CONFIDENTIAL PATIENT INFORMATION (Rev. 7/30/18)

All patient information is confidential and is released to others only with your approval. Answering all questions completely helps the doctor determine the extent of your health problems and verifies that they have a chiropractic solution. If we do not sincerely believe that we can help you, we will help you find someone who can.

Name: ______________________________ SS#: ______________ Date: ______________

Address: ____

City: ________________________________ State: __________ Zip Code: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Email Address: ____

Date of Birth: ____________ Age: _______ M / F # of Children: _______ Marital Status: S M D W

Occupation: ______________________________ Employer: ________________________

Spouse Name: ______________________________ Phone: ________________________

Other Nearest Relative: ____________________________ Phone: ______________________

Heard About Our Office Through: ____

CONSENT TO TREAT

I have fully evaluated the risks and benefits of undergoing treatment and I acknowledge that I know that no care is an option and that I am being treated voluntarily and hereby give my consent to treat.

________________________ ______________

Patient Signature Date

HIPAA ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of the "HIPAA NOTICE OF PRIVACY PRACTICES", and my understanding and my agreement to its terms.

____ ______________________

Patient Signature **Date**

Please read and initial each line. If you have questions, please ask us at the front desk for assistance.

1. _______ I have given the office my current and correct insurance information.
2. _______ I understand that I could be **charged $10 for a missed chiropractic appointment/ $25 for a missed massage appointment (no show) if a 24-hour notice of cancellation is not given.**
3. _______ I understand that I could possibly be discharged from the practice for failing to give 24 hour cancellation notice for two or more scheduled appointments.
4. _______ I understand that my co-payment is due at each visit.
5. _______ I understand that I may be responsible for charges related to the completion of forms and letters, e.g. FMLA paperwork is $20 (Fee schedule will be provided by the office.)

NOTICE: I attest that the above information is correct to the best of my knowledge. I authorize the release of any medical or other information necessary to process the claim. I authorize payment of insurance benefits to the physician or supplier for all services rendered. I am ultimately responsible for the balance of my account for any professional services rendered or fees associated with my care. I also agree that I am responsible for any collection fees should my account be turned over to a collection agency.

____ ______________________

Patient Signature **Date**

CONSULTATION/HISTORY FORM

Name: ____ Date: __________________

List primary reason for your appointment - specific areas of pain or discomfort - all recent injuries incurred.

____

____

Is your pain a result of: Auto Accident: _______ Work Injury: _______ Other: ______

When did the pain start? __________________

Recent Accidents/Injuries (auto, work, falls)

____

____

Any Surgeries

____

____

Old Accidents/Injuries/Hospitalizations
(even from childhood)

____

____

Other doctors I have seen for this condition:

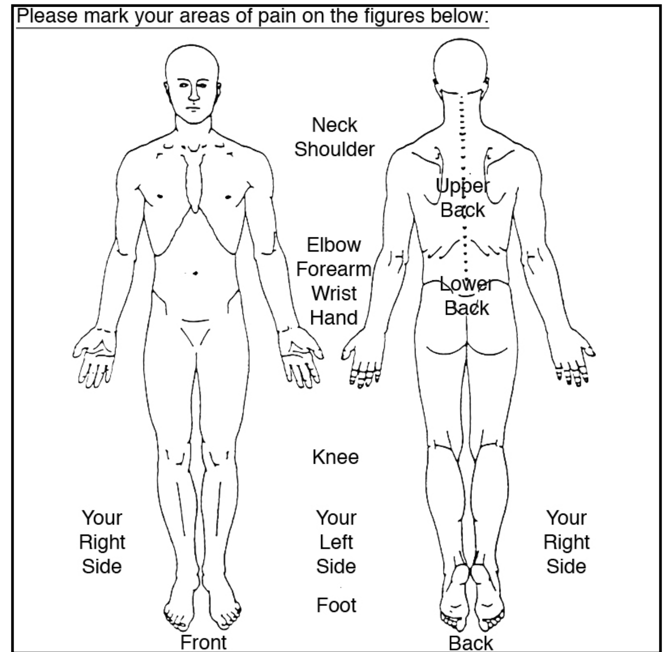
____

____

Please list all medications you are currently taking:

____

____



I would describe my pain as (circle as many as apply):

Constant Frequent Intermittent Occasional

Very Severe Severe Moderate-Severe Moderate Moderate-Mild Mild Very

Sharp/Stabbing Sharp/Stabbing Deep Burning Dull Aching

Other: ______________________________

What makes your pain worse? ____

What makes your pain better? ____

Do you have pain radiating down from your neck to your arms? _________________________

Do you have pain radiating down from your back to your legs? _________________________

I have tried the following solutions: ____

____

Have you been treated by a doctor for any health condition in the last year? Yes ____ No ____

Have you ever been under chiropractic care? Yes ____ No ____ When? __________________

Is there any other reason for your visit with the Chiropractor, another pain/discomfort?________

____

Name: ____ Date: _________________

Please list what you can't do fully in your life because of your condition (For example: playing with your children, cleaning, working, playing golf, gardening, etc.):

1.____

2.____

3.____

<u>Have you recently experienced:</u>

- ☐ Shoulder pain?
  - ☐ Numbness in your arms?
  - ☐ Tingling in your arms?
  - ☐ Pain in your arms?
  - ☐ Weakness in your arms?
  - ☐ Burning in your arms?
  - ☐ Pins & needles in your arms?
  - ☐ Numbness in your hands?
  - ☐ Tingling in your hands?
  - ☐ Pain in your hands?
  - ☐ Weakness in your hands?
  - ☐ Burning in your hands?
  - ☐ Pins & needles in your hands?
- ☐ Knee pain?
  - ☐ Numbness in your legs?
  - ☐ Tingling in your legs?
  - ☐ Pain in your legs?
  - ☐ Weakness in your legs?
  - ☐ Burning in your legs?
  - ☐ Pins & needles in your legs?
  - ☐ Numbness in your feet?
  - ☐ Tingling in your feet?
  - ☐ Pain in your feet?
  - ☐ Weakness in your feet?
  - ☐ Burning in your feet?
  - ☐ Pins & needles in your feet?
- ☐ Other ____

This is to certify that to the best of my knowledge I am not pregnant and that the doctor has permission to take x-rays.

_____________________________ ________________
Patient Signature Date

Name: ____ **Date:** _______________________

CIRCLE CURRENT CONDITIONS - CHECK FORMER CONDITIONS

Primary Symptoms

Musculoskeletal

Recurring Headache
Eye or Sinus Pain
Facial Spasms
Facial/Jaw Pain
Restricted Movement-
Head/Neck
Neck Pain
Neck Spasms
Poor Posture
Upper Back Pain
Sore, Aching,
“Top Shoulder” Muscles
Pain- Shoulder/Arm/Hand
Painful/Swollen/Stiff
Joints-
Elbow/Wrist
Swollen Arm/Hand
Restricted Movement-
Shoulder/Arm/Hand
Arthritis
Bursitis
Pain Beneath/Below
Breast Bone
Hiatal Hernia
Restricted Movement-
Torso
Scoliosis
Mid-Back Pain
Low Back Pain
Carpal Tunnel
Rheumatism
Neuritis
Neuralgia
Lumbago
Painful Tailbone
Buttock Pain
Swollen/Painful/Stiff Joints-
Knee/Ankle
Restricted Movement-
Leg/Foot
Leg Cramps
Leg Pain- Upper/Lower
Foot/Toe Pain
Sore/Weak Muscles
Walking Problems

Correlating Symptoms

Nervous System

Paralysis
Nervousness
Insomnia
Tremors
Convulsions
Anxiety
Fainting
Numbness/Tingling
Forgetfulness
Irritability
Dizziness
Hot/Cold Spots
Hiccups
Tension
Depression
Personality Change

Eye, Ear, Nose & Throat

Vision Problems
Zig Zag Flashes
Visual Disturbances
Eye Inflammation
Light Sensitivity
Eye Strain
Hearing Loss
Ear Discharge
Chronic Earache
Ear Noises
Head Colds
Hoarseness
Nose Discharge
Nose Bleeding
Sinus Trouble
Hayfever/Allergies
Difficulty Breathing
Through Nose
Dental Problems
Difficulty Speaking
Sore Mouth/Gums
Sore Throat
Canker Sores

Cardio-Vascular

Heart Attack
High Blood Pressure
Low Blood Pressure
Stroke
Rapid Heartbeat
Slow Heartbeat
Pain Over Heart
Hardening of Arteries
Swelling of Ankles
Varicose Veins
Poor Circulation

Gastro-Intestinal

Chronic Nausea
Vomiting Blood
Vomiting
Difficulty Chewing/
Swallowing
Gastritis/Heartburn
Food Allergy
Gallbladder Trouble
Liver Trouble
Jaundice
Distention of Abdomen
Pain Over Stomach
Diverticulitis
Excessive Hunger
Poor Appetite
Excessive Thirst
Black Stool
Bloody Stool
Belching Gas
Colitis
Constipation
Diarrhea
Hemorrhoids
Ulcers/Stomach Disorder

Respiratory

Tuberculosis
Asthma
Difficulty Breathing
Chronic Cough
Allergies
Chest Colds
Chronic Bronchitis
Coughing Phlegm/Blood

Skin

Shingles
Skin Disorder
Hives or Allergies
Itching
Boils
Bruise Easily
Acne
Dryness

Genito-Urinary

Urine Disorder-
Excessive/Scanty/
Painful/Discolored/
Blood/Pus
Bladder Trouble- Infection
Yeast Infections
Kidney Infections/Stones
Bed Wetting
Prostatitis
Impotency

Female

Periods, Painful/Excessive
Hot Flashes
Menopause
Breast- Lumps/Congested
Pregnant? Yes/No

Miscellaneous

Diabetes
Restless Legs
Cancer - Type?_________

Principled Chiropractic of Lawrenceburg
401 W Eads Parkway Ste. 320
Lawrenceburg, IN 47052

Patient Name: ____

I hereby request and authorize Principled Chiropractic to perform tests and render chiropractic adjustments and other treatment to said, above mentioned, minor. This authorization also extends to all other doctors and office staff and is extended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor 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 select and authorize this care should be revoked or modified in any way, I will immediately inform this office.

______________________________ ______________________
Signature Date

____
Printed Name

____
Relationship to Patient

____
Witness