

# Spine and Wellness Center, LLC

## Patient Information Form

Today's Date \_\_\_/\_\_\_/\_\_\_

Title (please circle) Mr. Ms. Mrs. Miss. Dr. Rev. Prof. Other

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

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

Phone (Home) \_\_\_\_\_ Phone (Cell) \_\_\_\_\_ Phone (Work) \_\_\_\_\_

Email address \_\_\_\_\_

Sex M F	Married Widowed	Single Divorced	Date of Birth / /	Social Security Number - -
Patient's Employer's Name _____ Address _____ City _____ State _____ Zip _____ Phone _____ Occupation _____			Employed Full Time Part Time Retired Not Employed  Student Full Time Part Time	

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

No. Children \_\_\_\_\_

### How did you hear about our office? (please circle)

Family Friend Internet Yellow Pages Drove By Physician Insurance Plan

**Insurance:** Please provide your current insurance card to the receptionist and we will verify it to see if covers chiropractic.

### Automobile Accident/Worker's Compensation Only

Insurance Company _____	Claim # _____	Policy # _____
Address _____	City _____	State _____ Zip _____
Adjusters Name _____	Phone _____	
Attorney's Name _____	Contact Name _____	
Address _____	City _____	State _____ Zip _____
Phone _____		

### In case of Emergency:

Who should we contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

### Please List Medical Doctors:

\_\_\_\_\_  
Phone: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_

### Release and Assignment

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

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

## Patient Health History

Are you taking any of the following medications? (please circle)

Pain Medication (including aspirin)    Muscle Relaxers    Anti-Inflammatory    Muscle Relaxers  
 Blood Thinners    Insulin    Other \_\_\_\_\_

1. Have you ever had pain like this before? YES/NO

If yes, please explain: \_\_\_\_\_

2. Was the injury accident related? \_\_\_Auto \_\_\_Work    When? \_\_\_\_\_

3. Has your condition affected your daily activities? YES/NO

If yes, please explain: \_\_\_\_\_

4. Have you lost work days? YES/NO    How many? \_\_\_\_\_

5. Has there been any changes in your bodily function? YES/NO

If yes, please explain: \_\_\_\_\_

6. Name other Doctors you have seen for this condition: \_\_\_\_\_

7. What surgeries have you had in the past? \_\_\_\_\_

8. What are your health goals? \_\_\_\_\_

How do you expect to achieve these goals? \_\_\_\_\_

Do you: (please circle) Take Supplements    Exercise    Smoke - How much per day \_\_\_\_\_    Special Diet

Are you wearing: \_\_\_Heal Lifts    \_\_\_Sole Lifts    \_\_\_Inner Soles    \_\_\_Arch Supports

What is the age of your mattress? \_\_\_\_\_

### Please mark if you have had any of these symptoms in the last 12 months

<input type="checkbox"/> Fractured Bones	<input type="checkbox"/> Neck Pain or Stiffness <b>R/L</b>	<input type="checkbox"/> Numbness, tingling, pain in Buttocks, legs, feet or toes <b>R/L</b>
<input type="checkbox"/> Auto Accidents ___ 0-1 years ago ___ 1-5 years ago ___ 5 or more	<input type="checkbox"/> Numbness, tingling, Pain in Arms, Hands, Fingers <b>R/L</b>	<input type="checkbox"/> Difficulty in Excessive Standing, Sitting, Riding, Bending, Lifting, or Twisting <b>R/L</b>
<input type="checkbox"/> Foot Trouble <b>R/L</b>	<input type="checkbox"/> Chest Pain, Asthma	<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Jaw Pain or Click(TMJ) <b>R/L</b>	<input type="checkbox"/> Other accidents or falls	<input type="checkbox"/> Stroke
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Shoulder pain <b>R/L</b>
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Liver Trouble
<input type="checkbox"/> Convulsions, Epilepsy	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Gall Bladder Trouble
<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Ringing in Ears <b>R/L</b>	<input type="checkbox"/> Digestive Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hearing Loss <b>R/L</b>	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Frequent Colds, Flu	<input type="checkbox"/> Blurred or Double Vision <b>R/L</b>	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Depressed	<input type="checkbox"/> Upper Back Pain or Stiffness	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Irritable	<input type="checkbox"/> Lower Back Pain or Stiffness	<input type="checkbox"/> Impotence
<input type="checkbox"/> Anemia	<input type="checkbox"/> Pain with Cough, Sneeze	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Allergy or Sinus Problems	<input type="checkbox"/> Hip Pain <b>R/L</b>	<input type="checkbox"/> Menstrual Problems, PMS
<input type="checkbox"/> Under Stress	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pregnant Now
<input type="checkbox"/> Eating Disorder		<input type="checkbox"/> Taking Birth Control
<input type="checkbox"/> Trouble Sleeping		<input type="checkbox"/> Ear Infections
<input type="checkbox"/> Learning Disability		<input type="checkbox"/> AIDS, HIV
<input type="checkbox"/> Mood Changes	<input type="checkbox"/> Other	<input type="checkbox"/> Bedwetting

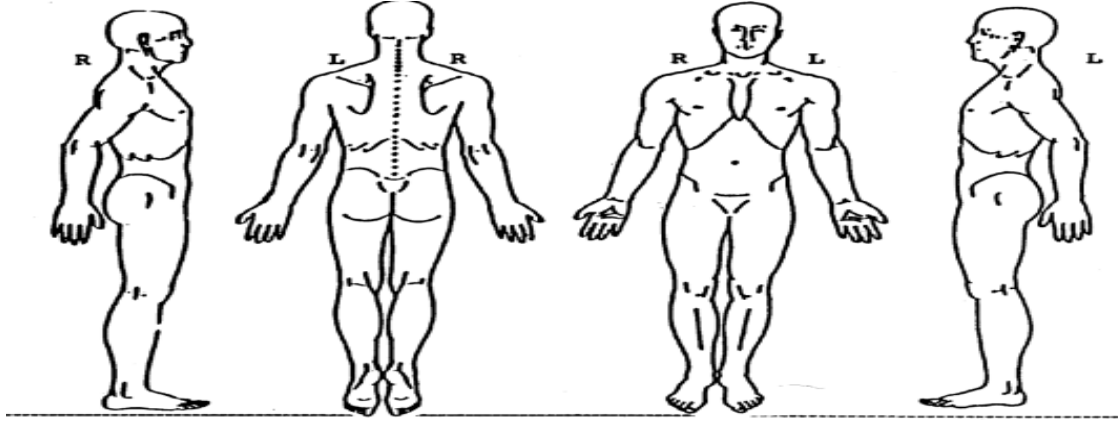
Family Health History: \_\_\_\_\_

# CHIEF COMPLAINT

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

What is your Major Complaint \_\_\_\_\_

## Site Please Circle Location of Your Pain



1. Do you have any other health problems that concern you?

2nd Complaint: 2. \_\_\_\_\_

3rd Complaint: 3. \_\_\_\_\_

4th Complaint: 4. \_\_\_\_\_

## Onset

1. When did complaint start? Date \_\_\_\_\_ GRADUALLY / SUDDENLY

2. Did anything cause or contribute to the onset? YES / NO

If yes please explain: \_\_\_\_\_

## Provoking & Palliative

1. What makes your condition worse? \_\_\_\_\_ Nothing \_\_\_\_\_ Lifting \_\_\_\_\_ Trying to Stand \_\_\_\_\_ Standing  
\_\_\_\_\_ Walking \_\_\_\_\_ Sitting \_\_\_\_\_ Movement \_\_\_\_\_ Exercise \_\_\_\_\_ Inactivity \_\_\_\_\_ Work Activities  
Other \_\_\_\_\_

2. What makes your condition better? \_\_\_\_\_ Nothing \_\_\_\_\_ Standing \_\_\_\_\_ Walking \_\_\_\_\_ Sitting  
\_\_\_\_\_ Movement \_\_\_\_\_ Exercise \_\_\_\_\_ Inactivity \_\_\_\_\_ Lying Down \_\_\_\_\_ Sleep \_\_\_\_\_ Hot Shower  
\_\_\_\_\_ Stretching Other \_\_\_\_\_

## Quality

1. Describe the sensation you feel. (Sharp, Dull, Burning, Throbbing, Etc) \_\_\_\_\_

2. Please rate your Pain. No pain 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Extreme Pain

## Radiating

1. Does your pain radiate to any other part of your body? Y/N Do you experience Numbness/Tingling? Y/N  
If yes please explain: \_\_\_\_\_

## Timing

1. Is your pain Constant – YES / NO Since when: \_\_\_\_\_

2. Is your pain Intermittent – YES / NO Frequency \_\_\_\_\_ Times Per Week \_\_\_\_\_ Hrs/Days

## Terms of Acceptance/Consent to Treatment

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working toward the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion and disappointment.

**Health:** A state of optimal physical, mental, and social well-being, not merely the absence of disease.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

**Adjustment:** The specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of is by specific adjustment of the spine.

**Potential Risks:** *The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.* While rare, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to: sprains/strains, increased symptoms and pain or no improvement of symptoms or pain, fractures, disc injuries, strokes, dislocations, and serious neurological impairment.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations or neuromusculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

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 on the facts then known, is in my best interest. I further Acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I, \_\_\_\_\_, have read and fully understand the above statement. I have also had an opportunity to ask questions and all my questions have been answered fully and satisfactorily. By signing below, I consent to treatment. 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 care.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

### Consent to evaluate and adjust a minor child (for treatment of a child under 18yrs).

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

## POLICIES

- All first visit charges are payable when services rendered unless other arrangements have been made.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Spine and Wellness Center, LLC will prepare all necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Spine and Wellness Center, LLC will be credited to my account upon receipt. *However*, I clearly understand and agree that all my services rendered me are charged directly to me and that I am personally responsible for payment.

*I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.* I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_