☐ Scanned Into Patient File Cabinet

☐ Entered into computer

PATIENT INFORMATION & CONDITION FORM

Date ____________________

Patient Name: First ________________________ Middle Initial _____ Last ____________________________

Nick Name _____________________________ Suffix ________________

Birth Date: _____/_____/_________ Gender: F M

Best Number to reach you (______) _________ - ______________

E-mail address: ____

Condition Related to?

☐ *Auto Accident (Occupant or Pedestrian)* ☐ *Accident in Someone Else's Home* ☐ *Other Accident*

☐ *Work-Related Accident* ☐ *Accident on the Premises of Someone Else's Business* ☐ *Non Accident*

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single

____

Preferred Language	**Race**	**Ethnicity**
☐ English	☐ Caucasian	☐ Not Hispanic or Latino
☐ Decline	☐ Decline	☐ Decline
☐ Other ______________	☐ Other ____________	☐ Other ______________

Smoking Status

☐ Current Every Day Smoker

☐ Current Some Day Smoker

☐ Former Smoker

☐ Never Smoker

Height and Weight

Height: _______

Weight: ______

CURRENT ADDRESS & PHONE

Street ____

City ____________________________ State ________ Zip ________________

Primary Phone (______) ______ - ____________

Cell Phone (______) ______ - ____________

☐ ***Please check if you agree to receive text/phone/ written messages from our office when necessary.***

EMERGENCY CONTACT INFORMATION

Parent/Guardian First ______________________ Middle Initial _____ Last ______________________________

Birth Date: ______/______/__________ Gender: F M

CURRENT ADDRESS & PHONE

Street ____

City __________________________ State ________ Zip ______________________

Primary Phone (_______) _______ - _____________ Cell Phone (_______) _______ - _____________

OR Spouse/Other Name First ______________________ Middle Initial ______Last______________________________

Birth Date: ______/______/__________ Gender: F M

CURRENT ADDRESS & PHONE

Street ____

City __________________________ State ________ Zip ______________________

Primary Phone (_______) _______ - _____________

Cell Phone (_______) _______ - _____________

Insurance Details

Name of Person who carries the Insurance (if other than Patient)

First ______________________ Middle Initial _______ Last ______________________________

IF Parent/Guardian/Spouse, please list: DATE OF BIRTH _______/_______/____________

CURRENT ADDRESS & PHONE

Street ____

City __________________________ State ________ Zip ______________________

Primary Phone (_______) _______ - _____________

Cell Phone (_______) _______ - _____________

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I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorneys who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: ____ Date: _____/_____/_______

Family ChiroCare

Condition & History Report

Self-Pay: ________
Insurance: ________________

Name: ______________________________ Age: ________ Date: __________

Reason for Visit: ______________________________

When did the symptoms appear: ______________________________

How did the symptoms begin: ______________________________

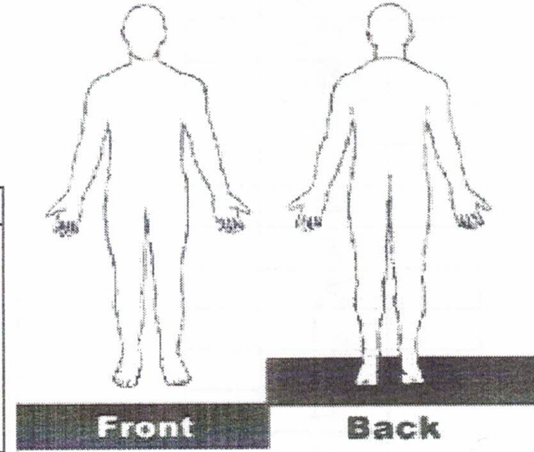
Is this condition getting progressively worse: ☐ Yes ☐ No

Place an "X" on the picture where you are experiencing any of the following:

Please check symptoms below

Grade your Symptoms: 1 (least) to 10 (severe)

	Symptom	Grade	Describe Symptom(s)
	Pain		Sharp, Achy, Dull, Stabbing, Radiating, Throbbing
	Stiffness		
	Weakness		
	Numbness		
	Tingling		
	Restriction		



How often do these symptoms occur:

☐ Infrequent (Less than 1 week) ☐ Occasional (25% of the day) ☐ Intermittent (50% of the day) ☐ Frequent (75% of the day) ☐ Constant (All day)

Does this affect activities of daily living (Work, activity, recreation): ☐ Yes ☐ No

If yes, how often (check one): ☐ Minimal ☐ Slight ☐ Moderate ☐ Severe

Activities that are painful:

☐ Sitting ☐ Standing ☐ Bending/Twisting ☐ Lifting ☐ Walking/Running ☐ Computer/Phone usage ☐ N/A

Things that relieve pain:

☐ MD/DC/Therapy ☐ Ice ☐ Heat ☐ Tylenol/Ibuprofen/Aleve ☐ Rest ☐ Stretching ☐ Sitting/Standing

Other Remedies: ______________________________

Social History:

Falls: ____________________ Surgeries: ____________________

Head Injuries: ____________________ Broken Bones: ____________________

Dislocations: ____________________ Accidents: ____________________

Medications: ______________________________

Medical History (check all that apply):

	Arthritis		Hernia		Liver Disease		Prostate Problems		Rheumatoid Arthritis
	Asthma		Migraine/HA		Osteoporosis		Thyroid Concern		Heart Disease
	Cancer		Stroke		Pace Maker		High BP or Cholesterol		Kidney Disease
	Diabetes		Pacemaker		Pinched Nerve		Tumors/Growths		Other: ________

Family ChiroCare

Informed Consent -- Chiropractic Care

Baldwin - Glenwood City - Woodville

Name:____

This document relates to your Informed Consent for care. Please read carefully before signing.

General. I, the below-signed patient/individuals, have read this document and Care Plan in their entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below. This form is good for all Chiropractors that I see in this office.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of the Care; Alternatives: Chiropractic manipulation / adjustment. As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

Contraindications to Manipulation / Adjustment. I understand that you will not give me an adjustment / manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Definitions. "You" and "office" refer to any provider who renders care to me at the Locations above. "Care" includes all care I receive from you in the future, including care related to other conditions.

Patient's Consent. I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my condition, and also all of the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all of the questions that I have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care.

Patient's Name: ____

Patient/Guardian Signature: ____________________________ Date: ____________

Office Witness: ____________________________ Date:____________