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 FORWARD:	☐B ☐A ☐R
BENDING BACK:	☐B ☐A ☐R	BENDING LEFT:	☐B ☐A ☐R	BENDING RIGHT:	☐B ☐A ☐R
TWISTING LEFT:	☐B ☐A ☐R	TWISTING RIGHT:	☐B ☐A ☐R	COUGHING:	☐B ☐A ☐R
SNEEZING:	☐B ☐A ☐R	STRAINING:	☐B ☐A ☐R	STANDING:	☐B ☐A ☐R
LIFTING:	☐B ☐A ☐R	SITTING:	☐B ☐A ☐R	HEAT:	☐B ☐A ☐R
COLD:	☐B ☐A ☐R	REST:	☐B ☐A ☐R	LYING DOWN:	☐B ☐A ☐R
MEDICATIONS:	☐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 FORWARD:	☐B ☐A ☐R
BENDING BACK:	☐B ☐A ☐R	BENDING LEFT:	☐B ☐A ☐R	BENDING RIGHT:	☐B ☐A ☐R
TWISTING LEFT:	☐B ☐A ☐R	TWISTING RIGHT:	☐B ☐A ☐R	COUGHING:	☐B ☐A ☐R
SNEEZING:	☐B ☐A ☐R	STRAINING:	☐B ☐A ☐R	STANDING:	☐B ☐A ☐R
LIFTING:	☐B ☐A ☐R	SITTING:	☐B ☐A ☐R	HEAT:	☐B ☐A ☐R
COLD:	☐B ☐A ☐R	REST:	☐B ☐A ☐R	LYING DOWN:	☐B ☐A ☐R
MEDICATIONS:	☐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 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

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

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

The CHIROPRACTIC Center of MARIETTA

File _____

LIEN AND AUTHORIZATION

INSURANCE BENEFITS AND ATTORNEY

Claim or File # _____ Insured's Name: _____

Date of Loss: _____ Address: _____

Patient: _____ _____ Policy #:

_____

To Whom It May Concern,
I hereby authorize and direct you my insurance company, liability insurance adjustor, and/or my attorney, to pay directly to the Chiropractic Center of Marietta such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and benefits, workmen's compensation benefits, or any other insurance benefits named herein, and any and all proceeds of any settlement, judgement or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office.

I understand that I remain personally responsible for the total amounts due the office for their services. I further understand and agree that this lien and authorization does not constitute any consideration for the office to await payments and they may demand payments from me immediately upon rendering services at their option. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. I agree to pay all costs of collection of any balance due this office, including reasonable attorney's fees. This agreement is made solely for said provider's additional protection and in consideration of the medical service provider awaiting payment in this matter.

I authorize the office to release any information pertinent to my case to any insurance company, adjustor or attorney to facilitate collection under this lien and authorization. I agree that the above mentioned office be given power of attorney to endorse/ sign my name on any and all checks for payment of my doctor bill. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him. A photocopy of the agreement shall be considered as effective and valid as the original.

Date: _____ Signed: _____

Witness: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict, as may be necessary to adequately protect said doctor above named.

Date:_____ Signed: _____

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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