ Other		
HAVE YOU HAD CHIROPRACTIC CARE BEFORE? ☐ No ☐ Yes	**If Yes, Where?**	**How Long Ago?**

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE #	RELATION TO YOU

INSURANCE INFORMATION

DO YOU HAVE ANY INSURANCE THAT MAY COVER FOR YOUR CARE? ☐ No ☐ Yes	INSURANCE COMPANY NAME:

REFERRAL INFORMATION

REFERRING PHYSICIAN:	REFERRING PATIENT:
ARE YOU WORKING WITH AN ATTORNEY: ☐ No ☐ Yes	If Yes, Attorney Name: _____

HOW DID YOU HEAR ABOUT US: ☐ Word of Mouth ☐ Internet ☐ Social Media ☐ Community Event ☐ Other: _____

REASON FOR VISIT FOR VISIT

ARE YOU HERE TODAY AS A RESULT OFANY OF THE FOLLOWING: ☐ No ☐ Yes (If yes, please check)

☐ A Fall ☐ An Auto Accident ☐ A Work Related Injury ☐ Other: _____

(IF DUE TO ANY OF THE ABOVE **STOP** AND **INFORM FRONT DESK**)

FIRST COMPLAINT

FIRST COMPLAINT (Reason why you are coming in today)?	**How long have you had this complaint?** ☐ Less than 5 days (Acute) ☐ Between 5-30 days (Sub Acute) ☐ More than 30 days (Chronic)
What caused this condition?	**What is the date this condition Began?** (SKIP IF DUE TO ACCIDENT AND INFORM FRONT DESK)
What terms describe your condition best? ☐ Numbness ☐ Tingling ☐ Stiffness ☐ Dull ☐ Aching ☐ Cramps ☐ Nagging ☐ Sharp ☐ Burning ☐ Shooting ☐ Throbbing ☐ Stabbing ☐ Other: _____	**On a scale from 1 to 10 how would you rate your current level of discomfort?** None Unbearable 0 1 2 3 4 5 6 7 8 9 10
How Often do You feel this discomfort? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent	**How has this condition changed since the onset?** ☐ Improved ☐ Worsened ☐ Remained the same
What Activity is most significantly affected by this discomfort? (Explain)	**What treatment have you received for this condition up to now?**
What aggravates this condition?	**Have other health care providers performed tests related to this condition?** ☐ No ☐ Yes **If Yes, Please list:**
DO YOU HAVE ANY OTHER COMPLAINTS? ☐ No ☐ Yes	**If Yes, Please list Below**

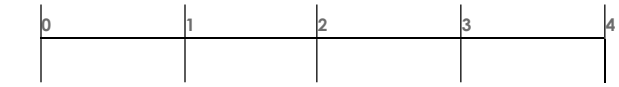
SECOND COMPLAINT	
SECOND COMPLAINT (Reason why you are coming in today)?	**How long have you had this complaint?** ☐ Less than 5 days (Acute) ☐ Between 5-30 days (Sub Acute) ☐ More than 30 days (Chronic)
What caused this condition?	**What is the date this condition Began?** **(SKIP IF DUE TO ACCIDENT AND INFORM FRONT DESK)**
What terms describe your condition best? ☐ Numbness ☐ Tingling ☐ Stiffness ☐ Dull ☐ Aching ☐ Cramps ☐ Nagging ☐ Sharp ☐ Burning ☐ Shooting ☐ Throbbing ☐ Stabbing ☐ Other: _____	**On a scale from 1 to 10 how would you rate your current level of discomfort?** None Unbearable 0 1 2 3 4 5 6 7 8 9 10
How Often do You feel this discomfort? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent	**How has this condition changed since the onset?** ☐ Improved☐ Worsened ☐ Remained the same
What Activity is most significantly affected by this discomfort? (Explain)	**What treatment have you received for this condition up to now?**
What aggravates this condition?	**Have other health care providers performed tests related to this condition?** ☐ No ☐ Yes **If Yes, Please list:**
DO YOU HAVE ANY OTHER COMPLAINTS?☐ No ☐ Yes	**If Yes, Please list Below**
THIRD COMPLAINT	
THIRD COMPLAINT (Reason why you are coming in today)?	**How long have you had this complaint?** ☐ Less than 5 days (Acute) ☐ Between 5-30 days (Sub Acute) ☐ More than 30 days (Chronic)
What caused this condition?	**What is the date this condition Began?** **(SKIP IF DUE TO ACCIDENT AND INFORM FRONT DESK)**
What terms describe your condition best? ☐ Numbness ☐ Tingling ☐ Stiffness ☐ Dull ☐ Aching ☐ Cramps ☐ Nagging ☐ Sharp ☐ Burning ☐ Shooting ☐ Throbbing ☐ Stabbing☐ Other: _____	**On a scale from 1 to 10 how would you rate your current level of discomfort?** None Unbearable 0 1 2 3 4 5 6 7 8 9 10
How Often do You feel this discomfort? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent	**How has this condition changed since the onset?** ☐ Improved☐ Worsened ☐ Remained the same
What Activity is most significantly affected by this discomfort? (Explain)	**What treatment have you received for this condition up to now?**
What aggravates this condition?	**Have other health care providers performed tests related to this condition?** ☐ No ☐ Yes **If Yes, Please list:**
DO YOU HAVE ANY OTHER COMPLAINTS?☐ No ☐ Yes	**If Yes, Please list Below**
FOURTH COMPLAINT	
FOURTH COMPLAINT (Reason why you are coming in today)?	**How long have you had this complaint?** ☐ Less than 5 days (Acute) ☐ Between 5-30 days (Sub Acute) ☐ More than 30 days (Chronic)
What caused this condition?	**What is the date this condition Began?** **(SKIP IF DUE TO ACCIDENT AND INFORM FRONT DESK)**
What terms describe your condition best? ☐ Numbness ☐ Tingling ☐ Stiffness ☐ Dull ☐ Aching ☐ Cramps ☐ Nagging ☐ Sharp ☐ Burning ☐ Shooting ☐ Throbbing ☐ Stabbing☐ Other: _____	**On a scale from 1 to 10 how would you rate your current level of discomfort?** None Unbearable 0 1 2 3 4 5 6 7 8 9 10
How Often do You feel this discomfort? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent	**How has this condition changed since the onset?** ☐ Improved☐ Worsened ☐ Remained the same
What Activity is most significantly affected by this discomfort? (Explain)	**What treatment have you received for this condition up to now?**
What aggravates this condition?	**Have other health care providers performed tests related to this condition?** ☐ No ☐ Yes **If Yes, Please list:**
DO YOU HAVE ANY OTHER COMPLAINTS?☐ No ☐ Yes	**If Yes, Pleaseask Front Desk for Additional Forms**

FUNCTIONAL RATING INDEX

In Order to Properly assess your condition, we must understand how much your **neck and / or back problems** have affected your ability to manage every day activities.

From each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

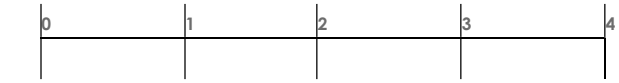


0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc.)



0	1	2	3	4
No Pain; No restrictions	Mild Pain; No Restrictions	Moderate Pain; Need to go slowly	Severe Pain; Need some assistance	Severe Pain; Need 100 % assistance

4. Travel (driving, etc.)

0	1	2	3	4
No Pain on Long Trips	Mild Pain on Long Trips	Moderate Painon Long Trips	Moderate Painon Short Trips	Severe Painon Short Trips

5. Work

0	1	2	3	4
Can do Usual work plus unlimited extra work	Can do Usual work; No extra	Can do 50% Ofusual work	Can do 25 % of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of Pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain After Several Hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with anystanding

CURRENT HEALTH			
OTHER THAN THE INFORMATION ALREADY PROVIDED, DO YOU HAVE ADDITIONAL HEALTH CONCERNS INVOLVING ANY OF THE FOLLOWING:			
Muscles, Bones or Joints	☐ No ☐ Yes	**Explain:**	
Nerves, Headaches, Dizziness or Emotional	☐ No ☐ Yes	**Explain:**	
Head, Eyes, Ears, Nose or Throat	☐ No ☐ Yes	**Explain:**	
Heart, Blood Pressure or Circulation	☐ No ☐ Yes	**Explain:**	
Shortness of Breath, Coughing, Asthma or Lung Condition	☐ No ☐ Yes	**Explain:**	
Stomach, Bowels or Digestive Conditions	☐ No ☐ Yes	**Explain:**	
Genital, Bladder or Urinary Conditions	☐ No ☐ Yes	**Explain:**	
Diabetes, Thyroid or Glandular Conditions	☐ No ☐ Yes	**Explain:**	
Skin or Bleeding Conditions	☐ No ☐ Yes	**Explain:**	
Allergies or Sensitivities	☐ No ☐ Yes	**Explain:**	
PERSONAL AND FAMILY HISTORY			
Have you had any surgical procedures?	☐ No ☐ Yes	**Explain:**	
Are there any past illnesses or conditions we should be aware of?	☐ No ☐ Yes	**Explain:**	
Do you have a past history of accidents or trauma?	☐ No ☐ Yes	**Explain:**	
Are there any past illnesses or conditions we should be aware of?	☐ No ☐ Yes	**Explain:**	
Are you presently taking any medication?	☐ No ☐ Yes	**Explain:**	
Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of?	☐ No ☐ Yes	**Explain:**	

ADULT MEN'S HEALTH	
Do you have pain or a lump in your scrotum or testicles?	☐ No ☐ Yes
Do you have an impaired libido (sex drive)	☐ No ☐ Yes
Do you have prostate issues?	☐ No ☐ Yes
When was your last prostate exam?	☐ Within the past year☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a prostate exam ☐ Prefers not to answer☐ Don't Know
When was your most recent PSA (Prostate-Specific-Antigen) blood test?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a PSA blood test ☐ Prefers not to answer ☐ Don't Know
What was your PSA (Prostate-Specific-Antigen) level on your latest test?	☐ Normal or Low ☐ Moderate ☐ High ☐ Never had a PSA level done ☐ Prefers not to answer ☐ Don't Know
ADULT WOMEN'S HEALTH	
Are you Pregnant?	☐ No ☐ Yes
Are you Nursing?	☐ No ☐ Yes
Are you taking Birth Control?	☐ No ☐ Yes
Do you experience Painful Periods?	☐ No ☐ Yes
Do you have irregular cycles?	☐ No ☐ Yes
Do you have breast implants?	☐ No ☐ Yes
Do you perform a regular self-breast examination?	☐ No ☐ Yes
Do you take Hormone Replacement Therapy?	☐ No ☐ Yes
Do you take oral contraceptives?	☐ No ☐ Yes
When was your last PAP/Pelvic Exam?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a PAP/Pelvic exam ☐ Prefers not to answer ☐ Don't Know
When was your last mammogram?	☐Within the past year☐Between 1-4 years ☐ Greater than 5 years ☐ Never had a mammogram ☐ Prefers not to answer ☐ Don't Know
What was the date of your last menstrual period?	☐Within the past month or currently ☐ Within the past 1-3 months ☐ Greater than 3 months ☐ postmenopausal ☐ Have not begun menstruation ☐ Prefers not to answer☐ Don't Know

INFORMED CONSENT TO TREATMENT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named above, for whom I am legally responsible) by the Doctor of Chiropractic named above and/or other licensed Doctors of Chiropractic or those working in the clinic or office who now or in the future treat me while employed by, working or associated with as a backup doctor for the Doctor of Chiropractic named above.

I have had the opportunity to discuss with the Doctor of Chiropractic, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that in the practice of chiropractic there are some risks to exam and treatment including but not limited to fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known is in my best interest. I further acknowledge that no guarantees or assurances have been made concerning the results intended from the treatment. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read, or have had read to me, the above consent, I have had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will becomeimmediatelydueuponsuspensionorterminationofmycareortreatment.

PRINT NAME SIGNATURE DATE

CONSENT FOR MINOR CHILD OR LEGALLY/PHYSICALLY INCAPACITATED

PRINT NAME OF PATIENT

PRINT NAME OF REPRESENTATIVE

RELATION /AUTHORITY OF REPRESENTATIVE

SIGNATURE OF PATIENT'S REPRESENTATIVE

NOTICE OF PATIENT PRIVACY PRACTICES

I have read a copy of the clinic/office's Notice of Patient privacy Practices.

PRINT NAME SIGNATURE DATE

PREGNANCY

I hereby authorize X-rays to be taken which are considered to be necessary. **I HEREBY CERTIFY THAT** I **AM NOT PREGNANT NOR DO I BELIEVE TO BE PREGNANT.** I further understand that if I am pregnant and I do not inform the doctor of same that radiation could cause permanent health problems or risks to my unborn child. Furthermore, I understand that the **clinic or office will not be held responsible for any of** the health problems or risks that my unborn child may suffer if I do not inform the doctor that I am pregnant or believe to be pregnant.

PRINT NAME SIGNATURE DATE