

Name: \_\_\_\_\_  
Date: \_\_\_\_\_  
File #: \_\_\_\_\_



OHIO FAMILY & SPORTS CHIROPRACTIC

## **Patient Information**

WELCOME! Please allow our staff to photocopy your driver's license and all available insurance cards.

### **PLEASE PRINT**

Full Name: \_\_\_\_\_ Gender: M F Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

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

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Do you have health insurance where you work?  Yes  No Plan/Group Number: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder Social Security #: \_\_\_\_\_

Your relationship to policy holder:  Self  Spouse  Child  Other \_\_\_\_\_

Name of Spouse, Parent, or Guardian: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_

Spouse's Phone: \_\_\_\_\_ Spouse's Email: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Is your condition due to an accident?  Yes  No Date of Accident: \_\_\_\_\_

Type of Accident:  Auto  Work  Home  Other \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

May we update your family physician on your condition?  Yes  No

### **Acceptance of Financial Responsibility**

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments and non-covered services. I also understand and agree to pay all copays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider, or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse's or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Name: \_\_\_\_\_  
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**Past/Family/Social History**

**15. Occupation** \_\_\_\_\_

**16. How would you rate your overall Health?**

- Excellent     Very Good     Good     Fair     Poor

**17. What type of exercise do you do?**

- Strenuous     Moderate     Light     None

**18. Indicate if you have any immediate family members with any of the following:**

- Rheumatoid Arthritis     Diabetes     Lupus     Heart Problems  
 Cancer     ALS     Other \_\_\_\_\_

**19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past.**

**If you presently have a condition listed below, place a check in the "present" column.**

	Past / Present		Past / Present		Past / Present			
Headaches:	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure:	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain:	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack:	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst:	<input type="checkbox"/>	<input type="checkbox"/>
Upper Back Pain:	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains:	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination:	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain:	<input type="checkbox"/>	<input type="checkbox"/>	Stroke:	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/Tobacco Use:	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain:	<input type="checkbox"/>	<input type="checkbox"/>	Angina:	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Dependence:	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain:	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones:	<input type="checkbox"/>	<input type="checkbox"/>	Allergies:	<input type="checkbox"/>	<input type="checkbox"/>
Elbow Pain:	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders:	<input type="checkbox"/>	<input type="checkbox"/>	Depression:	<input type="checkbox"/>	<input type="checkbox"/>
Wrist Pain:	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection:	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus:	<input type="checkbox"/>	<input type="checkbox"/>
Hand Pain:	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination:	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy:	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain:	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control:	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash:	<input type="checkbox"/>	<input type="checkbox"/>
Upper Leg Pain:	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems:	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS:	<input type="checkbox"/>	<input type="checkbox"/>
Knee Pain:	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain/Loss:	<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain:	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Appetite:	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain:	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain:	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain/Stiffness:	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer:	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis:	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis:	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disorder:	<input type="checkbox"/>	<input type="checkbox"/>
Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue:	<input type="checkbox"/>	<input type="checkbox"/>	Tumor:	<input type="checkbox"/>	<input type="checkbox"/>
Asthma:	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances:	<input type="checkbox"/>	<input type="checkbox"/>	Reduced Coordination:	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness:	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems:	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____:	<input type="checkbox"/>	<input type="checkbox"/>

**For Females Only**

- Birth Control Pills:      Hormonal Replacement:      Pregnancy:

**20. List all prescription medications you are currently taking:**

**21. List all of the Nutritional Supplements you are currently taking:**

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**22. List all surgical procedures you have had:**

\_\_\_\_\_

**23. What activities do you do at work?**

- Sit:**     Most of the day     Half the day     A little of the day  
 **Stand:**  Most of the day     Half the day     A little of the day  
 **Computer work:**  Most of the day     Half the day     A little of the day  
 **On the phone:**     Most of the day     Half the day     A little of the day

**24. What activities do you do outside of work?**

\_\_\_\_\_

**25. Have you ever been hospitalized?**     No     Yes

If yes, why \_\_\_\_\_

**26. Have you ever seen another chiropractor?**     Yes     No    If Yes, Chiropractor's Name: \_\_\_\_\_

What was the reason for your visit? \_\_\_\_\_

What spinal maintenance programs were you given to follow to maximize the future stability of your spine?

\_\_\_\_\_

Did you follow your program?     Yes     No    If No, why? \_\_\_\_\_

Why are you changing Chiropractors? \_\_\_\_\_

**27. Have you had significant past trauma?**     No     Yes

If yes, describe: \_\_\_\_\_

**28. Anything else pertinent to your visit today?** \_\_\_\_\_

\_\_\_\_\_

**29. Use of Alcohol?**     Never     Rarely     Moderate     Daily

**30. Stress level?**     High     Medium     Low

**31. What are your health goals?** \_\_\_\_\_

How do you expect to achieve these goals? \_\_\_\_\_

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File #: \_\_\_\_\_



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**32: Have you ever been diagnosed with or experienced:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Blood in urine    | <input type="checkbox"/> AIDS            | <input type="checkbox"/> Loss of bladder control |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Osteoporosis    | <input type="checkbox"/> Loss of bowel control   |
| <input type="checkbox"/> Stroke            | <input type="checkbox"/> Detached retina | <input type="checkbox"/> Fracture of the spine   |
| <input type="checkbox"/> TIA (mini stroke) | <input type="checkbox"/> Blood in stool  |  |

**33: Currently, do any of the following apply to you:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Possibility of pregnancy   | <input type="checkbox"/> Receiving chemotherapy      | <input type="checkbox"/> Taking blood thinners             |
| <input type="checkbox"/> Taking birth control pills | <input type="checkbox"/> Receiving radiation therapy | <input type="checkbox"/> Surgical/medical implants/devices |

**34: Are you losing weight without trying?**  Yes  No

**35: Does pain wake you up at night?**  Yes  No

**36: Do you have a sore that doesn't heal?**  Yes  No

**37: Have you had an obvious change in a wart or mole?**  Yes  No

**38: Have you recently had any unusual bleeding or discharge?**  Yes  No \_\_\_\_\_

**39: Have you recently traveled a long distance?**  Yes  No \_\_\_\_\_

**40: Have you ever had an adverse reaction following chiropractic care?**  Yes  No \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## **Informed Consent**

*Please read this consent form, discuss it with your clinician if you would like to, and then sign where indicated at the bottom.*

Doctors of chiropractic evaluate patients using standard examination and testing procedures (such as orthopedic and neurological evaluation, labs, x-rays) along with specialized chiropractic evaluation. The chiropractic evaluation focuses on specific structural and/or functional abnormalities. Correction of these abnormalities is often accomplished by performing a procedure unique to the chiropractic profession called an “adjustment”. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. In addition to adjustments, other treatments used by chiropractors include physiotherapy modalities (e.g. heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations, and rehabilitative procedures.

As is the case with all health care interventions, the benefits of care must be weighed against the inherent risks and limitations of receiving treatment. Chiropractic treatments are one of the safest interventions available to the public as evidenced by malpractice statistics. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Nonetheless, they must be considered when making the decision on whether or not to receive chiropractic care. Listed below are summaries of some key research articles that have addressed both common and rare side-effects/complications associated with chiropractic care.

One research study indicated that within the first 2 months of care, approximately half of patients report some “reaction” to chiropractic treatment. Of those who reported a reaction, the following were the most commonly reported reactions to initial chiropractic care <sup>(1)</sup>:

- Local discomfort (53%)
- Headache (12%)
- Tiredness (11%)
- Radiating discomfort (10%)

Most appeared within 4 hours of treatment and resolved within 24 hours.

Rare, yet possible side-effects/complications:

- Rib fracture
- Burns (if certain types of physiotherapy are used)
- Disc herniation
- Cauda Equina Syndrome (1 case per 100 million adjustments) <sup>(2)</sup>
- Compromise of the vertebralbasilar artery (i.e. stroke) (1 case per 400,000 to 1 million cervical spine adjustments) <sup>(3)</sup>

In addition to national guidelines <sup>(4)</sup>, our clinic has set criteria for how we manage our patients. Through questioning and examination, we will do our best to determine what risk, if any, chiropractic care may pose to you and advise you of those risks as well as the possible need for medical referral. We may also suggest alternate chiropractic or medical approaches if we detect absolute or relative contraindications to the treatment we provide.

1. Senstad O, et al. Frequency and Characteristics of Side Effects of Spinal Manipulative Therapy. Spine 1997; 22:435-41.
2. Shekelle PG, et al. Spinal Manipulations for Low-Back Pain. Ann Intern Med 1992;117(7):590-8.
3. Haldeman S, et al. Risk Factors and Precipitating Neck Movements Causing Vertebralbasilar Artery Dissection After Cervical Trauma and Spinal Manipulation. Spine 1999;(24):785-94.
4. Haldeman S, et al. Guidelines for Chiropractic Quality Assurance and Practice Parameters. Aspen Publishers, 1997.

Acknowledgements: I acknowledge that I have discussed, or have been given the opportunity to discuss, with my clinician the nature of chiropractic treatment in general and my treatment in particular as well as the contents of this consent.

Consent: I consent to the chiropractic treatment(s) offered or recommended to me by my clinician, including adjustment of the joints of my spine, pelvis, and extremities. I intend this consent to apply to all my present and future treatments at this clinic.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (if required): \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Parent/Guardian: \_\_\_\_\_