Chiropractic Center of Marietta

PT# ____________________

PATIENT INFORMATION

DATE OF FIRST APPOINTMENT _______________

LAST NAME: ________________________ **FIRST NAME:** ________________________ **M.I.:** ____

SSN: ________________________ **DATE OF BIRTH:** ____/____/_______ **AGE:** _________________

SEX: ☐MALE ☐FEMALE

HOME PHONE NUMBER: (______)_____________**CELL NUMBER:** (______)__________________

STREET ADDRESS: ____

CITY: ___________________ **STATE:** ______________ **ZIP CODE:** _______________________

EMAIL: ____

YOUR EMPLOYER: ____

WORK ADDRESS: ____

WORK PHONE NUMBER: _____________________ **OCCUPATION** ______________________

IF WE ARE FILING INSURANCE FOR YOU, PLEASE GIVE YOUR INSURANCE CARD TO THE FRONT DESK OR FILL IN THE FOLLOWING:

INSURANCE COMPANY: ____

POLICY NUMBER: ___________________ **PHONE:** ___________________________

IF YOUR INJURY WAS A RESULT OF AN AUTO ACCIDENT PLEASE PROVIDE US WITH THE FOLLOWING:

ATTORNEY: _____________________________ **CLAIM NUMBER:** __________________

WHO REFERRED YOU? ____

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Do you feel your condition is ☐Improving ☐Staying the same ☐Getting worse

Have you lost time from work? ☐Yes ☐No If yes, how long?____________________

Can you perform physical activities? ☐Yes ☐No

If no, because of: ☐Pain ☐Weakness ☐Stress

Activities of Daily Living: *please select all activities which you are currently experiencing problems*

☐Seeing ☐Tasting ☐Smelling ☐Eating
☐Hearing ☐Bathing ☐Grooming ☐Dressing
☐Reading ☐Typing ☐Writing ☐Grasping
☐Holding ☐Pinching ☐Standing ☐Leaning
☐Walking ☐Stooping ☐Squating ☐Climbing
☐Kneeling ☐Bending ☐Twisting ☐Carrying
☐Lifting ☐Pushing ☐Pulling ☐Reaching
☐Sitting ☐Driving ☐Riding in car ☐Air travel
☐Sports ☐Exercising ☐Loss of sex drive
☐Reclining ☐Restful sleep ☐Insomnia ☐Using the toilet
☐Loss of concentration ☐Nervous ☐Irritable
☐Change in personality ☐Tactile feeling

Can you go to sleep without problems? ☐Yes ☐No

Do you awaken because of pain? ☐Yes ☐No

If yes, where? ____________________

Did you have sleep problems before? ☐Yes ☐No

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DESCRIBE YOUR FIRST COMPLAINT:

WHAT HURTS? ______________________________

How bad does it hurt:
0----1----2----3----4----5----6----7----8----9----10
0= no discomfort 10 = extreme discomfort

IT CAME ON: ☐GRADUALLY ☐IMMEDIATELY

IT IS GETTING: ☐BETTER ☐SAME ☐WORSE

INTENSITY: ☐MINIMAL ☐SLIGHT ☐MODERATE ☐SEVERE

FREQUENCY ☐INTERMITTENT ☐OCASSIONAL ☐FREQUENT ☐CONSTANT

DESCRIBE THE FEELING: ☐DULL ☐SHARP ☐ ACHING ☐ SHOOTING ☐ SPASM ☐ THROBBING ☐ BURNING ☐NUMB ☐TINGLING ☐ OTHER

LOCATION OF PAIN: ☐RIGHT ☐LEFT ☐FRONT ☐REAR ☐ OTHER: ____

ACTIONS THAT AFFECT THIS PAIN: (B) BRINGS PAIN ON (A) AGRAVATES THE PAIN (R) RELIEVES THE PAIN

IN THE MORNING:	☐B ☐A ☐R	IN THE AFTERNOON:	☐B ☐A ☐R
BENDING BACK:	☐B ☐A ☐R	BENDING LEFT:	☐B ☐A ☐R
TWISTING LEFT:	☐B ☐A ☐R	TWISTING RIGHT:	☐B ☐A ☐R
SNEEZING:	☐B ☐A ☐R	STRAINING:	☐B ☐A ☐R
LIFTING:	☐B ☐A ☐R	SITTING:	☐B ☐A ☐R
COLD:	☐B ☐A ☐R	REST:	☐B ☐A ☐R
MEDICATIONS:	☐B ☐A ☐R		

BENDING FORWARD:	☐B ☐A ☐R
BENDING RIGHT:	☐B ☐A ☐R
COUGHING:	☐B ☐A ☐R
STANDING:	☐B ☐A ☐R
HEAT:	☐B ☐A ☐R
LYING DOWN:	☐B ☐A ☐R

OTHER 1: ____ ☐B ☐A ☐R

PAIN TRAVELS FROM PRIMARY COMPLAINT TO:

HEAD:	☐RIGHT ☐LEFT	NECK:	☐RIGHT ☐LEFT	SHOULDER:	☐RIGHT ☐LEFT
ARM:	☐RIGHT ☐LEFT	HAND:	☐RIGHT ☐LEFT	HIP:	☐RIGHT ☐LEFT
LEG:	☐RIGHT ☐LEFT	FOOT:	☐RIGHT ☐LEFT		

PAIN ALSO TRAVELS TO: ____

ADDITIONAL COMMENTS: ____

DESCRIBE YOUR SECOND COMPLAINT:

WHAT HURTS? ______________________________

How bad does it hurt:
0----1----2----3----4----5----6----7----8----9----10
0= no discomfort 10 = extreme discomfort

IT CAME ON: ☐GRADUALLY ☐IMMEDIATELY

IT IS GETTING: ☐BETTER ☐SAME ☐WORSE

INTENSITY: ☐MINIMAL ☐SLIGHT ☐MODERATE ☐SEVERE

FREQUENCY ☐INTERMITTENT ☐OCASSIONAL ☐FREQUENT ☐CONSTANT

DESCRIBE THE FEELING: ☐DULL ☐SHARP ☐ ACHING ☐ SHOOTING ☐ SPASM ☐ THROBBING ☐ BURNING ☐NUMB ☐TINGLING ☐ OTHER

LOCATION OF PAIN: ☐RIGHT ☐LEFT ☐FRONT ☐BACK ☐ OTHER ______________________

ACTIONS THAT AFFECT THIS PAIN: (B) BRINGS PAIN ON (A) AGRAVATES THE PAIN (R) RELIEVES THE PAIN

IN THE MORNING:	☐B ☐A ☐R	IN THE AFTERNOON:	☐B ☐A ☐R
BENDING BACK:	☐B ☐A ☐R	BENDING LEFT:	☐B ☐A ☐R
TWISTING LEFT:	☐B ☐A ☐R	TWISTING RIGHT:	☐B ☐A ☐R
SNEEZING:	☐B ☐A ☐R	STRAINING:	☐B ☐A ☐R
LIFTING:	☐B ☐A ☐R	SITTING:	☐B ☐A ☐R
COLD:	☐B ☐A ☐R	REST:	☐B ☐A ☐R
MEDICATIONS:	☐B ☐A ☐R		

BENDING FORWARD:	☐B ☐A ☐R
BENDING RIGHT:	☐B ☐A ☐R
COUGHING:	☐B ☐A ☐R
STANDING:	☐B ☐A ☐R
HEAT:	☐B ☐A ☐R
LYING DOWN:	☐B ☐A ☐R

PAIN TRAVELS FROM SECONDARY COMPLAINT TO:

HEAD:	☐RIGHT ☐LEFT	NECK:	☐RIGHT ☐LEFT	SHOULDER:	☐RIGHT ☐LEFT
ARM:	☐RIGHT ☐LEFT	HAND:	☐RIGHT ☐LEFT	HIP:	☐RIGHT ☐LEFT
LEG:	☐RIGHT ☐LEFT	FOOT:	☐RIGHT ☐LEFT		

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PAST MEDICAL HISTORY
(eg. Heart disease, stroke, diabetes, cancer, thyroid, asthma, ulcer etc.)

Please list the conditions for which you have had medical treatment in the past

PAST MEDICAL HISTORY 1: ______________________________

PAST MEDICAL HISTORY 2: ______________________________

PAST MEDICAL HISTORY 3: ______________________________

PAST MEDICAL HISTORY 4: ______________________________

PAST MEDICAL HISTORY 5: ______________________________

☐NONE

PAST SURGICAL HISTORY

Please list any surgeries you have had include the year of the surgery.

PAST SURGICAL HISTORY 1: ______________________________

PAST SURGICAL HISTORY 2: ______________________________

PAST SURGICAL HISTORY 3: ______________________________

PAST SURGICAL HISTORY 4: ______________________________

PAST SURGICAL HISTORY 5: ______________________________

☐NONE

PAST FAMILY HISTORY

Please list major health conditions that your mother, father and/or grand-parents has been diagnosed with

PAST FAMILY HISTORY 1: ______________________________

PAST FAMILY HISTORY 2: ______________________________

PAST FAMILY HISTORY 3: ______________________________

PAST FAMILY HISTORY 4: ______________________________

PAST FAMILY HISTORY 5: ______________________________

☐NONE

CURRENT MEDICATIONS

Please list medications you are currently taking

CURRENT MEDICATIONS 1: ______________________________

CURRENT MEDICATIONS 2: ______________________________

CURRENT MEDICATIONS 3: ______________________________

CURRENT MEDICATIONS 4: ______________________________

CURRENT MEDICATIONS 5: ______________________________

☐NONE

Allergies

☐NONE

____

____

____

____

SOCIAL HISTORY

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

CHILDREN: ______

ARE YOU CURRENTLY PREGNANT? ☐YES ☐NO **IF YES,** ______ **WEEKS**

HOW MUCH OF EACH DO YOU USE/DO IN A WEEK:

☐ TOBACCO ____________PACKS PER WEEK FOR ________ YEARS. QUIT? WHEN?___________

☐ ALCOHOL ________________DRINKS PER WEEK ☐ EXERCISE:________________HOURS PER WEEK

☐ COFFEE __________________8 oz. CUPS PER WEEK WHAT KIND OF EXERCISE? ____

DOMINANCE: ☐RIGHT HANDED ☐LEFT HANDED ☐AMBIDEXTROUS

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Authorization and Informed Consent to Perform Health Examinations, Diagnostic Testing and Treatment

I hereby request and consent to the performance of health examinations, diagnostic testing and treatment, which may include various modes of physical therapy and chiropractic, diagnostic x-ray, diagnostic ultrasound, nerve conduction studies, or any other necessary diagnostic or therapeutic procedures on me (or on the patient named below, for whom I am legally responsible) by the qualified staff of The Chiropractic Center of Marietta.

I understand and I am informed that in the practice of health care, there are some risks to examination, diagnostic testing and treatment including, but not limited to: exposure to radiation, injury by electric current, disc injuries, fractures, strokes, dislocations, sprains, and strains. I have had an opportunity to discuss with the staff/doctor of The Chiropractic Center of Marietta the risks, nature and purpose for any and all examinations, diagnostic tests or treatment. I do not expect the staff to be able to anticipate and explain all associated risks and complications. I hereby authorize the staff to exercise judgment for my health care (or on the patient named below, for whom I am legally responsible), based upon the facts currently known about my health status, or the current health status of the patient named below. I understand that any physical problem which is not within the scope of practice of the health care staff at the Chiropractic Center of Marietta will be referred or deferred to a more qualified health care provider.

I also understand that the Chiropractic Center of Marietta does provide health care for some patients in an open room setting and my health care information may be overheard by others. I agree to hold the staff harmless for any health information overheard by others while under care.

I have read or have had read to me the above authorization and informed consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named health examinations, diagnostic testing and treatment. I intend for this consent form to cover the entire course of my care for my present condition and for any future condition(s) for which I seek care.

____________________ Print Patient Name	____________________ Print Name of Patient's Guardian or Parent
____________________ Signature of Patient	____________________ Signature of Patient's Guardian or Parent
____________________ Date Signed	____________________ Date Signed

To the best of my knowledge I am NOT pregnant and the staff at the Chiropractic Center of Marietta has my permission to perform x-ray(s) on me for diagnostic interpretation. I agree to hold harmless the Chiropractic Center of Marietta and all of its health care practitioners for any and all damages occurred as a result of x-ray exposure.

____________________ Patient or Guardian Signature	____________________ Date

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OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

Our office is pleased to accept insurance assignment as soon as your exact coverage is verified by the responsible party. We will file your claim forms and assist you in every way we can.

However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

Our office policy with regards to assignments is as follows:

1. By taking your insurance assignment we have to wait for payment. This courtesy may be withdrawn if circumstances warrant it.
2. If you discontinue care without the doctor's authorization, the balance of your account is due and payable in full immediately.
3. Your insurance should pay within 30 days. If your insurance has not paid within 90 days, you must pay the balance due and be reimbursed by your insurance when and if it pays.
4. We will bill your insurance on 7 to 14 day cycles as long as you are receiving Medical Care in this office.
5. You agree to pay the percentage of your responsibility as you go along, unless other arrangements are made with our office manager, prior to treatment.
6. You are required to sign an "Authorization to Pay Physician" form and any other assignment documents required by your insurance.
7. Our office DOES NOT guarantee that your insurance will pay. Although we will make every attempt at the beginning of your health care to receive verification of your policy and what it covers. However, if for some reason your insurance claim is denied, you are responsible for the full amount of your bill.
8. Our office WILL NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation, we will however, provide you and your insurance company with all the necessary information to process your claim.
9. If you understand and agree with all of the above office policies please sign your name below and we will accept your insurance.

DATE: _________________ PATIENT SIGNATURE: _____________________

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CONFIDENTIALITY NOTICE

Because it is important for us to honor the confidentiality between patient and doctor, you are asked to consider whether you wish for your medical concerns to be discussed with your family members, should your doctor be contacted by them.

Please realize, of course, that by law it is required that we release requested medical information to your insurance company and others that request it.

PLEASE CHECK YOUR PREFERENCE BELOW:

__________ Discuss my medical concerns with me only.

__________ It is permissible to discuss my medical concerns with the following People should they contact my doctor.

1.____

2.____

__________ It is permissible to leave medical information on your answering machine.

I understand that a written request by me will be required to alter the above, and I will note specifically with whom my doctor may discuss my case.

____________________________________ ____________________

Patient Signature Date