# Confidential Patient Information

Name ______________________ ________ ________ ____ ____________ ____________
First and Last Name — Marital Status — DOB Mo/Day/Yr — Age — Home Ph — Cell

Address ______________________ City ____________ State_____ Zip Code __________
Include Street type such as St., Ave., etc.

Your Employment ______________________ ______________________
Company Name/What kind of work you do — **your email address:**

**Are you using your spouse's insurance?** ________ **Spouses' Name** ____________________**DOB** __________

**Who referred you to our office?** ________________ ________________
**Emergency Name/Phone**

**Is your visit due to an accident? ☐ No ☐Yes IF YES, PLEASE TELL FRONT DESK!**

**What is your present complaint** ______________________
BRIEFLY DESCRIBE YOUR SYMPTOMS ______________________
**List other doctor(s) seen for this condition** ______________________

Medical history (if any of the following are relevant to your medical history, please check the accompanying box:)

| | | | |
|---|---|---|---|
| ☐ Cancer | ☐ Muscular Dystrophy | ☐ Rheumatic Fever | ☐ Digestive Disorders |
| ☐ Polio | ☐ Multiple Sclerosis | ☐ Scarlet Fever | ☐ Sinus Trouble |
| ☐ Tuberculosis | ☐ Convulsions | ☐ Nervousness | ☐ Backaches |
| ☐ High Blood Pressure | ☐ Epilepsy | ☐ Asthma | ☐ Numbness |
| ☐ Heart Trouble | ☐ Concussion | ☐ Dizziness | ☐ Arthritis |
| ☐ Diabetes | ☐ Hepatitis | ☐German Measles | ☐ Venereal Disease |

Have you been treated by a physician for any health condition in the last year? θYes θ No If yes, please inform doctor.
Describe Condition ______________________ Date of last physical exam __________
Are you now taking any medication? Yes ☐ No ☐ What kind? ______________________
Are you allergic to any medication? Yes ☐ No ☐ What kind? ______________________
If female, please answer: Are you pregnant? Yes ☐ No ☐ Date of last menstrual period:______________

**My bill will be paid by: ☐Cash ☐Health Insurance ☐ Medicare ☐ Attorney or ☐Personal Lien ☐ Worker's Comp ☐Other**
**Insurance Company** ______________________ **Group/Policy No.** ______________
**Do you have a deductible? Yes ☐ No ☐ How much remains?** ________ **How much is your copay?** ______

# Informed Consent

I certify that the above information is correct to the best of my knowledge and hereby authorize the Chiropractor to treat my condition as deemed appropriate. I will not hold him/her or any staff member responsible for any errors or omissions that I may have made in the completion of this form. He/She will not be held responsible for any pre-existing medically diagnosed condition.

**Specific Risk Possibilities Associated with Chiropractic Care:** While chiropractic treatment, as well as other types of healthcare, is remarkably safe, you do need to be informed of those potential risks related to your care. They are as follows:

**Soreness:** Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable response to chiropractic care and physical therapy.

**Soft Tissue Injury:** Chiropractic treatment may aggravate a disc injury, minor joint, ligament, tendon or other soft tissue injury.

**Rib Injury:** Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize risk.

**Physical Therapy Burns:** Heat generated by PT modalities may cause minor burns to skin. If this rare situation occurs, report it to the doctor immediately

**Stroke:** Stroke is a serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in 5 million upper cervical adjustments.

**X-rays:** If I, the undersigned, choose not to have x-rays taken, I assume full responsibility in consideration of your treating me at my request. Should any untoward effects of any further illness or injury develop, as a result of such treatment, I do hereby release you from all causes of action, damages, and liabilities arising by reason of said treatment, whether heretofore or hereafter occurring and whether known or unknown by all parties.

**Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.**

**Patient's (Parent or Guardian's) Signature** ______________________________ **Date**__________

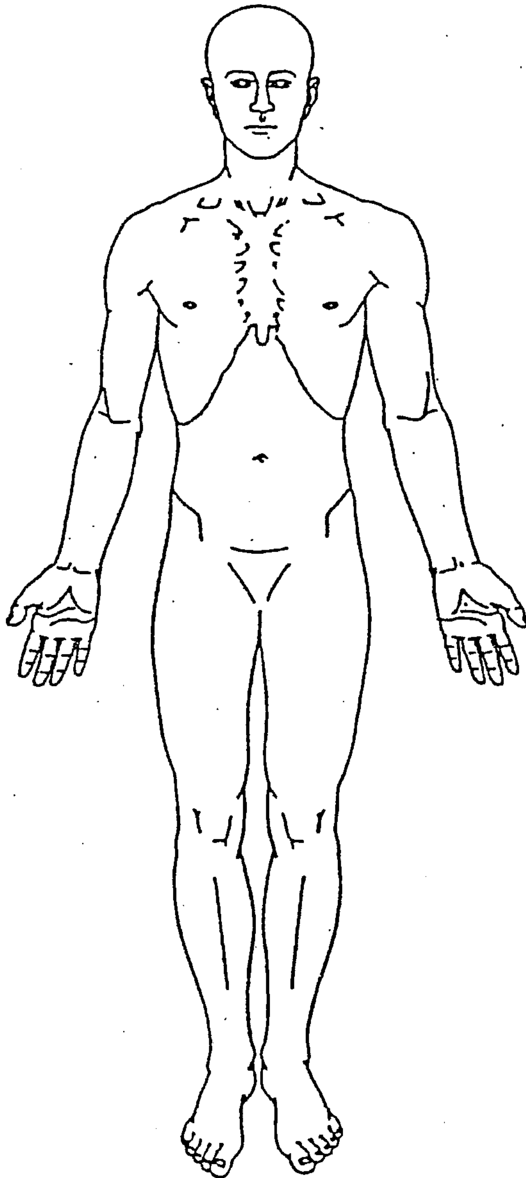
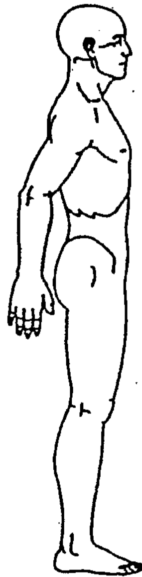
# GENERAL PAIN DISABILITY QUESTIONNAIRE

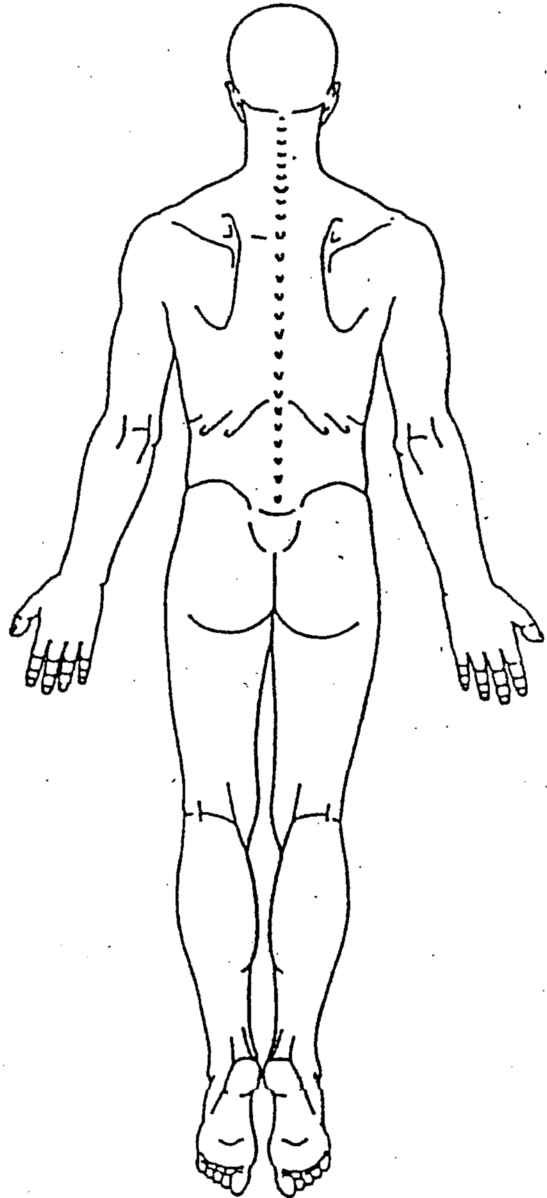
HOW LONG HAVE YOU HAD THIS PAIN? ____ YEARS ____ MONTHS _____ WEEKS

IS THIS YOUR FIRST EPISODE OF PAIN? ☐ YES ☐ NO

**USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW.**
(on the diagram below)

| KEY: | A=ACHE | B=BURNING | N=NUMBNESS |
|---|---|---|---|
| | P=PINS & NEEDLES | S=STABBING | O=OTHER |



Signature_________________________________ Date____________