

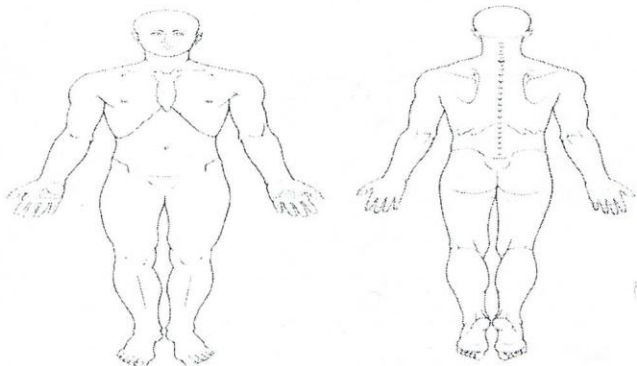
# Welcome to Our Office!

Date: \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_ Email \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ D.O.B \_\_\_\_\_ Spouse Ph \_\_\_\_\_ Employer \_\_\_\_\_  
 Children's Name & Ages \_\_\_\_\_  
 Have you had previous Chiropractic care?  yes  no Positive Experience:  yes  no  
 Who may we thank for referring you to our office? \_\_\_\_\_  Walk In  Google  MD Referral  Other \_\_\_\_\_  
 Who is your primary care physician? \_\_\_\_\_ Phone: \_\_\_\_\_ Date of last physical/exam? \_\_\_\_\_  
 May we update your medical doctor regarding your treatment in our office?  yes  no

**WHAT BRINGS YOU TO OUR OFFICE?** Please provide as much detail as possible.

Current Complaint: \_\_\_\_\_ Date when symptom first appeared \_\_\_\_\_  
 How Did it begin: \_\_\_\_\_  
 How often do you experience these symptoms?  Constant 100%  Frequent 75%  Intermittent 50%  Occasional 25%  Rare 10%  
 Have you ever experienced the same or similar symptoms?  yes  no When? \_\_\_\_\_  
 Have you been to another doctor for this problem?  yes  no Who/Where? \_\_\_\_\_  
 Type of Pain:  Sharp  Dull  Ache  Burn  Throb  Other Do you have Numbness or Tingling?  yes  no Where? \_\_\_\_\_  
 Does the Pain Radiate into:  Arm  Hand  Leg  Foot  Other \_\_\_\_\_  Does not radiate  
 What makes the symptoms increase? \_\_\_\_\_ What relieves the symptoms? \_\_\_\_\_  
 Drugs you now take:  Nerve Pills  Pain Pills  Muscle Relaxer  Blood Pressure  Other: \_\_\_\_\_  
 Do any family members suffer from the same complaint? If so, who? \_\_\_\_\_



**Please mark off all areas of complaint on the diagrams with the following indicators:**  
 AAA=ache DDD=dull NNN = numbness  
 TTT= tingling BBB= burning SSS=sharp/stabbing  
 XXX = other

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme)  
 0 ◊◊◊ 1 ◊◊◊ 2 ◊◊◊ 3 ◊◊◊ 4 ◊◊◊ 5 ◊◊◊ 6 ◊◊◊ 7 ◊◊◊ 8 ◊◊◊ 9 ◊◊◊ 10

Have you ever been in an auto accident?  Past Year  Past 5 Years  Over 5 Years  Never  
 Please describe: \_\_\_\_\_  
 Please list ALL surgeries, injuries, accidents, falls, etc: \_\_\_\_\_

**List all Medications/Vitamins:**

Do you smoke?  yes  no If yes, how many packs per week? \_\_\_\_\_ Have you ever smoked in the past?  yes  no When did you quit? \_\_\_\_\_  
 Do you consume alcohol?  yes  no If yes, how many drinks per week? \_\_\_\_\_  
 Do you consume caffeine?  yes  no If yes, how many drinks per day? \_\_\_\_\_  
 Do you exercise?  yes  no If yes, how many times per week and what type? \_\_\_\_\_  
 Do you have a high stress level?  yes  no If yes, list reasons: \_\_\_\_\_

Name: \_\_\_\_\_  
Date: \_\_\_\_\_

Is there any possibility that you may be pregnant? yes no Date of Last Menstrual Cycle \_\_\_\_\_

### Health History - Please circle all that apply

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M. S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V. D.	Whooping Cough	
Chronic Fatigue	High Blood Pressure		Fibromyalgia	Other _____			

**Family History** – List any diseases and conditions that are current health problems of family members.

### CHIROPRACTIC INFORMED CONSENT TO TREAT

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, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of 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 or 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 and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further 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 further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Initial \_\_\_\_\_

### Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Initial \_\_\_\_\_

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that South Lake Chiropractic P.C. will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to South Lake Chiropractic P.C. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_