

Chiropractic Sports & Wellness PC New Patient Questionnaire

Patient Information (Please Print) Please provide a photo id & a copy of your insurance card to the front desk

Name _____ Date _____ Birth Date ____/____/____
Address _____ City _____ State _____ Zip _____
SS# _____ Ethnicity (please check one) Hispanic **or** Non-Hispanic Sex _____
Race _____ Preferred Language _____ Height _____ Weight _____
Home Phone(____) _____ Cell(____) _____ Cell Provider _____
Work Phone(____) _____ E-mail Address _____
Employer _____ Occupation _____ #years _____
Spouse or Parent's Name _____ Birth Date _____ Phone # _____
Emergency Contact _____ Phone # _____ Relation _____
Whom may we thank for referring you to us? _____ **OR**
How did you find us: Internet? _____ Yellow Page Ad? _____ Other? _____
Name of local primary Physician: _____ May we contact them? _____

Insurance Information

Primary

Insured's Name _____ Insured's DOB ____/____/____
Patient's Relation to Insured: Self Spouse Child

Secondary

Insured's Name _____ Insured's DOB ____/____/____
Patient's Relation to Insured: Self Spouse Child

Auto Injury / Work Injury / Personal Injury

Insurance type: Auto Work Lien

Insurance Company: _____ Policy # _____ Claim# _____

Date of Accident: ____/____/____ State of Accident: _____

I, the undersigned, have insurance coverage and assign directly to Chiropractic Sports & Wellness PC all medical benefits, if any, otherwise payable to me for services rendered. 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 to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Patient Signature _____ Date ____/____/____

Confidential Patient Questionnaire

Symptoms

Main Complaint _____ How Bad? _____ How Often? _____

When did it start? _____ Getting Worse? _____ Getting Better? _____

What activity bothers it the most? _____

When is it at its best? _____ When is it at its worst? _____

Rate the pain - (0 is pain free - 10 is unbearable pain) 0 1 2 3 4 5 6 7 8 9 10

Other Chiropractors? _____ Positive Experience? _____

Other type of physician or therapist? _____ Positive Experience? _____

Secondary Complaint(s) _____

PAIN DRAWING

Using the symbols given below, mark the area on you body where you feel the described sensations. Include all affected areas.

Aching △△△△	Numbness =====	Pins & Needles ○○○○○	Burning XXX	Stabbing /////	Other
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The form contains two line drawings of a human figure. The left drawing is a front view, showing the head, neck, shoulders, chest, arms, hands, torso, abdomen, pelvis, legs, and feet. The right drawing is a back view, showing the head, neck, spine, shoulders, arms, hands, torso, pelvis, legs, and feet. The drawings are intended for the patient to mark areas of pain using the symbols provided in the legend above.

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Surgery and Drugs

Previous Surgeries and Dates: _____

List ALL Medications you are currently taking: **Please Print** (If you have a list please give it to the front desk)

Allergies (Prescription Drugs and Environmental)	Current Medication (Exclude Supplements)

What supplements do you take? _____

What kind of exercise do you do and how much? _____

Notice of privacy practice summary

This summary discloses how health information about you may be used.

Chiropractic Sports & Wellness PC uses health information about you for treatment, to obtain payment for treatment with your authorization as required, for administrative purposes, and to evaluate the quality of care you received. It will not disclose your information to others unless you tell us to do so or unless the law authorizes us to do so.

Chiropractic Sports & Wellness PC may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues and may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. You have a right to request restriction, request a report and retain a copy of your health record, request communication of your information by alternative means at alternative location, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Chiropractic Sports & Wellness PC must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints, please contact 307-635-7727.

I, the undersigned, attest that I have read and understand the above and that all the above questions have been answered accurately, and I understand that giving incorrect information can be dangerous.

Patient Signature _____ Date ____/____/____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As will all type of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement or symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medication, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measure and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: ___/___/_____
Parent or Guardian: _____ Signature: _____ Date: ___/___/_____
Witness: _____ Signature: _____ Date: ___/___/_____