**Patient Information**

Patients Name: First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_ Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthday: \_\_\_/\_\_\_/\_\_\_\_\_\_\_ Age: \_\_\_\_ Gender: Male Female Patient’s SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt. \_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact – Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Parent/Spouse Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday: \_\_\_/\_\_\_\_/\_\_\_\_\_\_

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

**Authorization**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize ChiroSport, PC to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such chiropractic care to third-party payers and/or health practitioners. I authorize and request my insurance company to pay directly to ChiroSport, PC insurance benefits that would otherwise be payable to me. I understand that my chiropractic insurance carrier may pay less than the full fee for services. I agree to be responsible for payment for all services rendered for myself and/or my dependents.

Patient Signature (or parent if a minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Treatment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize the doctors at ChiroSport P.C. (and whomever they may designate as their assistant(s) to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collections 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 will permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient Signature (or parent if a minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement & Receipt of Privacy Practices**

I have received a copy of ChiroSport P.C.’s Notice of Privacy Practices with an effective date of January 1, 2004.

Patient Signature (or parent if a minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

**ChiroSport, P.C. Financial Policy**

Dear Patient:

Thank you for choosing us as your health care provider. The following is our financial policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. If you have any questions or concerns about our payment policies, please do not hesitate to contact our office manager.

We ask that you read and sign our Financial Policy prior to seeing the doctor.

In special circumstances, we may accept an assignment of insurance benefits. However, you must understand that:

1. **Your insurance policy is a contract between you, your employer, and the insurance company.**

**ChiroSport, PC is NOT a party to that contract. ChiroSport, PC’s relationship is strictly with you, not the insurance company.**

1. **All charges will be the patient’s responsibility whether the insurance company remits payment or not. Certain services may not be covered. Fees for these services will then become the patient’s responsibility. We will attempt to make you aware of these situations as soon as possible.**
2. **Co-payments and co-insurance are due at the time of service. We accept cash, checks, Visa, MasterCard, and Discover. If you would like your claim processed through insurance, please make sure to provide proper insurance information.**
3. **If the insurance company has not paid your balance in full within 30 days, we will ask that you contact the carrier to help speed up the process.**
4. **If the insurance company has not paid in full within 45 days, you may be responsible for the balance due.**
5. **A 1.5% monthly interest charge may be applied to all balances exceeding 90 days.**

If a financial hardship occurs, we encourage you to communicate with us so that we may assist you in the management of your account.

Thank you for choosing ChiroSport, PCas your health care provider. We know you had many providers to choose from and we appreciate your trust in us and the opportunity to serve you.

Patient Signature (or parent if a minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

**Consent Form**

To the patient: please read the entire document prior to signing it. It is crucial that you understand the information contained within this document and we address any questions or concerns prior to signing.

**The material risk inherent in chiropractic adjustment:**

As with any healthcare procedure, certain complications may arise during chiropractic manipulation and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costal vertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to or contributing to serious complications, including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care. However, if you have a condition that would otherwise not come to the doctor's attention, it is your responsibility to inform them.

**The probability of those risks occurring:**

Fractures are rare occurrences and generally results from an underlying weakness of the bone. Screening for this will occur during the examination, health history check, and/or x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The remaining complications are also generally described as rare.

**Do not sign until you have read and understand the above. Please check the appropriate block and sign below**

**I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I discussed it with Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and have had my questions answered to my satisfaction. By signing below, I state that I weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risk, I hereby give my consent to treatment.**

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

Patient Signature (or parent if a minor) Date Doctor’s Signature Date

**Current Patient Condition**

Reason for visit and/or area of concern: When did symptoms appear?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Circle all that apply for the following questions:*

1. Progression of pain? Getting better Getting worse Unchanging Unknown
2. Type of pain? Sharp Dull Throbbing Numbness Aching Shooting Burning

 Tingling Cramps Stiffness Swelling Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Frequency of pain? Constant (100%) Frequent (75%) Occasional (25%) Intermittent (<25%)
2. What does it interfere with? Work Sleep Daily Routine Recreation
3. Movements that are painful? Sitting Standing Walking Bending Laying Other: \_\_\_\_\_\_\_
4. Rate your pain (10 being the worst): 1 2 3 4 5 6 7 8 9 10

**Pain Diagram**

Use the following letters to mark the characteristics of your pain:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| S=sharp | A=aching | B=burning | N=numbness/tingling | T=tight/stiff |



**Health Information**

Height: \_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_ Pregnant? \_\_\_\_\_ Recovering from cold/flu? \_\_\_\_\_\_\_\_

Laboratory procedures performed (e.g., stool analysis, blood/urine chemistries, bone density, saliva):

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

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

Outcomes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of medical treatment have you tried for this problem(s)? – circle all that apply:

PCP/Internist Orthopedist Neurologist Neurosurgeon Physiatrist Podiatrist Chiropractic Physical Therapy Acupuncture Homeopathy Vitamins/Minerals Diet Modification Conventional Drugs Herbs Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practitioner Name/Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Current health issues for which you are being treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Major hospitalizations, surgeries, and injuries, including any complications and dates:

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

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

Stress level 1-10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify major causes of stress (e.g., work, family, finances, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consider yourself – circle one: Underweight Overweight Just Right

Have you had an unintentional weight loss/gain for 10 pounds or more in the last 3 months? Yes No

Is your job associated with potentially harmful chemicals (pesticides, radioactivity, solvents, etc) or health and/or life-threatening activities (fireman, farmer, etc.)? Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you experience any of these general symptoms EVERYDAY? – circle all that apply:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Shortness of Breath | Low Grade Fever | Diarrhea | Bleeding | Nausea |
| Fecal Incontinence | Constipation | Headaches | Discharge | Vomiting |
| Urinary Incontinence | Itching/Rash | Chronic Pain/Inflammation | Insomnia | Dizziness |
| Medical History |  | Menstrual irregularities | Food Frequency (servings/day) |
|  | Arthritis |  | Premenstrual syndrome | Fruit: \_\_\_\_\_\_\_\_\_ |
|  | Allergies/hay fever |  | Vaginal infections | Dark green veggies: \_\_\_\_\_\_\_\_ |
|  | Alcoholism |  | Birth control (form: \_\_\_\_\_\_\_\_\_\_\_\_\_) | Grains (unprocessed): \_\_\_\_\_\_\_\_ |
|  | Alzheimer’s disease |  | Number of children: \_\_\_\_\_\_ | Beans, peas, legumes: \_\_\_\_\_\_\_\_ |
|  | Autoimmune disease |  | Number of pregnancies: \_\_\_\_\_\_ | Dairy, eggs: \_\_\_\_\_\_\_\_ |
|  | Blood pressure issues |  | C-section | Meat, poultry, fish: \_\_\_\_\_\_\_\_ |
|  | Bronchitis |  | Surgical menopause | Eating Habits |
|  | Cancer |  | Menopause |  | Skip breakfast |
|  | Chronic fatigue syndrome | Information on Cycle |  | 2 meals per day |
|  | Carpal tunnel syndrome |  | Changes in normal flow |  | 1 meal per day |
|  | Cholesterol issues | Date of last menstrual period: \_\_\_\_\_\_\_\_ |  | Graze (small frequency meals) |
|  | Circulatory issues | Length of cycle: \_\_\_\_\_\_\_\_\_\_\_ |  | Eat on the go |
|  | Colitis | Interval between cycles: \_\_\_\_\_\_\_\_\_\_ |  | Add salt to food |
|  | Dental issues | Family Health History | Supplements |
|  | Diverticular disease |  | Alcoholism/drug addiction |  | Multivitamin |
|  | Drug addiction |  | Alzheimer’s disease |  | Vitamin C |
|  | Depression |  | Arthritis |  | Vitamin E |
|  | Diabetes |  | Asthma |  | EPA/DHA |
|  | Eating disorder |  | Cancer |  | Calcium (source: \_\_\_\_\_\_\_\_\_\_\_\_\_) |
|  | Epilepsy |  | Depression |  | Magnesium |
|  | Emphysema |  | Diabetes |  | Zinc |
|  | Ear/eye/nose/throat issues |  | Glaucoma |  | Minerals (list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
|  | Environmental sensitivities |  | Heart disease |  | Friendly flora (acidophilus) |
|  | Fibromyalgia |  | Infertility |  | Digestive enzymes |
|  | Food intolerance |  | Learning disabilities |  | Amino acids |
|  | Gastroesophageal reflux disease |  | Mental illness/suicide |  | CoQ10 |
|  | Genetic disorder |  | Migraine headaches |  | Antioxidants (lutein, resveratrol, etc.) |
|  | Glaucoma |  | Neurological disorders |  | Herbs |
|  | Gout |  | Obesity |  | Protein shakes |
|  | Heart disease |  | Stroke |  | Super foods |
|  | Irritable bowel syndrome | Health Habits |  | Liquid meals |
|  | Kidney/bladder disease/stones |  | Beer: # glasses / day/week: \_\_\_\_\_\_\_ |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Mental illness |  | Coffee: # 6oz. cup/day: \_\_\_\_\_\_\_ | Would you like to: |
|  | Migraine headaches |  | Liquor: # oz. / day/week: \_\_\_\_\_\_\_\_ |  | Have more energy |
|  | Neurological disorders |  | Soda: # can/day: \_\_\_\_\_\_\_ |  | Sleep better |
|  | Thyroid issues |  | Tea: # 6oz. cup/day: \_\_\_\_\_\_\_ |  | Be stronger |
|  | Obesity |  | Tobacco: # / day: \_\_\_\_\_\_\_ |  | Have more endurance |
|  | Osteoporosis |  | Water: # oz. / day: \_\_\_\_\_\_\_\_ |  | Increase your sex drive |
|  | Pneumonia |  | Wine: # glasses / day/week: \_\_\_\_\_\_ |  | Be thinner |
|  | Sexually transmitted infection |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Be more muscular |
|  | Seasonal affective disorder | Exercise |  | Improve your complexion |
|  | Skin issues |  | 5-7 days per week |  | Have stronger nails |
|  | Sinus issues |  | 3-4 days per week |  | Have healthier hair |
|  | Tuberculosis |  | 1-2 days per week |  | Feel more motivated |
|  | Ulcer |  | 45+ minute workouts |  | Be less moody |
|  | Urinary tract infection |  | 30-45 minute workouts |  | Be more organized |
|  | Varicose veins |  | <30 minute workouts |  | Think more clearly / be more focused |
|  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Walking |  | Improve memory |
| Medical (Men) |  | Running, jogging, jumping rope |  | Do better on tests |
|  | Benign prostatic hyperplasia |  | Weightlifting |  | No use of over-the-counter drugs |
|  | Decreased sex drive |  | Swimming |  | Be free of pain |
|  | Infertility |  | Boxing |  | Stop using laxatives/stool softeners |
|  | Prostate Cancer |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Have stronger teeth |
| Medical (Women) | Nutrition & Diet |  | Have agreeable body odor |
|  | Breast Cancer |  | Mixed food diet (meat & vegetables) |  | Get rid of allergies |
|  | Decreased sex drive |  | Vegetarian |  | Have less colds and flus |
|  | Endometriosis |  | Vegan |  | Reduce risk of inherited disease tendencies |
|  | Fibrocystic breasts |  | Salt restriction |
|  | Fibroid/ovarian cysts |  | Fat restriction |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Infertility |  | Starch/carbohydrate restriction |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |