

APPLICATION FOR TREATMENT

Name _____ Age _____ Birthdate ___/___/___ Sex: M F

Street Address _____

Mailing Address _____

E-mail address _____

City _____ State _____ Zip Code _____

SSN#: _____ HM Phone _____ Wk Phone _____

Employer _____

Spouse's name _____ Birthdate ___/___/___ SSN# _____

Employer _____ Wk Phone _____

If Minor, Parent or Guardian _____

Chief Complaint _____ Date this condition began _____

How did it occur? _____ Have you had this condition before? Y N

If yes, when? _____ How were you referred to our office? _____

Name of Insurance Company _____

Address _____ Policy # _____

If Worker's Comp, please provide:

Safety Manager's Name _____ Phone _____

Supervisor's Name _____ Phone _____

In case of an emergency, please list:

Name of nearest relative (not living with you) _____

Address _____ Phone # _____

Primary Physician _____ Phone _____

Address _____

(We will send your PCP a report of findings unless otherwise stated)

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO: PERRY CHIROPRACTIC HEALTH CENTER, P.C., FOR SERVICES RENDERED.

SIGNATURE _____ DATE _____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIMS: _____

PERSON AUTHORIZING CARE/RESPONSIBILITY:

SIGNATURE _____ DATE _____

IT IS OUR POLICY THAT YOUR INITIAL VISIT BE PAID IN FULL

PATIENT FORM

YOUR FULL NAME: _____

ACCIDENT / INJURY HISTORY:

Please CHECK or FILL-IN the appropriate answers.

If this **WAS NOT AN ACCIDENT** - DATE your SYMPTOMS started: ____ / ____ / ____ OR ____ symptoms were gradual.

CAUSE of your SYMPTOMS: ____ Unknown OR (finish the sentence) "Symptoms were the result of..." _____

If this **WAS AN ACCIDENT** - DATE of the ACCIDENT: ____ / ____ / ____

Injuries were sustained via... ____ Auto ____ Work related ____ At home ____ Fall ____ Accident ____ Slip

OR ____ Other (complete the sentence: "I was injured in..." _____)

Additional information (Please describe fully - ask for extra paper if necessary): _____

YOUR PAIN:

Below are several areas in which we would like you to indicate where you have pain, and how it feels. Please check only ONE, if any, for each category.

NECK:

The PAIN is:

____ Constant
____ Intermittent
____ Occasional

The SEVERITY is:

____ Mild
____ Moderate
____ Severe
____ Extreme
____ Other _____

The QUALITY is:

____ Dull
____ Sharp
____ Burning
____ Stabbing
____ Other _____

The PAIN is (____ greater <optional>):

____ on the left side
____ on the right side
____ equal on both sides

MID BACK:

The PAIN is:

____ Constant
____ Intermittent
____ Occasional

The SEVERITY is:

____ Mild
____ Moderate
____ Severe
____ Extreme
____ Other _____

The QUALITY is:

____ Dull
____ Sharp
____ Burning
____ Stabbing
____ Other _____

The PAIN is (____ greater <optional>):

____ on the left side
____ on the right side
____ equal on both sides

LOW BACK:

The PAIN is:

____ Constant
____ Intermittent
____ Occasional

The SEVERITY is:

____ Mild
____ Moderate
____ Severe
____ Extreme
____ Other _____

The QUALITY is:

____ Dull
____ Sharp
____ Burning
____ Stabbing
____ Other _____

The PAIN is (____ greater <optional>):

____ on the left side
____ on the right side
____ equal on both sides

OTHER AREA:

Please tell us where the pain is (Ex: right forearm, left calf): _____

The PAIN is:

____ Constant
____ Intermittent
____ Occasional

The SEVERITY is:

____ Mild
____ Moderate
____ Severe
____ Extreme
____ Other _____

The QUALITY is:

____ Dull
____ Sharp
____ Burning
____ Stabbing
____ Other _____

The PAIN is (____ greater <optional>):

____ on the left side
____ on the right side
____ equal on both sides

ADDITIONAL AREAS OF PAIN:

Please describe any ADDITIONAL AREAS of pain, and tell us how it feels.

WHAT CAUSES YOU DIFFICULTY:

Please check as many as you like.

___ **STANDING** ___ **SITTING** ___ **LYING DOWN** ___ **OTHER** _____

WALKING:	RIDING (in auto):	BENDING:	TWISTING or TURNING:	LIFTING:	___ RISING TO WALK after sitting
___ minimal	___ minimal	___ minimal	___ light	___ light	
___ moderate	___ moderate	___ moderate	___ moderate	___ moderate	
___ extended	___ extended	___ excessive	___ excessive	___ heavy	___ COUGHING and
			___ repetitive	___ repetitive	SNEEZING

DOES THE PAIN RADIATE into your...?

Please check as many as you like. ___ **BASE OF SKULL** ___ **NECK**

SHOULDER(S)	ARM(S)	HIP(S)	LEG(S)	PAIN IS WORSE:	PAIN INTERFERES with
___ left	___ left	___ left	___ left	___ in the morning	___ work
___ right	___ right	___ right	___ right	___ in the evening	___ sleep
___ both	___ both	___ both	___ both	___ following:	___ personal activities
				___ routine activity	___ other _____
				___ moderate activity	_____

___ Other body area (complete the sentence: "The pain radiates into my... _____".

CHIEF COMPLAINTS:

Please check your symptoms on the accompanying Symptoms List. If no list is available, write in your symptoms in the space below. (Examples: Headache; Low back pain; etc.)

PREVIOUS MEDICAL HISTORY:

- Were you referred to this office by another physician? ___ **YES** ___ **NO**
- If yes, please give his/her name and type of doctor. (Example: Dr. John Smith, M.D.): _____
- If you have, or have had, any previous injuries or conditions which may contribute to your current problems, answer the following:
 - What was the nature of the injury or condition? _____
 - How long ago? ___ **Months** OR ___ **Years**
 - Are there any left-over effects? ___ **YES** ___ **NO** If yes, please answer D.
 - Do these effects occur ___ **Frequently** or ___ **Not very frequently** Approximately how many times a year? _____
- Please tell us in your own words about any other condition or injury you have had previously. _____

SYMPTOMS LIST:

Please check any symptoms you have from the list below, and write in any not on the list.

- | | |
|--|--|
| <input type="checkbox"/> 12. Anxiety | <input type="checkbox"/> 2. Neck pain |
| <input type="checkbox"/> 44. Buzzing and ringing in ears | <input type="checkbox"/> 5. Neck pain and stiffness |
| <input type="checkbox"/> 45. Buzzing in ears | <input type="checkbox"/> 3. Neck stiffness |
| <input type="checkbox"/> 14. Chest pain | <input type="checkbox"/> 63. Neuritis |
| <input type="checkbox"/> 16. Constipation | <input type="checkbox"/> 58. Numbness in arms |
| <input type="checkbox"/> 17. Depression | <input type="checkbox"/> 56. Numbness in arms and legs |
| <input type="checkbox"/> 10. Diarrhea | <input type="checkbox"/> 57. Numbness in fingers |
| <input type="checkbox"/> 60. Difficulty in prolonged riding in an automobile | <input type="checkbox"/> 55. Numbness in fingers and legs |
| <input type="checkbox"/> 15. Dizziness | <input type="checkbox"/> 54. Numbness in fingers, arms and legs |
| <input type="checkbox"/> 29. Double vision | <input type="checkbox"/> 59. Numbness in legs |
| <input type="checkbox"/> 31. Equilibrium problems | <input type="checkbox"/> 28. Pain behind the eyes |
| <input type="checkbox"/> 34. Excessive perspiration | <input type="checkbox"/> 30. Pain between the shoulder blades |
| <input type="checkbox"/> 27. Extreme fatigue | <input type="checkbox"/> 42. Pain extending in the left shoulder and arm |
| <input type="checkbox"/> 26. Extreme nervousness | <input type="checkbox"/> 23. Pallor |
| <input type="checkbox"/> 18. Eye strain | <input type="checkbox"/> 21. Palpitation |
| <input type="checkbox"/> 47. Eyes sensitive to light, loss of focus | <input type="checkbox"/> 52. Pins and needles in arms |
| <input type="checkbox"/> 20. Face flushed | <input type="checkbox"/> 51. Pins and needles in arms and legs |
| <input type="checkbox"/> 13. Fainting | <input type="checkbox"/> 53. Pins and needles in legs |
| <input type="checkbox"/> 39. Feet cold | <input type="checkbox"/> 41. Restriction of neck motion |
| <input type="checkbox"/> 11. Frequent severe headaches | <input type="checkbox"/> 46. Ringing in ears. |
| <input type="checkbox"/> 40. Hands cold | <input type="checkbox"/> 33. Shortness of breath |
| <input type="checkbox"/> 50. Head and shoulders feel heavy | <input type="checkbox"/> 24. Sinus trouble |
| <input type="checkbox"/> 49. Head and shoulders feel tired | <input type="checkbox"/> 22. Tremors |
| <input type="checkbox"/> 48. Head and shoulders feel tired and heavy | <input type="checkbox"/> 43. Upper back stiffness |
| <input type="checkbox"/> 32. Head seems too heavy | |
| <input type="checkbox"/> 1. Headaches | |
| <input type="checkbox"/> 4. Insomnia | |
| <input type="checkbox"/> 6. Irritability | |
| <input type="checkbox"/> 8. Loss of smell | |
| <input type="checkbox"/> 37. Low back pain | |
| <input type="checkbox"/> 62. Low back pain and stiffness | |
| <input type="checkbox"/> 38. Low back stiffness | |
| <input type="checkbox"/> 9. Lower back pain | |
| <input type="checkbox"/> 25. Mental dullness | |
| <input type="checkbox"/> 35. Mid back pain | |
| <input type="checkbox"/> 61. Mid back pain and stiffness | |
| <input type="checkbox"/> 36. Mid back stiffness | |
| <input type="checkbox"/> 7. Moderate to severe neck pain | |
| <input type="checkbox"/> 19. Nausea, vomiting | |

Write in your own symptoms: _____

FAMILY HEALTH HISTORY

Many health problems are hereditary in nature and may be handed down generation after generation.

Patient _____

Please review the below-listed diseases and conditions and indicate those that are current health problems of a family member. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTER(S)		CHILDREN		
	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []
Arthritis										
Asthma - Hay Fever										
Back Trouble										
Bursitis										
Cancer										
Constipation										
Diabetes										
Disc Problem										
Emphysema										
Epilepsy										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Nervousness										
Neuritis										
Neuralgia										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										

If any of the above family members are deceased, please list their age at death and cause: _____

Please list all medications and supplements/vitamins
that you are currently taking

Medications

Supplements/Vitamins

Name _____

INFORMED CONSENT

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS & DIAGNOSIS

A doctor of chiropractic conducts a clinical analysis to determine if you are a chiropractic candidate. If it is determined you are a chiropractic candidate, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not be giving a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy.

I have read, and understand the foregoing.

Date

Signature

HEALTH CARE AUTHORIZATION FORM

Patient's Name _____

Patients SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES PERRY CHIROPRACTIC HEALTH CENTER TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to PCHC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, thank you cards, testimonials, marketing materials, information about treatment alternatives or other health related information.
- If PCHC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give PCHC permission to treat me in an open therapy room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving PCHC permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The Authorization shall expire on the following date: _____

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of PCHC. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by PCHC for its own use/disclosure of PHI.
(Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, PCHC will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

* A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU **

Print Name of Patient

Signature of Patient

Date

Signature of Personal Representative

Description of Representative's Authority To Act for Patient: