

# WELCOME

Patient ID: \_\_\_\_\_

Date: \_\_\_\_\_

## Patient Information

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

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

Mailing Address: \_\_\_\_\_  
Street City State Zip Code

Phone # (Cell) \_\_\_\_\_ (Home) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  Male  Female

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor

Race  Caucasian  African American  Asian  Native American  Latin American  Other

Ethnicity  Hispanic  Latino  Non-Hispanic / Non-Latino

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

Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency contact: Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Phone #: (Cell) \_\_\_\_\_ (Home) \_\_\_\_\_

## Accident Information

Is this visit due to an accident?  Yes  No If yes, what type?  Auto  Work  Other \_\_\_\_\_

Has it been reported?  Yes  No If yes, to whom? \_\_\_\_\_

## Insurance Information

Policy Holder Name: \_\_\_\_\_ D.O.B. : \_\_\_\_\_

Relationship to patient (if other than self): \_\_\_\_\_ Phone # \_\_\_\_\_

Do you have health insurance?  Yes  No Name of Carrier: \_\_\_\_\_

Do you have secondary insurance?  Yes  No Name of Carrier: \_\_\_\_\_

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

## Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) \_\_\_\_\_ DATE \_\_\_\_\_



# Health History

Who is your primary care physician? (doctor and/or practice) \_\_\_\_\_

**Please check to indicate if you are currently experiencing any of the following conditions:**

- |  |  |  |  |                                     |
|--|--|--|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms  | <input type="checkbox"/> Light Bothers Eyes  | <input type="checkbox"/> Sudden Weight Loss    | <input type="checkbox"/> Nausea     |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs  | <input type="checkbox"/> Depression          | <input type="checkbox"/> Loss of Taste         | <input type="checkbox"/> Cold Feet  |
| <input type="checkbox"/> Arm/Hand Pain       | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Loss of Memory        | <input type="checkbox"/> Fainting   |
| <input type="checkbox"/> Leg/Knee Pain       | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension             | <input type="checkbox"/> Jaw Problems          | <input type="checkbox"/> Fever      |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Cold Sweats         | <input type="checkbox"/> Constipation          |                                     |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Stomach Problems      | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Blurred Vision        | <input type="checkbox"/> Night Pain          | <input type="checkbox"/> Bowel/Bladder Changes |                                     |

**Please check to indicate if you have ever had any of the following:**

- |   |  |   |   |                                      |
|---|--|---|---|--------------------------------------|
| <input type="checkbox"/> Aids/HIV           | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Stroke      |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Pacemaker            |                                      |
| <input type="checkbox"/> Suicide Attempt    |  |   |   |                                      |
| <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc     | <input type="checkbox"/> Parkinson's Disease  |                                      |
| <input type="checkbox"/> Thyroid Problems   |  |   |   |                                      |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Pneumonia            |                                      |
| <input type="checkbox"/> Tuberculosis       |  |   |   |                                      |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Polio                | <input type="checkbox"/> Tumors      |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Typhoid     |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Measles            | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Ulcers      |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Psychiatric Care     |                                      |
| <input type="checkbox"/> Vaginal Infections |  |   |   |                                      |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatoid Arthritis |                                      |
| <input type="checkbox"/> Venereal Disease   |  |   |   |                                      |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Rheumatic Fever      |                                      |
| <input type="checkbox"/> Whooping Cough     | <input type="checkbox"/> Gout                | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever        |                                      |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Other _____          |                                      |

Are you currently under drug and/or medical care?  Yes  No If yes, explain \_\_\_\_\_

Please list any medications you are currently taking (**Be sure to include dosage and frequency**) \_\_\_\_\_

Please list any surgeries and/or hospitalizations you have had (**type & date**): \_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Please list any supplements you are currently taking (vitamins/herbs/minerals): \_\_\_\_\_

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____  |                                      |
| <input type="checkbox"/> Cancer _____        | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Other _____ |

Do you exercise:  Never  Daily  Weekly  Walks  Runs  Swims

Do your work activities mostly involve:  Sitting  Standing  Light Labor  Heavy Labor

What is your daily/weekly intake of the following?

Caffeine \_\_\_\_\_ cups/day Alcohol \_\_\_\_\_ drinks/week Cigarettes \_\_\_\_\_ packs/day I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) \_\_\_\_\_ DATE \_\_\_\_\_

Reviewed by Provider \_\_\_\_\_ (Initials)



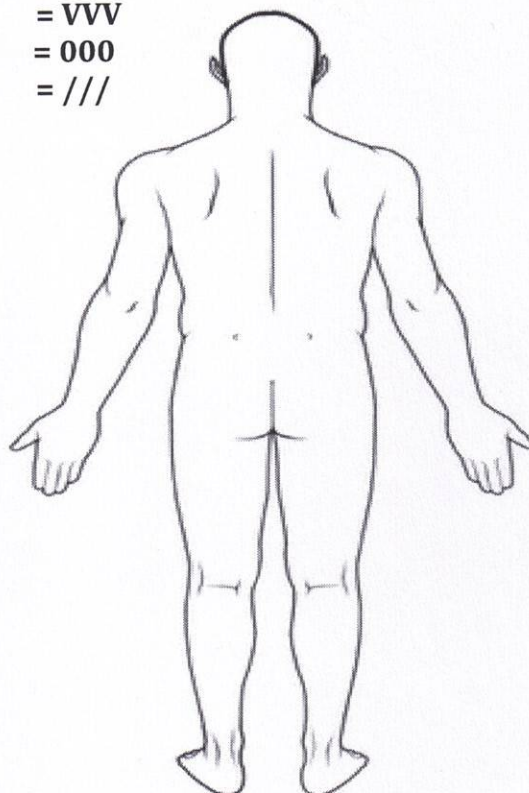
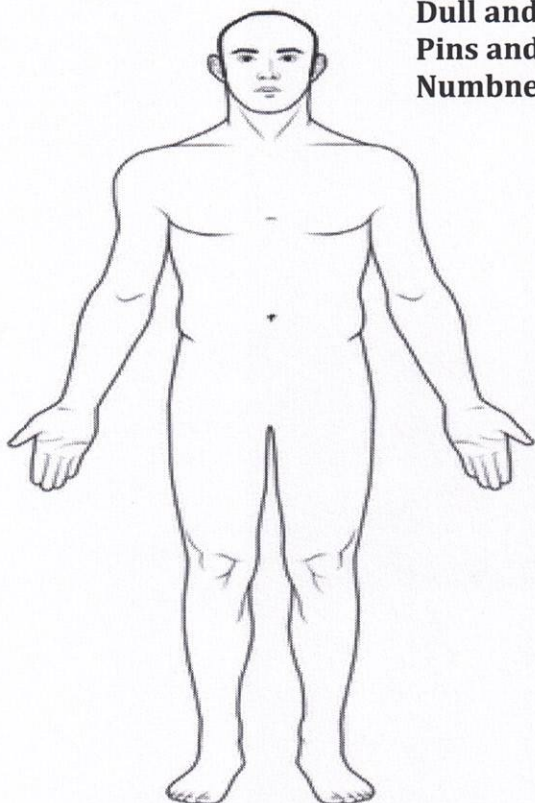


### DESCRIBE YOUR PAIN SIGNALS

Name \_\_\_\_\_ Patient ID # \_\_\_\_\_ Date \_\_\_\_\_

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing.

**Sharp and Stabbing = +++**  
**Dull and Achy = VVV**  
**Pins and Needles = 000**  
**Numbness = ///**



<b>Rate your activity level:</b>	<b>Low</b>	<b>Moderate</b>	<b>High</b>
Work Activity	Low 1 2 3 4 5		High
Pleasure Activity	Low 1 2 3 4 5		High

**Check # below to rate your current pain level**                      **C = Constant**  
**#1 being almost pain free - #10 being severe pain**                      **I = Intermittent**

Area of Pain	Normal	Mild Pain	Moderate Pain	Severe Pain	C	I
Neck	0 1	2 3 4	5 6 7	8 9 10	C	I
Mid Back	0 1	2 3 4	5 6 7	8 9 10	C	I
Lower Back	0 1	2 3 4	5 6 7	8 9 10	C	I
Hip(s) L - R	0 1	2 3 4	5 6 7	8 9 10	C	I
Shoulder(s) L - R	0 1	2 3 4	5 6 7	8 9 10	C	I
Arm(s) L - R	0 1	2 3 4	5 6 7	8 9 10	C	I
Leg(s)	0 1	2 3 4	5 6 7	8 9 10	C	I



## Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

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Patient's Signature

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Date

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

This notice is effective as of today and will expire seven years after the date on which you last received services from us.

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Patient Initials

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I acknowledge that I have reviewed the Notice of Privacy Practices of A&W Chiropractic/Elite HealthCare.

(Please initial one of the following options and sign below.)

\_\_\_\_\_ I wish to receive a paper copy of Privacy Notice.

\_\_\_\_\_ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

\_\_\_\_\_ I acknowledge that it is the policy of A&W Chiropractic to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

\_\_\_\_\_ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Suzanne Boesl, about my concerns.

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (Office Staff)

\_\_\_\_\_  
Date



## X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Patient Name: \_\_\_\_\_

- There is a possibility that I may be pregnant at this time.
- Yes, I am definitely pregnant
- No, I am definitely not pregnant at this time
- I request that x-ray films not be taken because: \_\_\_\_\_  
\_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

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

\_\_\_\_\_  
Date