Date: ___/___/_____

Name ____ DOB: ___/___/___ Age _____ Male/Female

Address_________________________________ City_______________________ State _____ Zip ________

SSN#: ____-____-____ Phone: Home (___) ____-_____ Cell (___) _____-_____ Cell Provider ______________

Email Address ___________________________ Occupation _______________ Employer_____________

Single / Married / Divorced / Widowed   Spouse's Name ______________________________________

Number of Children ______ Names, Ages, & Gender ____

Emergency Contact ___________________________#_______________ Relationship ______________

Who may we thank for referring you? ____

Please identify the condition(s), if any, that brought you to this office:
Primary: ____
Secondary: ____________________ Third: ______________________ Fourth: ____________________

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

Primary or chief complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? ____

How did the problem(s) begin? ____

When is the problem at its worst? ❑ AM ❑ PM ❑ mid-day ❑ Late PM

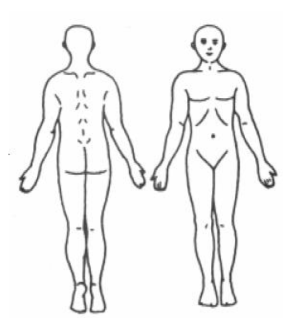
How long does it last? ❑ It is constant ❑ On and off during the day ❑ Comes/goes throughout week

Have you seen any other doctor for these conditions? ❑ No ❑ Yes **If yes,** when? __________________

Who? ____________________________ For how long? ____

What were the results? ❑ Favorable ❑ Unfavorable   Please explain_____________________________

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
R=Radiating **B=B**urning **D=D**ull **A=**Aching **N=N**umbness **S=S**harp/**S**tabbing **T=T**ingling



What makes you feel better? ____

What makes you feel worse? ____

Have you suffered with any of this or a similar problem in the past? ❑Yes ❑ No

If yes, how many times? _________ When was the last episode? _______________

Please identify any and all types of jobs you have had in the past that have cause excess physical, chemical, or emotional stress on you or your body: ____

____

Date: ___/___/______

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: ____________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Absolute CHIROPRACTIC

Date: ___/___/______

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past***, **C** for ***Currently*** have or **N** for ***Never*** have had**:**

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture

___Disability ___Heart Attack ___ Cancer ___Cerebral Vascular ___ Diabetes

___ Scoliosis ___Osteo Arthritis Other serious conditions: ________________________________

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

BY WHOM	HOW LONG AGO	TYPE OF CARE RECEIVED
INJURIES →		
CHILDHOOD DISEASES →		
ADULT DISEASES →		

Do you smoke: Cigars Pipes Cigarettes → How often? Daily Occasionally Never

Do you exercise: Heavy Moderate Light → How often? Daily Occasionally Never

List Prescription & Non-Prescription drugs you take:

____

____

List any surgeries you have had:____

____

____

I hereby authorize payment to be made directly to Absolute Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Absolute Chiropractic for any and all services I receive at this office.

Patient Signature: ____ **Today's Date:** ___/___/___

Doctor Signature: ____ **Today's Date:** ___/___/___

FAMILY HEALTH HISTORY

Please mark **any** of the below conditions that you or your family have or have had in the past:
Write "C" if current issue or "P" if past issue

	Yourself	Spouse	Children	Mother	Father
Acid Reflux					
Addiction					
ADHD					
Allergies					
Anxiety/Nervousness					
Arthritis					
Asthma					
Autism Spect. Disorder					
Autoimmune Disorder					
Bladder Problems					
Chronic Fatigue					
Depression					
Disc Problems					
Dizziness					
Ear Infections					
Epilepsy					
Fainting/syncope					
Fibromyalgia					
Headaches					
Heart Disorders					
High Blood Pressure					
Infertility					
Irritable Bowel Synd.					
Kidney Condition					
Lupus					
Menstrual Problems					
Migraines					
Multiple Sclerosis					
Nausea					
Numbness/tingling					
Sciatica					
Sinus problems					
Stiffness					
Stomach Conditions					
Throat Issues					
Thyroid Problems					
TMJ Disorder					
Ulcers					
Vertigo					

PATIENT'S NAME: ______________________________ **DATE:** ______________

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name ____ Date __________________________

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain ____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

---

1 – What is your pain RIGHT NOW?

No pain ____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain ____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain ____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain ____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

____

____

____

Examiner

INFORMED CONSENT

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic care concerns itself with the detection, analysis, and correction of **vertebral subluxation,** or malposition of the spinal vertebrae impacting nervous system function. It centrally involves what is known as a chiropractic **adjustment,** involving the use of hands or instruments with a precise direction and force to reposition anatomical structures. Potential benefits include restoring normal joint motion, reducing and swelling in a joint, reducing pain in the joint, improved neurological function and overall well-being. We will conduct diagnostic or examination procedures, which, while non-invasive, may be uncomfortable in some cases.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence do not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of care and the treatment. I have read the above content and understand the information provided. All questions I have about this information have been answered to my satisfaction. Having this knowledge, I intend this consent to cover the entire course of care from all providers in this.

Patient Name: _________________________ **Signature:** ______________________________________ **Date:** ___/___/___

Parent/Guardian: _____________________ **Signature:** ______________________________________ **Date:** ___/___/___

Doctor Signature: ____ **Date:** ___/___/___

In addition, by signing below, I give permission for the above-named minor patient to be managed by the doctor even when I am not present to observe such care.

Parent/Guardian Name: ___________________________________ Signature: ___________________________________

Relationship to patient: ____________________________________ Date: ____

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files.

THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.

Digital x-rays on a CD will be available within 72 hours of prepayment on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze **VERTEBRAL SUBLUXATIONS.** However, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS:

____________________________________ ____________________________________

PRINT YOUR NAME HERE DATE

____________________________________ ____________________________________

SIGNATURE YOUR AGE

FEMALE PATIENTS ONLY: *TO THE BEST OF MY KNOWLEDGE,* ***I BELIEVE I AM NOT PREGNANT*** *AT THE TIME X-RAYS ARE TAKEN AT ABSOLUTE CHIROPRACTIC.*

____________________________________ ____________________________________

SIGNATURE DATE

Notice of Privacy Practice Acknowledgement

I understand that I have certain right so f privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and/or indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians' certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my information is used to disclose or carry out treatment, payment, or healthcare operation. I understand that you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide my such restrictions.

Signature: ____________________________ Date: __________________