PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: _____ PT. NUMBER: _____

PATIENT NAME: _____ _____ _____
LAST FIRST MI

DATE OF BIRTH: _____/_____/_____ AGE: _____ SEX: M F

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

PHONE #: (_____) _____-_____ E-MAIL: _____ MAY WE LEAVE A MESSAGE? **Y / N**

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

PRIMARY CARE DOCTOR: _____ WHO REFERRED YOU TO US? _____

INSURANCE INFORMATION

ARE YOU ELIGIBLE FOR MEDICARE AND/OR MEDICAID? **YES NO**

PRIMARY INSURANCE COMPANY NAME: _____

INSURED NAME: _____ DATE OF BIRTH _____

MEMBER # _____ GROUP # _____ EMPLOYER _____

GENERAL HISTORY

LIST ALL SURGERY AND/OR HOSPITALIZATIONS INVOLVING YOUR **HEAD, NECK, SPINE, HIPS**

_____ _____
_____ _____
_____ _____

PLEASE LIST CURRENT MEDICATIONS

_____ _____
_____ _____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

EMPLOYER: _____ OCCUPATION: _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS ☐ OTHER _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

WHAT PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

HAVE YOU SOUGHT OR BEEN TREATED FOR THIS CONDITION BY ANOTHER DOCTOR/CHIROPRACTOR? **YES** **NO**

IF YES, BY WHOM? _____ WHEN? _____

IS THIS A REOCCURRING PAIN/PROBLEM? YES / NO WHEN DID IT BEGIN/START AGAIN? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES: _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

BRIEFLY DESCRIBE YOUR PAIN/PROBLEM: CHECK ALL THAT APPLY.

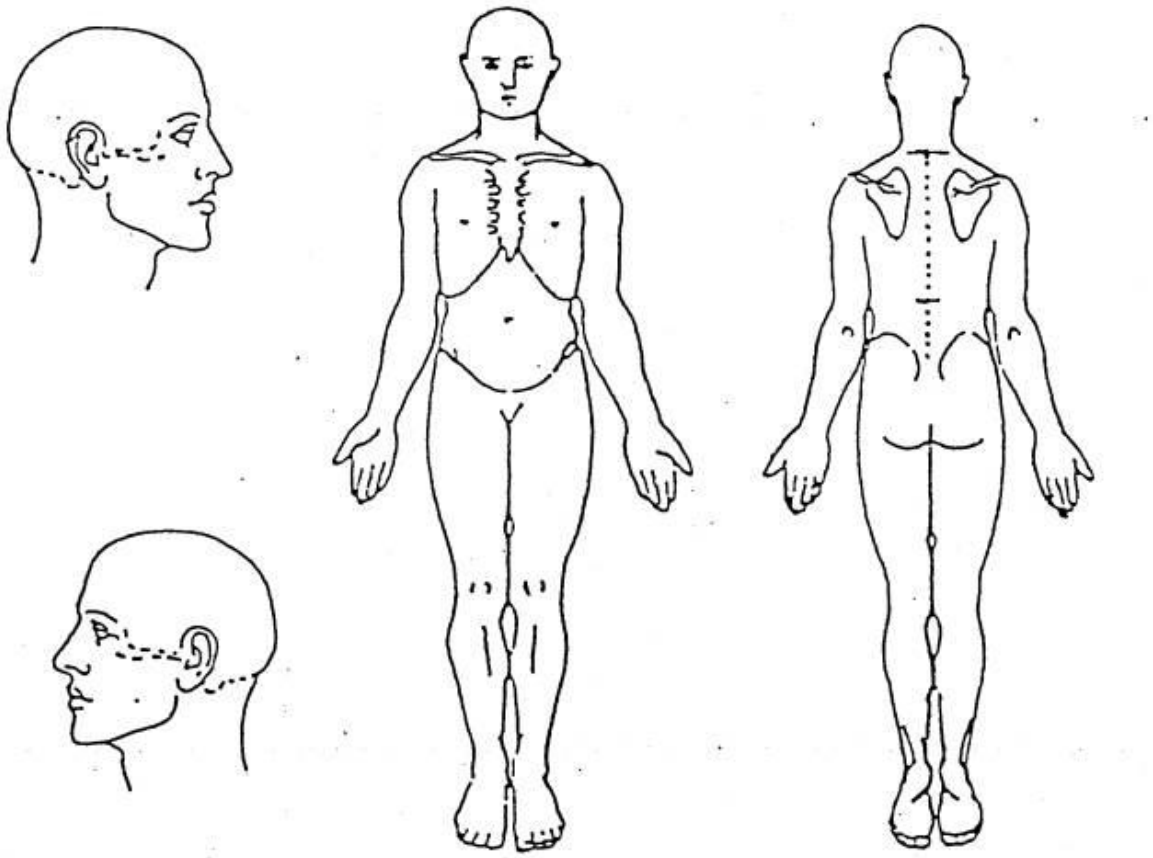
1. ☐ BEGAN ALL OF A SUDDEN ☐ GRADUALLY DEVELOPED OVER TIME
2. ☐ SHARP ☐ DULL ☐ RADIATING ☐ STABBING ☐ ACHING ☐ BURNING ☐ OTHER: _____
3. ☐ PAIN HAS STAYED THE SAME ☐ BECAME WORSE ☐ IMPROVED
4. FEELS WORSE BY: ☐ STANDING/WALKING/RUNNING ☐ RESTING (SITTING, LAYING DOWN) ☐ DAILY ACTIVITIES
5. FEELS BETTER BY: ☐ ICE ☐ SITTING ☐ RESTING ☐ STRETCHING ☐ OTHER: _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

ADDITIONAL DETAILS: _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____

PATIENT SIGNATURE (GUARDIAN) DATE

INSURANCE POLICY

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THIS OFFICE WILL PREPARE THE NECESSARY REPORT AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I PERMIT THIS OFFICE TO ENDORSE COUPLE ISSUED REMITTANCE FOR THE CONVENIENCE OF CREDIT TO MY ACCOUNT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL 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 AND TREATMENT ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE. I UNDERSTAND THAT INTEREST OF 1 ½% PER MONTH WILL BE CHARGED ON ACCOUNTS 30 DAYS PAST DUE. I WILL BE RESPONSIBLE FOR ALL THE ATTORNEY'S FEES, INTEREST AND OTHER COSTS INCURRED IN FLEXION MY ACCOUNT.

_____ _____

PATIENT SIGNATURE (GUARDIAN) DATE

I ACKNOWLEDGED THAT I WAS PROVIDED A COPY OF THE NOTICE OF THE PRIVACY PRACTICES AND THAT I HAVE READ THEM OR DECLINED TO UNITY TO READ THEM AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT THIS FORM WILL BE PLACED IN MY PATIENT CHART AND MAINTAIN FOR SIX YEARS.

_____ _____

PRINT PATIENT NAME DATE

_____ _____

PATIENT SIGNATURE (GUARDIAN) DATE

_____ _____

SIGNATURE OF DOCTOR DATE

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- Broken bones
- increased symptoms and pain
- Dislocations
- No improvement of symptoms or pain
- Sprains/strains
- Infection (acupuncture)
- Burns or frostbite (physical therapy)
- Punctured lung (acupuncture)
- Worsening/aggravation of spinal conditions
- Other

In rare cases there have been reported complications of arterial dissections (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

Dr. Michael K. Roberts

_____ _____
doctor signature date