RebarcakChiropractic
PAIN RELIEF CENTER

## PERSONAL INFORMATION

Date of First Visit____________________

Name______________________________________________________ Nickname________________________
FIRST MIDDLE INITIAL LAST

Address____________________________ City______________ ST___ Zip_________ Email____________________________

Age_______ Birthdate______-______-______ Home Phone_____________________ Cell Phone_______________________

Occupation__________________________ Employer___________________________ Work Phone______________________

Describe job duties______________________________________________________________________________

❒ Single ❒ Married Spouse_________________________ Employer____________________________ # Children_______

In case of emergency contact___________________________ Relation________________ Phone_________________________

Referred by: ❒ Insurance ❒ Employer ❒ Web Site ❒ Google ❒ Yelp ❒ Chamber of Commerce ❒ Phone Book ❒ Newspaper

❒ Attorney ❒ Doctor ❒ Patient ❒ Co-worker ❒ Trainer/Coach *Their Name*______________________________

❒ Other ____________________________________________________________________________

## MAJOR COMPLAINT

**Describe your *main* problem: 1.**_____________________________________________________________

**What caused this**: _____________________________________________ **When did *this* episode start**:______________________

**Have you ever had any *previous* episodes of this problem?**________ **When**_____________________________________________

**Describe the pain**: ❒ Sharp ❒ Dull Ache ❒Numbness ❒ Cramp-like ❒ Localized
❒ Stabbing ❒ Deep Ache ❒ Tingling ❒ Throbbing ❒ Radiating to________________

**Current Pain Level**: 0 1 2 3 4 5 6 7 8 9 10 [0=none 10=severe] **Range or level you *have* experienced:** ______ [0-10]

**Percentage of the time you have pain**: ❒ < 25% ❒ 25%-50% ❒ 50%-75% ❒ > 75% ❒ 100%

**Has your problem been**: ❒ Improving ❒ The Same ❒ Getting Worse **Work Days Missed**:_______________________

**Is your pain worse**: ❒ Morning ❒ Day ❒ Night **What makes the pain worse**:__________________________________

**What have you done to relieve this**: ❒ Heat ❒ Ice ❒ Rest ❒ Medication Other________________________________

**Circle any areas that are affected in your normal daily living**:

❒ Sleeping ❒ Lifting ❒ Recreation ❒ Walking ❒ Sitting ❒ Standing ❒ Concentration ❒ Working

**Other doctors you have seen for this condition**:

Name: ________________________ Date: __________ Diagnosis:________________ Treatment:_____________________
Name: ________________________ Date: __________ Diagnosis:________________ Treatment:_____________________

**Describe any *secondary* problems:**

**2.**______________________________________________________________________________________

**3**. _____________________________________________________________________________________

**Do you have any concerns we should be aware of?** ________________________________________________________

## HEALTH HISTORY

**Check any problems you have had**:

| | | | | |
|---|---|---|---|---|
| ❒ Cancer | ❒ Stroke | ❒ Diabetes | ❒ Broken Bones | ❒ Headaches |
| ❒ Dizziness | ❒ Fatigue | ❒ Ear Noises | ❒ Cold Hands/Feet | ❒ Visual Disturbances |
| ❒ Heart | ❒ Kidney | ❒ Bladder | ❒ Colon | ❒ Difficulty Sleeping |
| ❒ Sinus | ❒ Prostate | ❒ Low Back | ❒ Mid Back | ❒ Upper Back |
| ❒ Leg | ❒ Neck | ❒ Hip | ❒ Blood Pressure | ❒ ___________________________ |

Explain_____________________________________________________________________________________________

**Current medications and dosage**: None 1.__________________________________ 2.__________________________________

3.__________________________________ 4.__________________________________ 5.__________________________________

**Surgical Operations and dates**_________________________________________________________________________

**Have you *ever* had *any* car accidents, falls, or serious injuries?** ❒ No ❒ Yes Date______________________________

Describe___________________________________________________________________________________________

**Any family history of back or neck problems?** ______________________________________________________________

**Do you exercise regularly?** ❒ No ❒ Yes Describe_________________________________________________________

**Family Medical Doctor**_____________________________ Last physical exam____-____-____ Results________________________

**Previous chiropractic care?** ❒ No ❒ Yes Dr.__________________ Last visit____-____-____ X-rays?_____Date_____________

**Minors**:__________________________________ **Females**: Are you pregnant or could you be?_____ Date Last Cycle____________

### ☑ INFORMED TREATMENT CONSENT

With any healthcare procedure, there may be complications that arise. Physical medicine ones are very rare but may include: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains, bruises, and injuries to neck arteries. We make every effort during the examination to screen for contraindications; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to let us know. Your signature below signifies that you have been informed and weighed the risks of care and that you hereby give your consent.

**X**_______________________________________________________ ______________________

**Signature** **Date**

### ☑ PRIVACY NOTICE CONSENT

The Health Insurance Portability and Accountability Act (HIPAA) requires us to let you know how your Patient Health Information (PHI) is going to be used. I agree to allow this office to use my PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. All staff will take precautions to assure my records are not available to those who do not need them. I also understand there are some semi-private areas here.

**X**_______________________________________________________ ______________________

**Signature** **Date**

### ☑ FINANCIAL AND INSURANCE CONSENT *(check all that apply)*

We will verify benefits and process your claims and do whatever we can to see your carrier meets their obligation for payment. Your signature below authorizes us to release information necessary and may assign benefits to our office. In the unlikely event that your insurance carrier refuses to pay for treatment, you agree to be financially responsible for charges. Our policy is to collect in the office so no statements are necessary. Thank you!

| | |
|---|---|
| ❒ INSURANCE | For our verified insurance patients, only your co-pay and any deductible are due today. |
| ❒ MEDICARE | Medicare and any supplemental insurance will reimburse you, so today's visit will be due from you. |
| ❒ MEDICAID | A one-time reduced Medicaid exam for $15 plus a $1 co-pay will both be due today. |
| ❒ AUTO ACCIDENT | No matter who was at fault, we file with *your auto insurance med-pay,* they generally cover all services. |
| ❒ WORK ACCIDENT | Your employer's worker's compensation carrier will usually cover all claims. |
| ❒ TIME OF SERVICE | If you have no third-party payer, payment is due today, after services are rendered. |

**Payment today:** *(check one box)* ❒ Cash ❒ Check ❒ Visa ❒ MasterCard ❒ Discover ❒ American Express

**X**_______________________________________________________ ______________________

**Signature** **Date**