PATIENT INFORMATION

First Name _____ Last Name _____

Gender ☐ M ☐ F Date of Birth _____ /_____ /_____ Age _____

Home Address _____

City _____ State _____ Zip Code _____

Phone _____ ☐ W ☐ H ☐ C 2nd Phone _____ ☐ W ☐ H ☐ C

Email _____

What is your preferred method of communication? ☐ Phone ☐ Text ☐ Email

Employer _____

Work Address _____

City _____ State _____ Zip Code _____

Emergency Contact _____ Phone _____ ☐ W ☐ H ☐ C

→ _____ _____

(Patient or Legal Guardian Signature) (Date)

The Corporate CHIROPRACTOR
Chiropractic Care at Your Convenience

PATIENT HISTORY

Name _____ Age _____ Date of Birth _____/_____/_____ Gender ☐ M ☐ F

Height _____ft._____in. Weight _____lbs. Occupation _____ For how long? _____yrs. _____mos.

1. Have you had chiropractic care before? ☐ Yes ☐ No If yes, how recently? _____

2. Reason for today's visit:

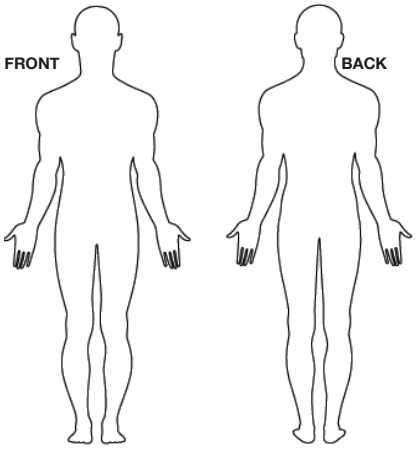
☐ Pain ☐ Discomfort ☐ Stiffness ☐ Maintenance Care ☐ Recent Injury ☐ Previous Injury ☐ Other _____

3a. When did your complaint(s) first begin? _____ 3b. Today, is the condition: Same ☐ Better ☐ Worse

Explain what helps and/or worsens the condition: _____

	4. Where is/are your area(s) of complaint today? Check all that apply	Rate pain and discomfort between 1-10 (1 = minimal, 10 = severe)	Check off the type of Complaint: Radiating	Sharp	Dull	Tingling	Numbnes	Burning	Inflamed/ swollen	Frequency: Constant	Intermittent
☐	Headache/Migraine										
☐	Neck										
☐	Shoulder(s)										
☐	Arm(s)										
☐	Elbow(s)										
☐	Wrist(s)										
☐	Upper Back										
☐	Middle Back										
☐	Lower Back										
☐	Hip(s)										
☐	Sciatica										
☐	Knee(s)										
☐	Ankle(s)										
☐	Other										

5. Use the figures below to place an "X" on any specific area(s) where you are experiencing pain, discomfort or limited range of motion.



For Clinic Use Only: BP: _____ / _____

6. Have you experienced this/these complaint(s) before? ☐ Yes ☐ No

if yes, when? _____

7. Are you pregnant? ☐ Yes ☐ No ☐ N/A If yes, how many weeks? _____

8. Are you currently experiencing any of the following:

☐ Nausea or vomiting ☐ Rapid eye movement ☐ Numbness on one side of the face or body ☐ Fainting or lightheadedness ☐ Dizziness

☐ Difficulty walking ☐ Difficulty speaking ☐ Headache or neck pain ☐ Difficulty swallowing ☐ Double vision

(If yes to any, please describe) _____

9. Current prescriptions or over-the-counter medications: _____

PAST HISTORY: MUSCULOSKELETAL CONDITIONS (please check all that apply)

☐ Headaches/Migraines
☐ Neck Pain/Discomfort
☐ Shoulder Pain/Discomfort
☐ Upper Back Pain/Discomfort
☐ Middle Back Pain/Discomfort
☐ Low Back Pain/Discomfort
☐ Inflammation/Swelling; where _____
☐ Hip Pain/Discomfort
☐ Sciatica
☐ Elbow Pain/Discomfort
☐ Wrist Pain/Discomfort
☐ Knee Pain/Discomfort
☐ Ankle Pain/Discomfort
☐ Arthritis
☐ Fused/Fixated Joints
☐ Herniated Disc
☐ Joint Replacement
☐ Osteoporosis
☐ Osteopenia

OTHER CONDITIONS

☐ Cancer
☐ Tumors
☐ Stroke
☐ Seizure Disorders
☐ High Blood Pressure
☐ Pacemaker
☐ Allergies
☐ Other _____
☐ Heart Disease
☐ AIDS/HIV
☐ Diabetes
☐ Hepatitis
☐ Tuberculosis
☐ Hernia

10. Indicate if you have experienced any of the following and mark how recently.

Surgeries?	☐ Yes ☐ No →	☐ Less than 1 month	☐ 1-6 months	☐ 6-12 months	☐ More than 12 months	_____ yrs.
Accidents/Broken Bones?	☐ Yes ☐ No →	☐ Less than 1 month	☐ 1-6 months	☐ 6-12 months	☐ More than 12 months	_____ yrs.
Hospitalizations?	☐ Yes ☐ No →	☐ Less than 1 month	☐ 1-6 months	☐ 6-12 months	☐ More than 12 months	_____ yrs.

If yes to any, list and describe _____

11. Family Health History: (check all that apply) ☐ Cancer ☐ Tumors ☐ Stroke ☐ Seizures ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease

_____ _____

(Patient or Legal Guardian Signature) (Date)

PATIENT ACTIVITY ASSESSMENT FORM

The Corporate CHIROPRACTOR
Chiropractic Care at Your Convenience

Name _____ Today's Date _____/_____/_____

Occupation _____ Age _____

The purpose of this form is to assist the doctor in better understanding your daily activities, your ability to perform them, and how they relate to the function of your body. Your answers will provide important information in establishing a customized plan of care designed to place you on the path toward attaining and maintaining your health care goals.

STANDING OR SITTING

Do you primarily stand or sit at work: ☐ Stand ☐ Sit

Approximately how many hours per week:

☐ 0-20 hours ☐ 20-40 hours ☐ 40+ hours

Are those hours primarily spent:

On the phone:

☐ Cell ☐ Desktop Phone ☐ Headset ☐ No headset

Typing at a keyboard:

☐ Laptop ☐ Desktop computer

☐ Other: _____

What is your most common posture:

☐ Sitting upright ☐ Slouched ☐ Crossed legs ☐ Stand

Does your work require you to:

☐ Bend ☐ Twist ☐ Lift ☐ Carry ☐ N/A

What type of shoes do you wear on a regular basis:

☐ Dress ☐ Heels ☐ Running ☐ Boots ☐ Athletic ☐ Sandals

☐ Other: _____

Do you wear orthotics: ☐ Yes ☐ No

SLEEPING

What type of bed do you sleep in:

☐ Memory foam ☐ Adjustable Firmness ☐ Inner spring

☐ Other: _____

How many hours of sleep do you get per night: ☐ 8 hrs or less ☐ More than 8 hrs

What position do you sleep in: ☐ Back ☐ Stomach ☐ Side ☐ All

Do you regularly wake up with any back stiffness: ☐ Yes ☐ No

Do you regularly wake up with any neck stiffness: ☐ Yes ☐ No

BODY STRESSORS

Do your daily activities require you to lift and/or carry objects: ☐ Yes ☐ No

If yes, how often:

☐ Occasionally ☐ Frequently ☐ Constant

If yes, approximately, how heavy:

☐ 10 lbs or less ☐ 10-30 lbs ☐ More than 30 lbs.

Do you exercise: ☐ Yes ☐ No

If yes, approximately how many days per week:

☐ 0-1 day(s) ☐ 1-3 days ☐ 3+ days

Type(s) of exercise:

Weight training:

☐ Free weights ☐ Machines ☐ Other: _____

Cardio training:

☐ Elliptical ☐ Treadmill/Running ☐ Other: _____

Do you participate in sports: ☐ Yes ☐ No

If yes, please indicate all that apply:

☐ Football ☐ Basketball ☐ Skiing ☐ Body building ☐ Soccer

☐ Tennis ☐ Walking/Hiking ☐ Volleyball ☐ Racquetball ☐ Yoga

☐ Dancing ☐ Cycling/biking ☐ Golf

☐ Other _____

Do you have children at home? ☐ Yes ☐ No

If yes, how many? ☐ 1 ☐ 2-3 ☐ More than 3 _____

Do any of your children require you to carry them? ☐ Yes ☐ No

CHIROPRACTIC ACTIVITY ASSESSMENT

Did You Know: the absence of pain is not an indication of health? ☐ Yes ☐ No

Did You Know: pain has a cause and many times that cause begins in the spine? ☐ Yes ☐ No

Did You Know: over-the-counter pain medications and / or prescriptions may only mask the pain? ☐ Yes ☐ No

Did You Know: your daily activities can cause joint pain and dysfunctions in the spine and extremities? ☐ Yes ☐ No

Did You Know: these joint dysfunctions can cause decreased joint motion and function in the body? ☐ Yes ☐ No

Did You Know: decreased joint motion can also affect your ability to enjoy a healthy and active lifestyle? ☐ Yes ☐ No

Did You Know: the health benefits of routine chiropractic care ☐ Yes ☐ No

1) Improved nerve communication
2) Improved joint motion
3) Improved joint coordination
4) Improved physical function
5) Improved physical performance
6) Improved posture
7) Increased daily activity
8) Provide pain and stress relief

Our mission is simple: "To improve quality of life through routine and affordable chiropractic care." We congratulate you on your decision to invest in yourself and commitment towards achieving improved joint function and healthier, more active lifestyle. Our journey towards that goal begins here.

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARILY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

(Print Name)

(Signature) (Date)

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW

PARENT/GUARDIAN'S NAME **DATE**

RELATIONSHIP TO MINOR/CHILD **DATE**

WITNESS SIGNATURE (OFFICE STAFF)

TERMS OF ACCEPTANCE

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine

B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functionsthrough the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.

C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.

D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.

E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic.

G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

H. This office utilizes an “open-adjusting” environment for ongoing patient care. “Open adjusting” involves several patients being seen in the same room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patient’s and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private and confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment, other arrangements will be made for you.

By my signature below, I have read and fully understand the above statements.
All questions regarding the doctor’s objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

→ _____ _____

(Patient or Legal Guardian Signature) (Date)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose, to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

→ _____ _____

(Patient or Legal Guardian Signature) (Date)

