THE SOURCE CHIROPRACTIC

PATIENT INFORMATION

Date ____/_____/_____

Patients Full Name_____ Birthdate_____
First Middle Last

Physical Address _____ City _____ State_____ Zip _____

Mailing Address (if different) _____ City_____ State _____ Zip _____

E-Mail Address _____ Circle YES / NO to sign up for our newsletter!

Age_____ Sex_____ Height_____ Weight_____ No. of Children_____ Marital Status: S M D W

Occupation_____ Employer_____

Spouses Name_____ Occupation_____ Employer_____

PHONE NUMBERS

Home Phone_____

Cell Phone_____

Work Phone_____

Nearest relative NOT living with you
Name_____
Home # _____
Cell #_____

Nearest friend NOT living with you
Name_____
Home #_____
Cell #_____

ACCIDENT INFORMATION

Is this due to an accident? YES NO

Type of Accident
(circle one)

Auto Work Home Other

Who have you reported this accident to?

Auto Ins____ Employer_____ Other_____

Attorney's Name_____

How did you hear about us?

Internet _____ Insurance _____ Walked by _____ Referral _____ Other _____

HEALTH HISTORY

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.

Please check all the appropriate boxes for any of the following symptoms which you now have or have had previously. It is very important that we have all the facts about your health before we treat you. ***THIS FORM IS CONFIDENTIAL.***

□ AIDS/HIV	□ Cataracts	□ Hepatitis	□ Mumps	□ Stroke
□ Alcoholism	□ Chemical Dependency	□ Hernia	□ Osteoporosis	□ Suicide Attempt
□ Allergy Shots	□ Chicken Pox	□ Herniated Disc	□ Pacemaker	□ Thyroid Problems
□ Anemia	□ Depression	□ Herpes	□ Parkinson's Disease	□ Tonsillitis
□ Anorexia	□ Diabetes	□ High Cholesterol	□ Pinched Nerve	□ Tuberculosis
□ Appendicitis	□ Emphysema	□ Hypertension	□ Pneumonia	□ Tumors, Growths
□ Arthritis	□ Epilepsy	□ Kidney Disease	□ Polio	□ Typhoid Fever
□ Asthma	□ Fractures	□ Liver Disease	□ Prostate Problems	□ Ulcers
□ Bleeding Disorders	□ Glaucoma	□ Measles	□ Prosthesis	□ Vaginal Infections
□ Breast Lump	□ Goiter	□ Migraine Headaches	□ Psychiatric care	□ Venereal Disease
□ Bronchitis	□ Gonorrhea	□ Miscarriage	□ Rheumatoid Arthritis	□ Whooping Cough
□ Bulimia	□ Gout	□ Mononucleosis	□ Rheumatic Fever	□ Other_____
□ Cancer	□ Heart Disease	□ Multiple Sclerosis	□ Scarlet Fever	_____

Please list any medications or supplements that you are currently taking _____

_____

Are you allergic to any medication? (please list) _____

Have you ever been hospitalized? (describe) _____

Had surgery? ☐ YES ☐ NO Please Describe: _____

Have you ever seen a chiropractor before? ☐ YES ☐ NO If YES, who & when? _____

Did it help? ☐ YES ☐ NO

Describe your NORMAL work activity: ☐ SITTING ☐ STANDING ☐ LIGHT LABOR ☐ HEAVY LABOR

HABITS

Smoking- ☐ YES ☐ NO # per day_____ How long _____

Alcohol- ☐ YES ☐ NO # per day_____ How long _____

Caffeine- ☐ YES ☐ NO # per day_____ How long _____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____
Children	_____	_____	_____	_____	_____

Date of last medical exam? _____

Are you pregnant?
☐ YES ☐ NO Due Date _____

Nursing?
☐ YES ☐ NO

Birth Control?
☐ YES ☐ NO

Please circle your stress level:

Low 1 2 3 4 5 High Cause: WORK FAMILY FINANCIAL PAIN OTHER_____

Do you exercise? ☐ NONE ☐ OCCASIONALLY ☐ DAILY Intensity? ☐ Light ☐ Moderate ☐ Intense

How would you describe your diet and eating habits? _____

TELL US WHY YOU ARE HERE TODAY

Reason for visit _____ When did symptoms first appear? (date)_____

Is there any specific activity or event that caused your pain? _____

Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Other

Have you ever experienced similar symptoms in the past? ☐ YES ☐ NO How long ago? _____

Does anything make it feel better? _____ Worse? _____

Type of pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Numbness ☐ Shooting ☐ Tingling
☐ Stiffness ☐ Burning ☐ Swelling ☐ Cramps ☐ Other _____

How often do you have this pain? _____ Is it constant or does it come & go? _____

Does the pain radiate/travel to different areas? ☐ YES ☐ NO Where else do you feel it? _____

As a result of your symptoms, are you restricted in your ability to perform work and/or daily activities? ☐ YES ☐ NO

Please describe _____

Do you have any other symptoms that you feel are associated with your current condition? _____

What treatment have you received for this condition? ☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ Medication

Have you ***ever*** had x-rays taken? ☐ YES ☐ NO Body location of X-ray _____

List any accidents and/or falls and their dates:

Falls: _____

Motor Vehicle: _____

Sports: _____

Other: _____

List any broken bones or dislocations: _____

Have you ever had any spinal taps or spinal injections? □ YES □ NO When? _____

Have you ever been knocked unconscious? □ YES □ NO When? _____

Have you ever had a lapse of memory? □ YES □ NO When? _____

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

Services Rendered Agreement

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I am fully responsible for all charges due for services rendered. All charges must be paid at the time of service. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor any medical diagnosis.

*Patient's signature*_____ _____*Date*_____

CONSENT FORM

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, heat application, cold application, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5 – 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

Patient signature Date

Please read the following carefully and initial each statement.

_____ I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, etc.), I should discuss this with the chiropractic physician because it may affect care.

_____ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, The Source Chiropractic reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans.

Notice: Patient Privacy

How Medical Information About You May Be Used and Disclosed and How You Can Access This Information.

We are committed to protecting the privacy of your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996, we are required by law, to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide, and related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information and/or records for other purposes without your consent or authorization.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligation under the law. We may revise our notice from time to time. The effective date is the date signed and indicates the date of the most current notice in effect.

You have a right to receive a copy of our most current notice in effect. If you have not yet reserved a copy of our current notice, please ask the front desk and we will provide you with our most current copy.

If you have any questions, concerns or comments about the notice or your medical information, please contact our office at (713) 203-979.

_____ _____

Signature Date

_____