

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:

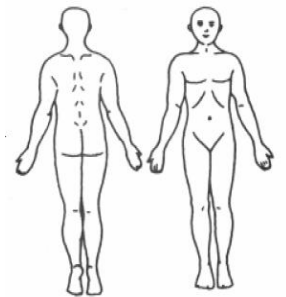
R=Radiating B=Burning D=Dull A=Aching N=Numbness S=Sharp/Stabbing T=Tingling

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: _____

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	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lift Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Read/Concentrate	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform



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:

Table with 3 columns: BY WHOM, HOW LONG AGO, TYPE OF CARE RECEIVED. Rows include INJURIES, CHILDHOOD DISEASES, and 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: ___/___/___



Date: ___/___/___

PRENATAL HISTORY:

1. Is this your first pregnancy? Yes No If so, tell us about your previous pregnancies (i.e. comfortable, easy labor, any difficulties, post-partum depression, etc).

2. Any Complications during previous pregnancy/delivery? No Yes If so, explain:

3. Previous Birth Intervention(s): Forceps C – Section Vacuum Extraction Pitocin
 Epidural Episiotomy Manual traction of neck
 None If C- Section, was it: Planned Emergency

4. Location of Birth(s): Hospital Birthing Center Home

5. Conception History (check all that apply):

No Difficulty IVF IUI Took longer than expected

Any further details: _____

CURRENT PRENATAL STATUS:

6. What is your estimated due date? _____ 7. How far along are you now? _____ weeks

8. Any concerns during this pregnancy? (malposition/breech, morning sickness, difficulty breathing, etc). _____

9. Are you taking any pre-natal or birthing classes? No Yes If yes, what? _____

10. What was your exercise/activity level/type previous to this pregnancy?

11. Has this changed with your current pregnancy? Please explain: _____

12. Is there anything else you think we should know? _____

13. What are your goals for this pregnancy (check all that apply)

Happiest, Healthiest Birth Possible Medication-Free Birth Home Birth
 VBAC Less Pain, More Comfort Natural Delivery
 Intervention Free Birth Healthiest Baby possible

Other/Additional: _____

14. What are your current birth providers? (OB/midwife/doula/birth coach/etc.)

Provider Name: _____ Name of Clinic: _____

Provider Name: _____ Name of Clinic: _____

Do we have permission to communicate with your other providers regarding your plan of care in our office? Yes No

Patient Signature: _____ Date: _____ Doctor Signature: _____



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:** _____



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 knowledgeably 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: _____