

**CONFIDENTIAL PATIENT INFORMATION**

Date \_\_\_\_\_

Name: \_\_\_\_\_ What would you like to be called? \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Sex:  M  F Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Single  Married  Widowed  Divorced  Partnered Name of Spouse/Partner: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Spouse's Work Phone: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_ Spouse's SSN: \_\_\_\_\_ (if needed)

How did you hear about our office?  Referral - Who? \_\_\_\_\_  Google  Advertisement - \_\_\_\_\_

Other: \_\_\_\_\_

Have you ever had chiropractic care before?  No  Yes Where? \_\_\_\_\_

How long ago was your last adjustment? \_\_\_\_\_ Reason for not returning: \_\_\_\_\_

Were the results satisfactory?  No  Yes  N/A

**Major complaints and symptoms** - Briefly describe your symptoms in order of severity, with worse symptom(s) first. You will be given the opportunity to include more detail on following pages.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this problem due to a work-related injury?  
 No  Yes

Is this problem due to a motor vehicle collision?  
 No  Yes

Do you have pain that wakes you out of a sound sleep?  No  Yes

Do you have any current impairment of bowel or urinary function?  No  Yes

Do you have night sweats?  No  Yes

Have you lost or gained weight in the past year?  No  Yes

Have you had any recent infections?  No  Yes

Have you lost any work do to any of your current problems?  No  Yes Day and date you last worked \_\_\_\_\_

Family Physician's Name: \_\_\_\_\_

Location: \_\_\_\_\_

Would you allow us to send a report to your family physician?  No  Yes

What other wellness professionals are currently part of your health care team?

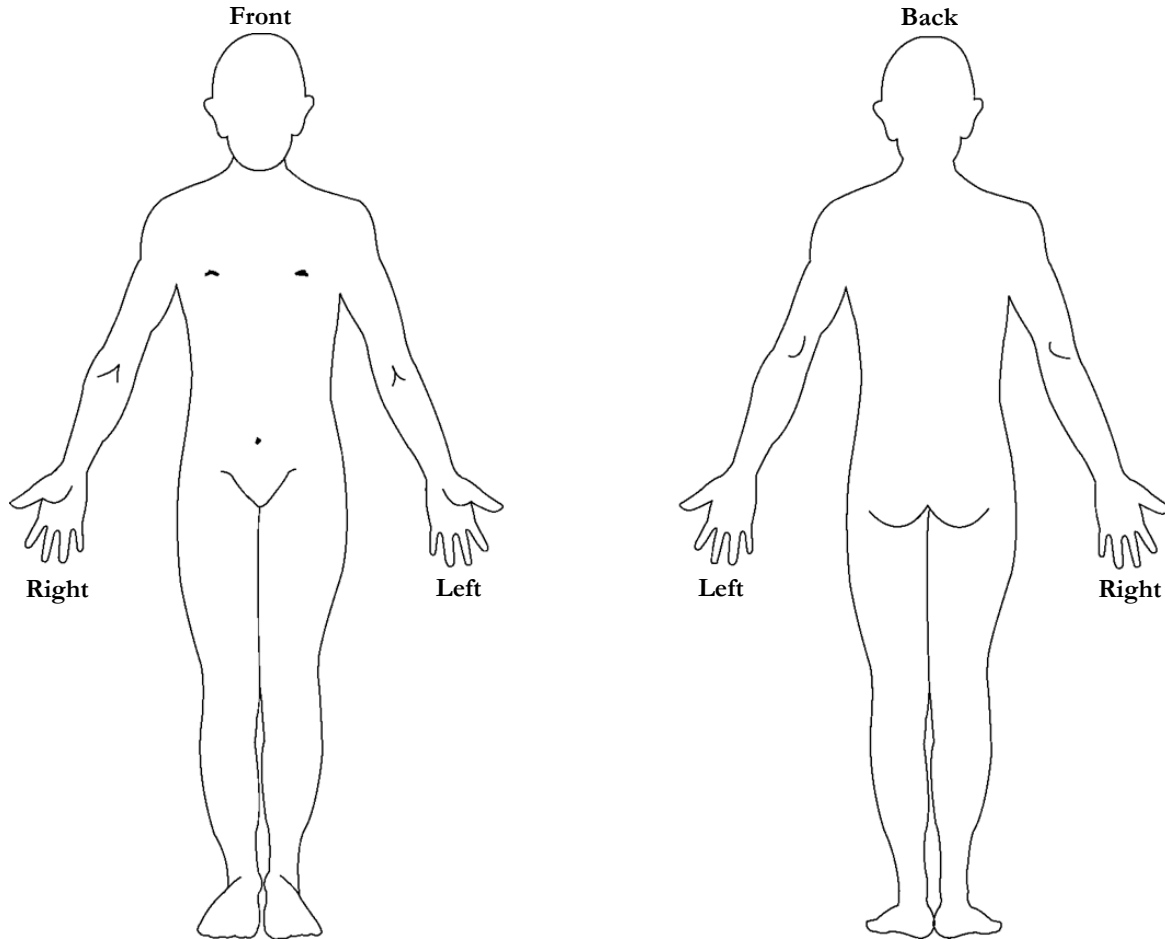
Massage Therapist  Personal Trainer  Nutritionist  Acupuncturist  Naturopath  Other: \_\_\_\_\_

**CONFIDENTIAL PATIENT INFORMATION**

SHOW ALL AREA(S) OF PAIN OR UNUSUAL FEELING

- Mark the areas on this body where you feel the described sensations.
- Use the appropriate symbols. Mark areas of radiation. Describe in words if the symbols. Include all affected areas

<u>Numbness</u>	<u>Pins &amp; Needles</u>	<u>Burning</u>	<u>Aching</u>	<u>Stabbing</u>
-----	00000	xxxxx	*****	/////
-----	00000	xxxxx	*****	/////
-----	00000	xxxxx	*****	/////



**EXPECTATIONS**

I would like to have the following benefits from **Chiropractic Care**: (Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Relief of a symptom or problem  | <input type="checkbox"/> Healthier spine and nerve system |
| <input type="checkbox"/> Relief and prevention of a symptom or problem   | <input type="checkbox"/> Optimal health on all levels     |
| <input type="checkbox"/> Preventive maintenance plan which includes diet, exercise and chiropractic so that I stay as healthy as possible. |   |

What are your top three health goals?

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_

**Main Complaint/Problem** - Please fill out the following page as accurately as you can. Please **ONLY** describe the **MOST** important problem on this page, like neck pain **OR** low back pain **OR** headaches. Use the following page to describe any other problems that you might have.

1. What is the presenting problem/chief complaint? Only list **ONE** problem here. \_\_\_\_\_

2. Where is the pain located? \_\_\_\_\_

3. Have you experienced this condition before or a similar condition? \_\_\_\_\_

4. How long ago did the problem begin?  Today  Yest.  1 wk  2-3 wks  1 mo  2 mo  3-6 mo  7-12 mo  Years  \_\_\_\_\_

5. How do you believe your problem began? \_\_\_\_\_

6. Describe the pain:  Sharp  Dull Ache  Burning  Throbbing  Spasm  Numbness  Tingling  
(Check all that apply)  Shooting  Soreness  Stabbing  Excruciating  Other: \_\_\_\_\_

7. Did it begin:  Gradually  Suddenly 8. Is this problem:  Improved  Unchanged  Getting Worse

9. How often do you experience this problem?  1-2x/wk  3-4x/wk  5-6x/wk  Daily  other: \_\_\_\_\_

10. How often do you experience these symptoms throughout the day?  
 Constantly (76-100%)  Frequently (51-75%)  Occasionally (26-50%)  Intermittently (0-25%)  Only with activity

11. Is the pain worse or better at any time of the day? If so, when? \_\_\_\_\_

12. Please grade the intensity of this problem. Circle the number. (0= No Pain, 5= I need pain medication and 10= worst pain imaginable):  
Right Now: 0--1--2--3--4--5--6--7--8--9--10 Best Pain: 0--1--2--3--4--5--6--7--8--9--10 Worst Pain 0--1--2--3--4--5--6--7--8--9--10

13. Does anything increase the pain? List or Check Below. \_\_\_\_\_

Check those activities below during which you experience difficulty or pain:

- Lying on back  Kneeling  Pushing  Sitting  Bending forward  Using Computer
- Lying on side  Walking  Pulling  Prolonged Sitting  Bending backward  Reading
- Rolling over  Running  Lifting  Standing  Getting in/out of car  Housework
- Lying on stomach  Climbing Stairs  Reaching  Prolonged Standing  Dressing Self  Cooking
- Certain Movements  Descending Stairs  Stooping  Sneezing/Coughing  Sexual Activity  Yard Work

14. Does anything decrease the pain? List or Check Below. \_\_\_\_\_

Check those activities below during which you experience relief or easing of your pain:

- Rest  Moving Around  Walking  Hot Packs  Shoe Inserts
- Lying on back  Exercise  Running  Cold Packs  Rubbing Muscles
- Lying on side  Stretching  Standing  Ben Gay / Biofreeze  Massage Therapy
- Lying on stomach  Better Posture  Bending forward  Pain Medication (NSAIDs)  Physical Therapy
- Sitting Down  Careful Lifting  Bending backward  Prescription Pain Meds  Chiropractic Treatment

15. Does the pain or numbness radiate into your arms or legs? No Yes Where? \_\_\_\_\_

16. Does your complaint interfere with:  Work  Sleep  Hobbies  Daily Routine Explain. \_\_\_\_\_

17. Have you seen any other doctors or therapists for this problem? No Yes If yes, who? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

How effective was the care? \_\_\_\_\_

18. What imaging have you had for this problem?  None  X-ray  MRI  CT When? \_\_\_\_\_

**DOCTOR'S NOTES:**


**Secondary Complaint/Problem** - Please fill out the following page as accurately as you can. Please **ONLY** describe the **SECOND MOST** important problem on this page, like neck pain **OR** low back pain **OR** headaches. Use the following page to describe any other problems.

1. What is the presenting problem/chief complaint? Only list **ONE** problem here. \_\_\_\_\_

2. Where is the pain located? \_\_\_\_\_

3. Have you experienced this condition before or a similar condition? \_\_\_\_\_

4. How long ago did the problem begin?  Today  Yest.  1 wk  2-3 wks  1 mo  2 mo  3-6 mo  7-12 mo  Years  \_\_\_\_\_

5. How do you believe your problem began? \_\_\_\_\_

6. Describe the pain:  Sharp  Dull Ache  Burning  Throbbing  Spasm  Numbness  Tingling  
 (Check all that apply)  Shooting  Soreness  Stabbing  Excruciating  Other: \_\_\_\_\_

7. Did it begin:  Gradually  Suddenly

8. Is this problem:  Improved  Unchanged  Getting Worse

9. How often do you experience this problem?  1-2x/wk  3-4x/wk  5-6x/wk  Daily  other: \_\_\_\_\_

10. How often do you experience these symptoms throughout the day?  
 Constantly (76-100%)  Frequently (51-75%)  Occasionally (26-50%)  Intermittently (0-25%)  Only with activity

11. Is the pain worse or better at any time of the day? If so, when? \_\_\_\_\_

12. Please grade the intensity of this problem. Circle the number. (0= No Pain, 5= I need pain medication and 10= worst pain imaginable):

Right Now: 0--1--2--3--4--5--6--7--8--9--10      Best Pain: 0--1--2--3--4--5--6--7--8--9--10      Worst Pain 0--1--2--3--4--5--6--7--8--9--10

13. Does anything increase the pain? List or Check Below. \_\_\_\_\_

Check those activities below during which you experience difficulty or pain:

- |  |  |                                   |   |  |   |
|--|--|-----------------------------------|---|--|---|
| <input type="checkbox"/> Lying on back     | <input type="checkbox"/> Kneeling          | <input type="checkbox"/> Pushing  | <input type="checkbox"/> Sitting            | <input type="checkbox"/> Bending forward       | <input type="checkbox"/> Using Computer |
| <input type="checkbox"/> Lying on side     | <input type="checkbox"/> Walking           | <input type="checkbox"/> Pulling  | <input type="checkbox"/> Prolonged Sitting  | <input type="checkbox"/> Bending backward      | <input type="checkbox"/> Reading        |
| <input type="checkbox"/> Rolling over      | <input type="checkbox"/> Running           | <input type="checkbox"/> Lifting  | <input type="checkbox"/> Standing           | <input type="checkbox"/> Getting in/out of car | <input type="checkbox"/> Housework      |
| <input type="checkbox"/> Lying on stomach  | <input type="checkbox"/> Climbing Stairs   | <input type="checkbox"/> Reaching | <input type="checkbox"/> Prolonged Standing | <input type="checkbox"/> Dressing Self         | <input type="checkbox"/> Cooking        |
| <input type="checkbox"/> Certain Movements | <input type="checkbox"/> Descending Stairs | <input type="checkbox"/> Stooping | <input type="checkbox"/> Sneezing/Coughing  | <input type="checkbox"/> Sexual Activity       | <input type="checkbox"/> Yard Work      |

14. Does anything decrease the pain? List or Check Below. \_\_\_\_\_

Check those activities below during which you experience relief or easing of your pain:

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> Rest             | <input type="checkbox"/> Moving Around   | <input type="checkbox"/> Walking          | <input type="checkbox"/> Hot Packs                | <input type="checkbox"/> Shoe Inserts           |
| <input type="checkbox"/> Lying on back    | <input type="checkbox"/> Exercise        | <input type="checkbox"/> Running          | <input type="checkbox"/> Cold Packs               | <input type="checkbox"/> Rubbing Muscles        |
| <input type="checkbox"/> Lying on side    | <input type="checkbox"/> Stretching      | <input type="checkbox"/> Standing         | <input type="checkbox"/> Ben Gay / Biofreeze      | <input type="checkbox"/> Massage Therapy        |
| <input type="checkbox"/> Lying on stomach | <input type="checkbox"/> Better Posture  | <input type="checkbox"/> Bending forward  | <input type="checkbox"/> Pain Medication (NSAIDs) | <input type="checkbox"/> Physical Therapy       |
| <input type="checkbox"/> Sitting Down     | <input type="checkbox"/> Careful Lifting | <input type="checkbox"/> Bending backward | <input type="checkbox"/> Prescription Pain Meds   | <input type="checkbox"/> Chiropractic Treatment |

15. Does the pain or numbness radiate into your arms or legs? No Yes Where? \_\_\_\_\_

16. Does your complaint interfere with:  Work  Sleep  Hobbies  Daily Routine Explain. \_\_\_\_\_

17. Have you seen any other doctors or therapists for this problem? No Yes If yes, who? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

How effective was the care? \_\_\_\_\_

18. What imaging have you had for this problem?  None  X-ray  MRI  CT When? \_\_\_\_\_

**DOCTOR'S NOTES:**


**Tertiary Complaint/Problem** - Please fill out the following page as accurately as you can. Please **ONLY** describe the **THIRD MOST** important problem on this page, like neck pain **OR** low back pain **OR** headaches. .

1. What is the presenting problem/chief complaint? Only list **ONE** problem here. \_\_\_\_\_

2. Where is the pain located? \_\_\_\_\_

3. Have you experienced this condition before or a similar condition? \_\_\_\_\_

4. How long ago did the problem begin?  Today  Yest.  1 wk  2-3 wks  1 mo  2 mo  3-6 mo  7-12 mo  Years  \_\_\_\_\_

5. How do you believe your problem began? \_\_\_\_\_

6. Describe the pain:  Sharp  Dull Ache  Burning  Throbbing  Spasm  Numbness  Tingling  
 (Check all that apply)  Shooting  Soreness  Stabbing  Excruciating  Other: \_\_\_\_\_

7. Did it begin:  Gradually  Suddenly

8. Is this problem:  Improved  Unchanged  Getting Worse

9. How often do you experience this problem?  1-2x/wk  3-4x/wk  5-6x/wk  Daily  other: \_\_\_\_\_

10. How often do you experience these symptoms throughout the day?  
 Constantly (76-100%)  Frequently (51-75%)  Occasionally (26-50%)  Intermittently (0-25%)  Only with activity

11. Is the pain worse or better at any time of the day? If so, when? \_\_\_\_\_

12. Please grade the intensity of this problem. Circle the number. (0= No Pain, 5= I need pain medication and 10= worst pain imaginable):

Right Now: 0--1--2--3--4--5--6--7--8--9--10      Best Pain: 0--1--2--3--4--5--6--7--8--9--10      Worst Pain 0--1--2--3--4--5--6--7--8--9--10

13. Does anything increase the pain? List or Check Below. \_\_\_\_\_

Check those activities below during which you experience difficulty or pain:

- Lying on back       Kneeling       Pushing       Sitting       Bending forward       Using Computer
- Lying on side       Walking       Pulling       Prolonged Sitting       Bending backward       Reading
- Rolling over       Running       Lifting       Standing       Getting in/out of car       Housework
- Lying on stomach       Climbing Stairs       Reaching       Prolonged Standing       Dressing Self       Cooking
- Certain Movements       Descending Stairs       Stooping       Sneezing/Coughing       Sexual Activity       Yard Work

14. Does anything decrease the pain? List or Check Below. \_\_\_\_\_

Check those activities below during which you experience relief or easing of your pain:

- Rest       Moving Around       Walking       Hot Packs       Shoe Inserts
- Lying on back       Exercise       Running       Cold Packs       Rubbing Muscles
- Lying on side       Stretching       Standing       Ben Gay / Biofreeze       Massage Therapy
- Lying on stomach       Better Posture       Bending forward       Pain Medication (NSAIDs)       Physical Therapy
- Sitting Down       Careful Lifting       Bending backward       Prescription Pain Meds       Chiropractic Treatment

15. Does the pain or numbness radiate into your arms or legs? No Yes Where? \_\_\_\_\_

16. Does your complaint interfere with:  Work  Sleep  Hobbies  Daily Routine Explain. \_\_\_\_\_

17. Have you seen any other doctors or therapists for this problem? No Yes If yes, who? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

How effective was the care? \_\_\_\_\_

18. What imaging have you had for this problem?  None  X-ray  MRI  CT When? \_\_\_\_\_

**DOCTOR'S NOTES:**


Name \_\_\_\_\_

Date \_\_\_\_\_

**Additional Complaints/Problems** - Please fill out the following page as accurately as you can. Please **ONLY** describe the **FOURTH MOST** important problem on this page, like neck pain **OR** low back pain **OR** headaches. PLEASE REPRINT THIS PAGE TO DETAIL ANY ADDITIONAL COMPLAINTS.

1. What is the presenting problem/chief complaint? Only list **ONE** problem here. \_\_\_\_\_

2. Where is the pain located? \_\_\_\_\_

3. Have you experienced this condition before or a similar condition? \_\_\_\_\_

4. How long ago did the problem begin?  Today  Yest.  1 wk  2-3 wks  1 mo  2 mo  3-6 mo  7-12 mo  Years  \_\_\_\_\_

5. How do you believe your problem began? \_\_\_\_\_

6. Describe the pain:  Sharp  Dull Ache  Burning  Throbbing  Spasm  Numbness  Tingling  
(Check all that apply)  Shooting  Soreness  Stabbing  Excruciating  Other: \_\_\_\_\_

7. Did it begin:  Gradually  Suddenly 8. Is this problem:  Improved  Unchanged  Getting Worse

9. How often do you experience this problem?  1-2x/wk  3-4x/wk  5-6x/wk  Daily  other: \_\_\_\_\_

10. How often do you experience these symptoms throughout the day?  
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11. Is the pain worse or better at any time of the day? If so, when? \_\_\_\_\_

12. Please grade the intensity of this problem. Circle the number. (0= No Pain, 5= I need pain medication and 10= worst pain imaginable):  
Right Now: 0--1--2--3--4--5--6--7--8--9--10 Best Pain: 0--1--2--3--4--5--6--7--8--9--10 Worst Pain 0--1--2--3--4--5--6--7--8--9--10

13. Does anything increase the pain? List or Check Below. \_\_\_\_\_  
Check those activities below during which you experience difficulty or pain:  
 Lying on back  Kneeling  Pushing  Sitting  Bending forward  Using Computer  
 Lying on side  Walking  Pulling  Prolonged Sitting  Bending backward  Reading  
 Rolling over  Running  Lifting  Standing  Getting in/out of car  Housework  
 Lying on stomach  Climbing Stairs  Reaching  Prolonged Standing  Dressing Self  Cooking  
 Certain Movements  Descending Stairs  Stooping  Sneezing/Coughing  Sexual Activity  Yard Work

14. Does anything decrease the pain? List or Check Below. \_\_\_\_\_  
Check those activities below during which you experience relief or easing of your pain:  
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 Lying on back  Exercise  Running  Cold Packs  Rubbing Muscles  
 Lying on side  Stretching  Standing  Ben Gay / Biofreeze  Massage Therapy  
 Lying on stomach  Better Posture  Bending forward  Pain Medication (NSAIDs)  Physical Therapy  
 Sitting Down  Careful Lifting  Bending backward  Prescription Pain Meds  Chiropractic Treatment

15. Does the pain or numbness radiate into your arms or legs? No Yes Where? \_\_\_\_\_

16. Does your complaint interfere with:  Work  Sleep  Hobbies  Daily Routine Explain. \_\_\_\_\_

17. Have you seen any other doctors or therapists for this problem? No Yes If yes, who? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

How effective was the care? \_\_\_\_\_

18. What imaging have you had for this problem?  None  X-ray  MRI  CT When? \_\_\_\_\_

**DOCTOR'S NOTES:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_

**CONFIDENTIAL PATIENT INFORMATION**

**MEDICAL HISTORY**

Have you been treated for any condition by a physician in the past year?  No  Yes

If yes, what condition? \_\_\_\_\_

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc. (even as a child)?

No  Yes When? \_\_\_\_\_

Have you ever broken any bones?  No  Yes \_\_\_\_\_ Any dislocations?  No  Yes \_\_\_\_\_

Are you allergic to anything which you are aware of?  No  Yes If yes, name them. \_\_\_\_\_

Do you take vitamins, supplements or herbs?  No  Yes If yes, please list them \_\_\_\_\_

\_\_\_\_\_

Are you presently taking any medications or over-the-counter products (aspirin, ibuprofen, etc. included)?  No  Yes

If yes, name them. \_\_\_\_\_

\_\_\_\_\_

What operations have you had? (Please list type and year) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any major illness you have had, with dates (month/year) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever been diagnosed with diabetes?  No  Yes When? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Have you ever been diagnosed with a cardiac (heart) condition, a blood vessel condition (like arteriosclerosis, atherosclerosis, or vasculitis), or hypertension (high blood pressure)?  No  Yes When? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Explain: \_\_\_\_\_

Have you ever had a stroke or heart attack?  No  Yes When? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Explain: \_\_\_\_\_

Give dates you have had any of the following? (if exact date is unknown, give approximate date)

Lab Tests (Blood or Urinalysis) \_\_\_\_\_

Imaging (X-Rays, MRI, CT or ultrasound) \_\_\_\_\_

Do you have any health problems not listed above? \_\_\_\_\_

\_\_\_\_\_

Are you healthier now than you were one (1) year ago?  No  Yes If yes, what did you do to accomplish this? \_\_\_\_\_

\_\_\_\_\_

Do you have a plan on improving your health?  No  Yes If Yes, What is it? \_\_\_\_\_

\_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_

**SOCIAL HISTORY**

Cigarettes:  Never     Current Smoker - How many packs a day? \_\_\_\_\_ How many years total? \_\_\_\_\_  
 Former Smoker – Quit When? \_\_\_\_\_ How many packs a day? \_\_\_\_\_ How many years did you smoke? \_\_\_\_\_

Coffee? \_\_\_\_\_ Quantity \_\_\_\_\_ cups a day    Tea? \_\_\_\_\_ Quantity \_\_\_\_\_ cups a day

Alcohol? \_\_\_\_\_ Quantity \_\_\_\_\_ drinks a week    Soda/Pop? \_\_\_\_\_ Quantity \_\_\_\_\_ cans a day

Do you currently use recreational drugs?  No  Yes    What type, how often, and how long? \_\_\_\_\_

Have you used recreational drugs in the past?  No  Yes    What type, how often, and how long? \_\_\_\_\_

Do you have any special dietary restrictions?  No  Yes    What type? \_\_\_\_\_

Do you exercise regularly?  No  Yes    What kind of exercise? \_\_\_\_\_

Hobbies \_\_\_\_\_

If you have any children, what are their ages? \_\_\_\_\_

What do you do for a living? \_\_\_\_\_ How many hours a week? \_\_\_\_\_

Do you have a second job? \_\_\_\_\_ How many hours a week? \_\_\_\_\_

Describe your work environment: \_\_\_\_\_

What is your highest level of education?  Some High School  HS  Some College  College  Post Grad  Professional

Other: \_\_\_\_\_

**FAMILY HISTORY**

- Arthritis:         No  Yes                      • Diabetes:         No  Yes                      • High Blood Pressure:  No  Yes
- Asthma:          No  Yes                      • Heart Disease:  No  Yes                      • Other \_\_\_\_\_
- Cancer:          No  Yes                      • Stroke:          No  Yes

**FEMALE HISTORY**

Beginning date of your last period. \_\_\_\_\_

Do you get pain or cramps?  No  Yes

Date of last pelvic exam. \_\_\_\_\_

Date of last pap test. \_\_\_\_\_

Are you on birth control pills?  No  Yes

Have you ever been pregnant?  No  Yes

Are you currently pregnant?  No  Yes

Have you ever had a cesarean section?  No  Yes

DOCTOR'S NOTES: _____



**PAST HISTORY – REVIEW OF SYMPTOMS**

Check if you have ever had any of the following conditions. Please circle all current problems.

**JOINTS & MUSCLES**

- Arthritis
- Joint pains or aches
- Muscle pains or aches
- Stiffness
- Swollen, tender joints
- Pain Between Shoulders
- Joint Replacement(s)
- Spinal Fusion(s)
- Herniated Disc
- Pinched Nerve
- Numbness
- Tingling

**DIGESTIVE TRACT**

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Indigestion
- Bloating feeling
- Belching or passing gas
- Gall bladder trouble
- Ulcers
- Abdominal pain
- Irritable Bowel Syndrome
- Hernia

**EYES**

- Glasses/contacts
- Watery eyes
- Itchy eyes
- Dark circles
- Blurred vision

**EARS**

- Hearing difficulty
- Ringing in ears
- Ear aches
- Ear infections
- Drainage from ear
- Itchy ears

**MOUTH & THROAT**

- Chronic cough
- Gagging
- Often clear throat
- Sore throat
- Canker sores

**LUNGS**

- Chest congestion
- Asthma
- Bronchitis
- Shortness of breath
- Difficulty breathing
- Pneumonia
- COPD

**HEART**

- Heart trouble
- Stroke
- High blood pressure
- High cholesterol
- Irregular heartbeat
- Rapid heartbeat
- Chest pains

**SKIN**

- Acne
- Hives, rashes
- Hair loss
- Flushing, hot flashes
- Excessive sweating

**HEAD/MIND**

- Headaches
- Migraines
- Fainting
- Dizziness
- Insomnia
- Epilepsy
- Poor memory
- Confusion
- Poor concentration

**NOSE**

- Allergies
- Stuffy nose
- Sinus problems
- Sneezing attacks
- Post-nasal drip

**ENERGY & ACTIVITY**

- Weakness
- Fatigue
- Apathy, lethargy
- Attention deficit (ADHD)
- Hyperactivity
- Restlessness
- Cravings for sweets
- Anemia

**EMOTIONS**

- Mood swings
- Anxiety, fear
- Irritability, anger
- Depression
- Aggressiveness
- Nervousness

**WEIGHT**

- Binge eating
- Food cravings
- Excessive weight
- Compulsive eating
- Water retention
- Underweight

**OTHER**

- Frequent illnesses
- Diabetes
- Liver trouble
- Thyroid trouble
- Tumors/lumps
- Cancer

DOCTOR'S NOTES: \_\_\_\_\_

# PATIENT AGREEMENT

Your insurance plan, managed care program, or third party payor provides a limited range of benefits compared to the services available at this office. Your carrier provides coverage for "medically necessary" services as defined by them, for coverage or "eligible" benefits. In other words, no insurance carrier pays for everything. If possible, when the services you receive at this office exceed the covered or eligible benefit limits, or fall outside the payor's definition of "medically necessary" we will attempt to inform you in advance. Please understand that it is virtually impossible to predict in advance, given the literally hundreds of plans in existence today, what the insurance company will or will not pay. We will certainly comply with our contractual obligations when they exist, and apply the "appropriate" write-offs and fee reductions, but we make no representation that all services will be covered. As such you are responsible for anything not covered by the carrier that exceeds the benefits described in the insurance booklet provided by your employer or health carrier. We recommend you become familiar with your benefits so there are no surprises for either of us. We will check your benefits and communicate them to you, but you realize that you are responsible for understanding your benefits.

***The following is a partial list of the services generally available at this office. Most insurances pay for spinal manipulation to some degree, but the benefits vary. The other services may or may not be covered. Again, check your insurance booklet for a listing of available benefits.***

Exams, therapies, spinal manipulation, supplements, orthotics/pillows/supports, ice packs, maintenance or supportive care, physical therapy modalities, rehab, Kinesio Taping, Graston Technique and many other services too numerous to list here.

***There are numerous reasons for possible denial by your insurance company. Examples include:*** No referral from primary care provider, care deemed "not medically necessary", no prior authorization was obtained, treatment extends beyond initial allowance, etc. There are literally hundreds of reasons which your insurance company may give for denial of benefits. As always, we honor our contract with the carriers and apply the appropriate write-offs, but no insurance company pays for everything and you should become familiar with your benefit package.

## PATIENT AGREEMENT & ACCEPTANCE OF LIABILITY

As you know, our office participates with many third party payor programs and as a result it becomes virtually impossible to predict in advance your available benefits. By signing this agreement you acknowledge that it remains your responsibility to understand your benefits, and it remains our responsibility to comply with any contract we have with certain carriers. As such, we will apply the appropriate reductions and write-offs for "covered benefits" only. **You must pay for all appropriate co-pays, deductibles, and non-covered benefits.** Additionally, you agree that you have been notified that your carrier might deny payment for the services identified above. If your carrier denies payment for any reason, you agree to be personally and fully responsible for payment. If you do not have any insurance coverage, you agree that you are personally and fully responsible for payment. I authorize the use of my signature on all insurance submissions and assign benefits to HCC.

**Missed Appointments:** If a patient fails to attend a scheduled appointment and/or does not give a 24 hours notice of cancellation a \$25.00 fee will be charged. This is the patient's responsibility and cannot be billed to the insurance company.

**24-Hour Cancellation Policy:** If you are unable to keep the appointment you have reserved, please call with more than 24 hours notice to avoid being charged. Please call the office phone number to cancel as other methods of communication will not be accepted. Appointments cancelled with less than 24 hours notice will be charged the rate of \$25. Dr. Royer may waive fees in advance if there may be a possible schedule conflict or for another reason.

**Delayed Payment Charge:** A \$5 fee will be added to your account if payment is not received within 30 days and an additional \$5 fee will be added automatically every month until payment is received. A late fee is merely reimbursement of the costs of collection. This fee will be waived if details are worked out in advance with Dr. Royer and/or if you are still treating with Harmony Chiropractic Center, Inc.

**Returned Checks:** There will be a \$30.00 charge for all returned checks.

**Collection Costs:** If your account is sent to collections, the responsible party will pay all collection fees, court fees, doctor's fees for any written documentation or correspondence, legal appearances (\$300 per hour), attorney's fees or any other fees related to collection on this account. By signing, I also agree and understand that Harmony Chiropractic Center, Inc. may use and disclose all pertinent information to the collection agency in order to collect the balance due. Our office is not required to send statements for unpaid balances more than 60 days past due. After 60 days, unpaid account balances may be forwarded to a collection agency.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient's Signature (Parent or Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

## HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review Harmony Chiropractic Center, Inc.'s Notice of HIPAA Privacy Practices for protected health information. I acknowledge this is available on HCC's website and at the front desk.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient's Signature (Parent or Guardian)

\_\_\_\_\_  
Date

# INFORMED CONSENT



Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent. Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently, adjustments create a "pop" or "click" sound/sensation in the area being treated. In this office, we use trained staff personnel to assist the doctor with portions of your consultation, examination, physical therapy application, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Patient Initials

**STROKE:** Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The most recent studies (Journal of the CCA, Vol. 37 No. 2 June, 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

**DISC HERNIATIONS:** Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. Rarely chiropractic adjustments may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

**SOFT TISSUE INJURY:** Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

**RIB FRACTURES:** The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

**PHYSICAL THERAPY BURNS:** Some of that machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin had different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify the probability.

**SORENESS:** It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell you doctor about it.

**OTHER PROBLEMS:** There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

**NOT FOLLOWING TREATMENT PLAN:** Failure to adhere to the treatment prescribed by your doctor will negatively impact your recovery. It is very detrimental to your health if you do not attend your appointments or if you do not perform exercises as instructed. Attending your appointments with the recommended frequency can help you to continue your progress, prevent a relapse and even help avoid problems in the future.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient's Signature (Parent or Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

Harmony Chiropractic Center, Inc.

5800 Monroe St. A11

Sylvania, OH 43560

419-517-5055