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: _____

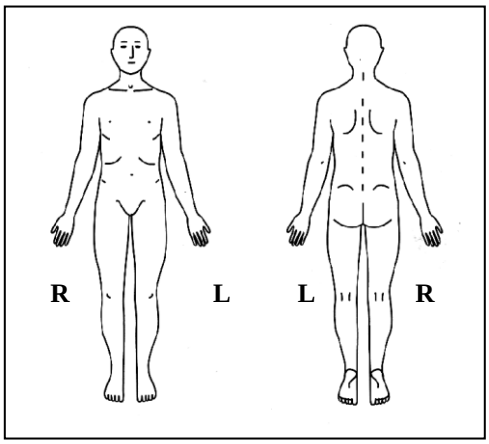
Name: _____
Date: _____
File #:_____

OHIO FAMILY & SPORTS CHIROPRACTIC

History of Present Illness:

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation □ Other

2. Where are your symptoms located? (Please mark drawing with symbols below)



Type of Symptom:

Sharp ///	Dull ===	Achy +++
Tingling ***	Numbness NNN	Shooting SSS
Burning ^^^	Throbbing <<<	Stiff ###

3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

5. Please rate your pain on the scale below:

0 1 2 3 4 5 6 7 8 9 10
(1-3 Minimal) (Slight 4-6) (Moderate 7-9) (Severe 10)

6. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

7. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER physician □ Orthopedist
□ Massage Therapist □ Physical Therapist □ No one □ Other:_____

9. How long have you had this problem? _____

10. How do you think your problem began?_____

11. What aggravates your problem? _____

12. What alleviates your problem? _____

13. What concerns you the most about your problem; what does it prevent you from doing?_____

_____

14. What is your: Height_____ **Weight** _____ **Date of Birth** _____

Name: _____
Date: _____
File #:_____

OHIO FAMILY & SPORTS CHIROPRACTIC

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

_____

Name: _____
Date: _____
File #:_____

OHIO FAMILY & SPORTS CHIROPRACTIC

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? _____

Name: _____
Date: _____
File #:_____

OHIO FAMILY & SPORTS CHIROPRACTIC

32: Have you ever been diagnosed with or experienced:

□ Blood in urine	□ AIDS	□ Loss of bladder control
□ Cancer	□ Osteoporosis	□ Loss of bowel control
□ Stroke	□ Detached retina	□ Fracture of the spine
□ TIA (mini stroke)	□ Blood in stool	

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

□ Possibility of pregnancy	□ Receiving chemotherapy	□ Taking blood thinners
□ Taking birth control pills	□ Receiving radiation therapy	□ 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:_____

Name: _____
Date: _____
File #:_____

OHIO FAMILY & SPORTS CHIROPRACTIC

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 [(1)]:

- 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) [(2)]
- Compromise of the vertebrobasilar artery (i.e. stroke) (1 case per 400,000 to 1 million cervical spine adjustments) [(3)]

In addition to national guidelines [(4)], 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 post 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 Vertebrobasilar 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: _____