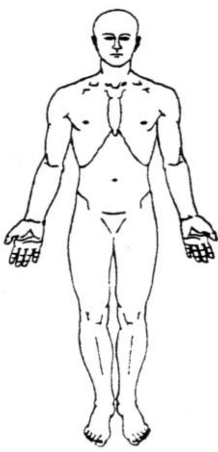
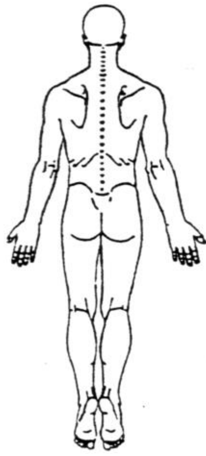
Confidential Patient Record

Name____ Sex_M/F__ Age______ Birth Date_________ Date_________
Address____ City_________________ State_______________ Zip______
Home Phone___________________________ Cell___________________________ Work___________________________
Social Security #__________________________ E-mail____
Occupation____________________________________ Employer____
Spouse ____________________________________Birth Date_____________SS# if primary on insurance_______________________
Names/Ages of Children____
In case of emergency, whom should we contact?____# _________________
How did you hear about our office?____
Have you been to a chiropractor before? _Y/N_ If yes which doctor?____________________Did you like the care? _Y/N

Rank your **Major Problems** or **Reason for office visit** ☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Low back pain
____
____

Mark any areas of your body where you **currently feel pain**, abnormal sensation or have scars.





R L L R

Rate you pain by circling the number that best describes your pain at its *WORST in the past 24 hours*, where **1 is no pain and 10 is the worst pain you can imagine.**
1 2 3 4 5 6 7 8 9 10

Rate your pain by circling the number that best describes your pain at its *LEAST in the past 24 hours.*
1 2 3 4 5 6 7 8 9 10

Rate your pain by circling the number that best describes your pain on *AVERAGE for the past week.*
1 2 3 4 5 6 7 8 9 10

Is this condition a result of an **injury that occurred at work**, in a **motor vehicle accident**, or a manner that may result in a legal dispute? ____

Date problem began______________________**How problem began**____
How often are your symptoms present?(Occasional) ☐ **0-25%** ☐ **26-50%** ☐ **51-75%** ☐ **76-100% (Constant)**
Describe the pain (ie burning, sharp, shooting, aching, deep ache, etc) ______________________________________
Does anything decrease the pain? ____
Does anything make the pain worse? ____
Does the pain travel into the legs or arms? ____
Is the pain worse or better at any time of the day? If so, when? ____
____
List any other symptoms you have experienced since this condition began? ________________________________
____
Does the pain affect any of your normal daily activities? What/How? _____________________________________
____
Have you sought any medical attention for this complaint yet? If so, who did you see and what was the therapy? ____
HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes
Date(s) taken________________ **What areas were taken?**____

What types of therapy have you tried for this problem(s)? ☐ Physical therapy ☐ prescription drugs
☐ over the counter Medication ☐ Acupuncture ☐ Chiropractic ☐ Homeopathy ☐ Vitamins/Minerals
☐ Diet modification ☐ Surgery ☐ Other ____

Medical History: List current health problems for which you are currently being treated ______________________________

____

____

Surgeries/Hospitalizations: Please list any operations or surgeries you have undergone and the date of their occurrence

____

____

Please check all that apply to you:

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____________
☐ Corticosteroid Use (cortisone, prednisone, etc.)
☐ Taking Birth Control Pills

☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐Osteoporosis
☐ Epilepsy/Seizures
☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems

☐ Currently Pregnant, # Weeks______
☐ Abnormal Weight ☐ No ☐ Yes
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbance
☐ Cancer/Tumor

Medications: Please list medications you are taking, or have taken in the past 6 months. State the reason for taking it.

☐ Antacids
☐ Antibiotics
☐ Antidepressants
☐ Antihistamines

☐ Anti-inflammatory
☐ Birth Control Pills
☐ Blood Pressure Medication
☐ Cardiac/Heart Medication

☐ Diuretics
☐ Hormones (estrogen, progesterone, DHEA, testosterone, thyroid)

☐ Muscle Relaxers
☐Pain Killers
☐ Parasite Medication

☐ Steroids (cortisone)
☐ Yeast/Fungal Medications

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____

Family History:

Allergies ______________________________ Mental disease ______________________________
Arthritis (type) ______________________________ Thyroid Imbalance ______________________________
Asthma ______________________________ Stroke ______________________________
Cancer (type) ______________________________ Rheumatoid Arthritis ______________________________
Diabetes ______________________________ High Blood Pressure ______________________________
Heart Disease ____
Other ____

Stress Level: Rate your stress level on a scale from 1-10. Low 1 2 3 4 5 6 7 8 9 10 High
Energy Level: High/Medium/Low **AM**_H/M/L_ **Afternoon**_H/M/L_ **Evening**_H/M/L_ **After meals**_H/M/L_ **Overall**_H/M/L_

Sleep Quality: How is your sleep? (Circle all that apply) Restful Restless Hard to get to sleep Wake up often Nightmares
What time do you usually go to sleep?____________ Hours of sleep/night___________ What position do you sleep?______________

Exercise: Do you exercise?_____________ How much?______________________________ For how long per session? ___________
What type of exercise do you do?____

Smoking: Do you Smoke?_________________How much?_____________________How long?______________________

Allergies: Please list any known allergies, ____

Daily Habits: For each of these items listed below specify if you consume them and how often (i.e. 2 cups/day)
Coffee/Tea_____________ Soda_____________ Alcohol______________Water_____________ Fast food___________________
Vitamins/Minerals____
How do you spend your spare time (hobbies, ect.)?____

Goals: What are your goals for seeing Dr. Clark?____

Release of Information (all patients must sign this section)

I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan, Medicare. I also authorize the release of my medical records to my other health care professionals and I give permission to Dr. Clark to request my medical records from other health care facilities.

Signed ________________________________ Date ____________

Payment Agreement (all patients must sign this section)

Payment for this initial consultation and treatment with Dr. Clark is required at the time of service. For your convenience, we accept cash, checks, MasterCard and Visa. If you have no chiropractic insurance coverage, all fees are due at the time the services are rendered.

If you have chiropractic insurance, we are interested in you receiving the maximum benefits. As an added service to you, our office will process your insurance claim for you. However, please be advised:

1. Your insurance policy is a legal contract between you, your employer, and your insurance company. We as health care providers are NOT a party to the contract.
2. Dr. Clark is currently a participating provider for a number of insurances. Be sure to ask if your Insurance is one of them and what your insurance covers.
3. Many insurance companies will advise you that your coverage will be a percentage, e.g. 80% of treatment charges, usually after a yearly deductible amount has been paid by you directly to health care providers. What is often not specified by the insurance company are plan fee schedules, annual maximums, and other limitations that will have a direct bearing on the reimbursement allowed.
4. Any insurance balance unpaid after 90 days becomes your responsibility. You remain ultimately responsible for all charges incurred in this office.
5. Appointments missed, or cancelled without providing 24 hours notice will be charged at the regular fee.
6. I authorize the use of my signature on all insurance submissions from Dr. Clark's office.

Signed ____________________________________ Date ____________

Informed Consent

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 below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of the chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. 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 upon the facts then known, is in my best interests.

I have read the previous information regarding risks of chiropractic care and my doctor has explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

PATIENT SIGNATURE ____ DATE ________________

PARENT/GUARDIAN SIGNATURE _________________________________ DATE ________________

DOCTOR SIGNATURE ____ DATE_________________