Total Care Chiropractic · 40 Arena Way, Suite 1 · Council Bluffs · IA · 51501
Phone 712.329.1863 · Fax 712.323.1089 · Denise C. Woods, DC

Patient Name_____ Date _____

Sex: M F Marital Status: M S D W Circle Dominant Hand: Right Left

Address_____City_____

State_____Zip_____ H. Phone(_____)_____W. Phone(_____)_____

Cell Phone (_____)_____ Date of Birth_____ Age_____

Social Security #_____ Email Address: _____

Occupation_____ Employer_____

Referred by: _____

Have you ever received Chiropractic Care? □Yes □No If yes, when/where?_____

1. Reason for seeking care today:

Primary reason: _____

Secondary reason: _____

Is this a work related injury? _____ Is this injury the result of a motor vehicle accident?_____

Date Complaint Began and how? _____

Grade Intensity/Severity: (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

What aggravates the complaint? _____

What relieves the complaint? _____

Type of pain □Sharp □Dull □Throbbing □Numbness □Aching □Shooting □Burning □Tingling □Cramps □Stiffness

□Swelling □Other_____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_____

What activities aggravate your pain?_____

What activities lessen your pain? _____

Is the pain worse during certain times of the day? □Yes □No If yes, when _____

Is this condition interfering with Work?_____Sleep?_____Routine?_____Other? _____

Other symptoms: (please mark all that apply)

□Headaches	□Neck Pain	□Sleeping Problems	□Back Pain
□Nervousness	□Tension	□Irritability	□Chest Pain
□Dizziness	□Stiff Neck	□Pins & Needles in Legs	□Pins & Needles in Arms
□Numbness in Fingers	□Numbness in Toes	□Shortness of Breath	□Fatigue
□Depression	□Light Bothers eyes	□Ears Ring	□Numbness in Lips
□Fever	□Diarrhea	□Constipation	□Upset Stomach
□Loss of Balance	□Cold Hands	□Cold Feet	□General Tension

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2. Previous doctors, treatments, medications, surgery, or care you've sought for your current condition:

_____

_____

3. Past Health History:

A. Primary Care Physician: _____

B. Previous serious illnesses you've had in your life:

_____

C. Previous Injury or Trauma: _____

Have you ever broken any bones? Specify _____

C. Allergies: _____ Do you have a **Pace Maker** or other implant: □Yes □No

D. Medications:

Current Medications You Are Taking	Reason For Taking The Medication
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____

F. Females:

ARE YOU CURRENTLY PREGNANT? (Circle) yes no If yes, projected due date _____

What was the date of the beginning of your last menstrual period? _____

4. Family Health History:

Health problems of relatives: _____

_____

5. Social History:

A. Recreational activities:_____

B. Lifestyle:

Exercise □Yes □No Type/Frequency: _____

Alcohol consumption □Yes □No Consumption Frequency _____

Tobacco Use □Yes □No Consumption (packs per day) _____

Recreational Drug Use □Yes □No

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Statement of Acknowledgement of Financial Responsibility

Please have available and present your Insurance Cards to the front desk at your first appointment.

- I understand that I will be financially responsible for any charges incurred at Total Care Chiropractic including copays, deductibles, and/or charges for services I elect to have performed which are not covered by insurance companies.
- I realize my care may be subject to pre-certification by the insurance company, and I accept any responsibility for charges which may not be approved. The insurance company will review any/all documentation submitted by Total Care Chiropractic for review for medical necessity and base their approval/denial upon this documentation.
- Total Care Chiropractic may seek payment from me for any services my health insurance plan determine to be not medically necessary.

_____ Patient Initials

Privacy Practices Acknowledgement

The privacy practices information is posted in the office. I can request a copy from the office if I wish. I acknowledge that I am aware of this information.

_____ Patient Initials

Signature

I have read the above information and certify it to be true and correct to the best of my knowledge.

_____ _____
Patient or Guardian Signature Date

_____
If not patient, relationship to patient

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CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as Chiropractic adjustments or chiropractic manipulative treatments) and any other associated Procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

When a person seeks Chiropractic care and we agree to provide said care, it is essential for both to be working towards the same objective. We do not offer to diagnose or treat any disease. Our focus in this office is on pain management treatment involving the 24 vertebra of the spine resulting in nerve dysfunction. However, if we encounter non-chiropractic or unusual findings we will advise you and refer you to another healthcare provider for treatment.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: disc injuries, dislocations, muscle strain, fractures, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I have read (or have had read to me) the above explanation of the chiropractic treatments. By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Signaure_____Date_____

CONSENT TO EVALUATE AND ADJUST A MINOR

I, _____being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

Signaure_____Date_____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and staff have my permission to perform an x-ray if necessary during the examination process. Date of last menstrual period:
_____

Signaure_____Date_____