

Westside Family Chiropractic & Rehabilitation
Patient Information Form
Please Print

Patient Information

Full Name _____ Today's Date ____ / ____ / ____

Date of Birth ____ / ____ / ____ Sex: Male Female

Home Address _____
Street City State Zip Code

Home Phone () _____ Work Phone () _____ Mobile Phone () _____

Email _____

Student Employed Unemployed

Employer/School _____

Single Married Divorced Widowed Separated

Spouse's Full Name _____

Spouse's Employer _____

Emergency Contact _____ Phone # _____

Primary Care Physician _____ Office # () _____

Were you referred by a patient? Yes No If yes, please list name _____

Consent for Treatment

I request and consent to the performance of chiropractic, examination, adjustment/manipulation and any and all other chiropractic procedures permitted by our State law, including medical records review, various modes of physiotherapy and necessary diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible) by any of the treating doctors of chiropractic on staff and/or any licensed chiropractor deemed appropriate by the office. I understand that results of treatment are not guaranteed. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are risks associated with treatment, although rare, including, but not limited to, fracture, disc injuries, strokes, dislocations, strains, and worsening symptoms. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

I understand it is my responsibility to fill out my case history completely and to the best of my knowledge, and to inform the doctor of any information that is not listed on my case history. I also understand that it is my responsibility to inform the doctor of any changes that may occur once I have filled out that information. I authorize Westside Family Chiropractic & Rehabilitation to treat me.

I have read and understand the foregoing.

Signed: _____ Date ____ / ____ / ____

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Consent for Treatment of a Minor

I hereby request and authorize Westside Family Chiropractic & Rehabilitation to perform diagnostic tests and render chiropractic adjustments and other treatment to _____.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signed _____ Date ____ / ____ / ____

Printed Name

Relationship to Patient

Privacy

Receipt of Notice of Privacy Practices Written Acknowledgement (Please Initial)

_____ I was provided a Notice of Privacy Practices by Westside Chiropractic to read and keep as my own.

I authorize the release of my medical or incidental information necessary to provide continuity of my (the patient's) medical care and to process my (the patient's) medical insurance.

My Protected Health Information may be disclosed to:

- Self Only Parent/Guardian _____
 Spouse/Partner _____ Other _____

Financial Policy

(Please Initial)

_____ I understand that I am financially responsible for any balance. Our office participates with all major health plans. We will file primary and secondary claims for you. All deductible and copays are your responsibility.

If your plan requires a referral, it is your responsibility to obtain that referral prior to your visit.

For any services rendered, I authorize the assignment of benefits (payments) from my insurance to come direction to Westside Family Chiropractic & Rehabilitation

Insurance

Do you have health insurance?

- Yes** Please provide a copy of card at time of service. Copayment is required at time of service.
 No Payment is expected at time of service. We accept Cash, Check, or Credit Card.

Signed: _____ Date ____ / ____ / ____

Case History

Please Print

History of Present Illness

Approximately when did the conditions or symptoms begin to occur? _____ (date)

Is this the result of a work injury? Yes No Or an Auto Accident? Yes No

Describe the conditions, symptoms or purpose of the appointment: _____

Social

Do you smoke? Yes No Do you drink alcohol? Yes No
Number of packs (per week) _____ Number of drinks (per week) _____
Female patient: **Are you pregnant?** Yes No Unsure but could be
Date of last menstrual cycle: _____ Regular Irregular Using Birth control?

Medications

Please list any current medications:

I will provide a list of medications.
1 _____ Prescribed for: _____
2 _____ Prescribed for: _____
3 _____ Prescribed for: _____
4 _____ Prescribed for: _____

Allergies

Please list any known allergies, and allergies to medications.

1 _____ 3 _____
2 _____ 4 _____

Past Medical History

List any past surgeries (including appendix, tonsils, wisdom teeth, etc)

1 _____ 2 _____
3 _____ 4 _____

List any other hospitalizations & when & for what _____

List any major or minor falls & when they occurred _____

List any cracked or broken bones & when they occurred _____

Signed: _____ Date ____ / ____ / ____

Case History

Please Print

Additional Information Related to the Condition:

Describe your pain: Burning Sharp Dull Ache

What caused it? _____

What aggravates it? _____

What relieves it? _____

Has the patient ever had the same or similar symptoms to this condition? Yes No

When? ____ / ____ / ____

Describe _____

Please indicate any other healthcare providers who the patient has seen for the condition:

- | | | |
|--|--|---|
| <input type="checkbox"/> Chiropractor, List Date of Last Treatment | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> ER Physician | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Massage Therapist | |

Have you missed work or school due to your injuries? Yes No

Review of Systems

Have you experienced any of the below symptoms in the past 2 weeks or since your last visit?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Tension | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Pain in legs/feet |
| <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Sharp / shooting pain |
| <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Burning muscle pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Numbness arms/hands | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Fainting | <input type="checkbox"/> Ears ring |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Feet cold | <input type="checkbox"/> Pain in arms/hands | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Tingling in legs/feet | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Loss of Strength - Arms | <input type="checkbox"/> Constipation | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Tingling in arms/hands | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Chest pain/rib pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Loss of strength - legs | <input type="checkbox"/> Numbness legs/feet | _____ |
| <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Fever | _____ |

Changes in Systems

Have you experienced changes to any of the following?

- | | | | | |
|---------------------------------------|---|---------------------------------------|--|----------------------------------|
| <input type="checkbox"/> Eyes (sight) | <input type="checkbox"/> Ears (hearing) | <input type="checkbox"/> Nose (smell) | <input type="checkbox"/> Mouth (taste) | <input type="checkbox"/> Bladder |
| <input type="checkbox"/> Bowels | <input type="checkbox"/> Sleep | <input type="checkbox"/> Emotion | <input type="checkbox"/> Appetite | Please Explain: _____ |

Have you been diagnosed with or experienced any of the following?

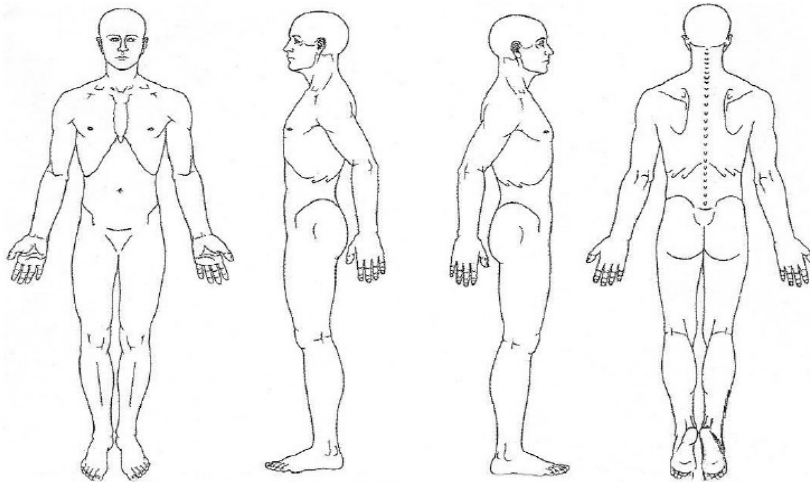
- | | | | | | |
|--|--|--|--|---------------------------------|---------------------------------------|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Osteopenia/Osteoporosis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Degenerative Joint/Disc Disease | <input type="checkbox"/> Autoimmune Disorder | _____ | |
| <input type="checkbox"/> Prostate Disorder | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer | _____ | |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Other | _____ |

Signed: _____ Date ____ / ____ / ____

Pain Index Questionnaire

Please Print

Pain Index



Please mark the areas on the picture below that correspond to the areas of your body where you feel the described sensations. Use appropriate symbols. Mark areas of radiation. Include all affected areas.

Do Not Simply Circle The Affected Area

Numbness ----

Aching ****

Pins & Needles oooo

Burning xxxx

Stabbing ////

Signed: _____

Date ____ / ____ / ____

Vitals

To be filled in by the office staff.

Height

Weight

Blood Pressure

Right Left

Pulse

_____ ins.

_____ lbs

____ / ____ mmHG

seated?

_____ BPM