Westside Family Chiropractic Rehabilitation

Patient Information Form

Patient Information

Full Name _____ **Date** ___/___/___

Date of Birth ___/___/___ Sex: ☐ Male ☐ Female Social Security # _____

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 _____ Date of Birth ___/___/___

Spouse's Employer _____ Spouse's Occupation _____

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** ___/___/___

Westside Family Chiropractic Rehabilitation

Patient Information Form

Patient Name _____ **D.O.B.** _____

Consent for Treatment of a Minor

I hearby request and authorize Westside Family Chiropractic and Rehabilitaion 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 WFC to read and keep as my own.

_____ I declined a copy that was offered to me, but I am aware of my rights.

_____ 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 all notices)

_____ 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 medical insurance?

☐ **Yes** Please provide a copy of card at time of service. Co-payment is required at time of service.

☐ **No** Payment is expected at time of service. We accept Cash, Check, Visa or Mastercard.

Signed _____ **Date** ___/___/___

This was published and becomes effective June 2016

Westside Family Chiropractic Rehabilitation

Case History

Please Print

Patient Name _____ **D.O.B.** _____ **Date** _____

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** ___/___/___

Westside Family Chiropractic Rehabilitation

Case History

Please Print

Patient Name _____ **D.O.B.** _____ **Date** _____

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:

Name	Type of Physician	Date of Last Visit
		___/___/___
		___/___/___

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?

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

Changes in Systems

Have you experienced changes to any of the following?

☐ Eyes (sight) ☐ Ears (hearing) ☐ Nose (smell) ☐ Mouth (taste) ☐ Bladder

☐ Bowels ☐ Sleep ☐ Emotion ☐ Appetite Please Explain: _____

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

☐ Fatigue ☐ Depression ☐ Osteopenia/Osteoporosis ☐ Heart Disease ☐ Stroke ☐ Tuberculosis

☐ Obesity ☐ Diabetes ☐ Degenerative Joint/Disc Disease ☐ Autoimmune Disorder _____

☐ Prostate Disorder ☐ Kidney problems ☐ High blood pressure ☐ Cancer _____

☐ Thyroid Problems ☐ Asthma ☐ Ulcer ☐ Seizure Disorder ☐ Other _____

Signed _____ **Date** ___/___/___

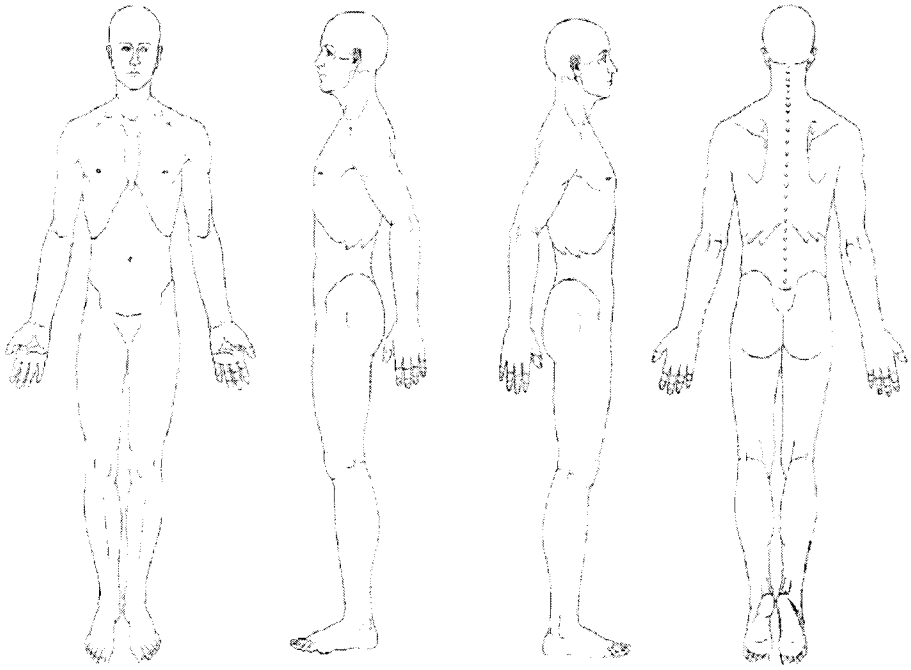
Westside Family Chiropractic Rehabilitation

Pain Index Diagram

Please Print

Patient Name _____ **D.O.B.** _____ **Date** _____

Pain Index Diagram



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			Pulse	
_____ in	____lbs ___ ozs	___/____mmHG	☐ Right	☐ Left		☐ Right Handed
			☐ Seated?		____BPM	☐ Left Handed