Patient Information

Name: _____ Preferred name: _____ DOB: ____/____/_____

Home Address: _____ Gender: M F

City, State, Zip: _____ Marital Status: S M D W S

Cell Phone: _____ Email Address: _____

Occupation: _____ Employer Name: _____

Emergency contact (name and number): _____

How were you referred to this office? _____

Purpose For This Visit

***If your symptoms are the result of an auto accident or work related injury, please let the front desk staff know.**

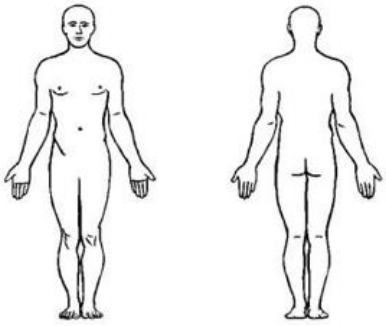
Main Complaint

1) _____ Onset:___/___/___ How did symptom start? _____

Frequency: Constant Frequent Intermittent Occasional **Severity**: mild 1 2 3 4 5 6 7 8 9 10 severe

Please **check** the type(s) of pain you are experiencing in the box on the left and **circle** the location on the figure and descriptions to the right.

☐ Pain ☐ Weakness
☐ Numbness ☐ Dizziness
☐ Muscle spasms ☐ Sharp/Stabbing
☐ Headache ☐ Dull/ache
☐ Tightness ☐ Radiating
☐ Stiffness ☐ Burning
☐ Tingling ☐ Tension



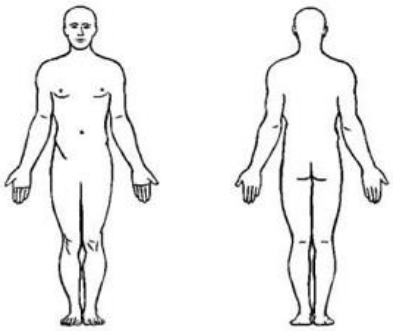
Head/Neck/TMJ
Shoulder/Arm (Left/Right)
Elbow//Hand (Left/Right)
Chest/Ribs/Upper Back
Lower Back/Abdomen
Knees/Hip

Secondary Complaint

2)_____ Onset:___/___/___ How did symptom start? _____

Frequency: Constant Frequent Intermittent Occasional **Severity**: mild 1 2 3 4 5 6 7 8 9 10 severe
Please mark the type(s) of pain you are experiencing

☐ Pain ☐ Weakness
☐ Numbness ☐ Dizziness
☐ Muscle spasms ☐ Sharp/stabbing
☐ Headache ☐ Dull/ache
☐ Tightness ☐ Radiating
☐ Stiffness ☐ Burning
☐ Tingling ☐ Tension



Head/Neck/TMJ
Shoulder/Arm (Left/Right)
Elbow//Hand (Left/Right)
Chest/Ribs/Upper Back
Lower Back/Abdomen
Knees/Hip

Symptoms interfere with: ☐ Bending ☐ Computer Work ☐ Daily Routine ☐ Exercise ☐ Lifting ☐ Sitting ☐ Sleep ☐ Standing ☐ Walking ☐ Work
☐ Other: _____

Is there anything that relieves your symptoms? Yes No If yes, explain: _____

Have you experienced these symptoms before? Yes No

If yes, explain: _____

Have you been treated for this? □Yes □ No When were your last treated? _____

What treatment was performed? _____

Have you seen a chiropractor before? Yes No Who? _____

Health & Lifestyle

Do you exercise? □ Yes □ No How often? _____ days per week; Other _____

What activities? □ Walking □ Running □ Weight Training □ Cycling □ Yoga □ Pilates Other _____

Do you smoke? □ Yes □ No Do you drink alcohol? □ Yes □ No

Other

Please list any health conditions not mentioned: _____
_____

Please list any medications and supplements (include name, dose, and for what condition)

_____ _____
_____ _____
_____ _____

Please list any surgeries (include type of surgery and date it was performed): _____

_____ _____
_____ _____

FAMILY HEALTH HISTORY

Have any of your family members ever been diagnosed with the following (please indicate Y for You, and O for Other than you, or both if applicable):

__ Diabetes
__ Fibromyalgia
__ High blood pressure
__ Kidney disease
__Liver disease
__ Herniated disc
__Epilpesy/seizures
__ Vertigo
__ Circulatory problems
__ Heart disease
__ Migraine headaches
__ Metal implants
__ TMJ dysfunction
__Digestive disorders
__Thyroid problems
__ Neurological problems
__Parkinson's disease
__Cancer
__Arthritis
__Chronic fatigue
__ADD/ADHD
__Multiple sclerosis
__Blood sugar problems
__Tumors
__Depression
__Osteoporosis
__Hernia
__Asthma
__Stroke
__Scoliosis
__High cholesterol

Other: _____
_____

Women: Are you pregnant? □Yes □ No Due Date: _____

HEALTH CARE AUTHORIZATION FORM

Patient's Name _____ Date _____ DOB _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **SpineCare Chiropractic Center** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to **SpineCare** to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives or other health related information.

- If **SpineCare** contacts me by phone, I give them permission to leave a phone message with a member of my household, on my answering machine or voice mail.

- By signing this form you are giving **SpineCare** permission to use and disclose your protected health information in accordance with the directives listed above, and in accordance with our Notice of Privacy Practices. A copy of this Notice is available per request.

SpineCare Chiropractic Center utilizes an open adjusting approach to treating patients, other patients may be in the room while you are being treated and they may be able to overhear some of your protected health information during the course of care. However if you need to speak with the doctor at any time in private, the doctor will provide a room for these conversations. If you have a problem with the open room treatments please notify the doctor immediately.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this Authorization, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **SpineCare Chiropractic Center**. The written notice must contain the following information: Your name, Social Security number and date of birth; a clear statement of your intent to revoke this AUTHORIZATION; the date of your request, and your signature.
The revocation is not effective until it is received by the Privacy Official.
You have the right to refuse to sign this Authorization. If you refuse to sign this AUTHORIZATION, **SpineCare Chiropractic Center** will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

A COPY OF THE NOTICE OF PRIVACY PRACTICES HAS BEEN MADE AVAILABLE TO ME.
_____(Patients Initials)

Print Name of Patient _____ Date _____

Signature of Patient _____ Signature of Witness _____

Massage Therapy Informed Consent

The general benefits of massage, possible contraindications, and the treatment procedure have been explained to me. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medication, and that spinal manipulations are not part of massage therapy. I hereby consent for my therapist to treat me with massage therapy including such assessments, examinations, and techniques which may be recommended by my therapist.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I immediately communicate that to the therapist so that treatment can be adjusted.

We request that you respectfully provide 24 hours notice of cancellation. If you fail to cancel an appointment in less than 24 hours or fail to attend a scheduled appointment you will be charged the regular fee for that appointment. In order to schedule a massage we do require a credit card being placed on file.

If you choose to participate in our auto debit program for massage therapy we require a 3 month minimum commitment. With the autodebit program there will are no refunds and all missed appointments must be made up within 60 days.

I understand the therapist's policies, and agree to abide by them. I understand that at any time I may withdraw my consent and treatment will be stopped.

_____ _____

Patient Name (Print) Date

_____

Signature of Patient/Guardian