East Valley Chiropractic

Welcome to our office!

Today's Date ____/____/____

Patient Title: Mr. Mrs. Ms. Miss Dr.

Name: _____ Preferred Name: _____

Address: _____

City: _____State: _____Zip Code: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email Address: _____

Preferred Contact Method: Home Phone Work Phone Mobile Phone Email

Date of Birth ____/____/____ Age: _____ Gender Male Female

Social Security # _____-_____-_____

Race: White/Caucasian Black/African American Hispanic Asain

Other _____ I choose not to specify

Marital Status: Single Married Other

Spouse's Name:_____# of children _____

Emergency Contact Phone |#: _____ Relationship: _____

Referred to our office by: _____

Employment Status: Employed Full-Time Part-Time Student Retired Other

Occupation: _____Employer: _____

_____

Health Information

Do you currently take any medications? Yes No

	Medication Name	Dosage	Frequency	For What Condition
1				
2				
3				
4				
5				

Are you allergic to any medications? Yes No

If yes, please list known allergies to medications: _____

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Current Problem

Reason for this visit? _____

_____

What level of intensity would you rate your pain?

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Please select all that apply:

Achy	Burning	Cramping	Deep	Dull
Numbness	Radiating	Sharp	Shooting	Soreness
Stabbing	Stiff	Throbbing	Tightness	Tingling

What is the frequency of your symptoms?

Constant Frequent Intermittent Occasional

What makes your symptoms worse? _____

What makes your symptoms better? _____

What did the symptoms start? _____

How did you injure yourself? _____

Have you ever experienced this before? Yes No

How does this affect your personal life? (Hobbies, sports, etc…) _____

_____

How does this affect your job? (Missed days, inability to lift, stand, sit, etc…) _____

_____

What home remedies have you tried? _____

Have you been to another doctor for this problem? Yes No

Have you ever been to a Chiropractor before? Yes No

Does this affect any of the following tasks?

Bathing/Showering	Bending Forward	Driving
Brushing Teeth	Bending Left	Golfing
Drying Hair	Bending Right	Exercising
Cleaning	Carrying Objects	Hobbies
Combing Hair	Getting Out of Chair	Home Maintenance
Eating	Kneeling	Household Chores
In/Out of Bed	Leaning Back	Mowing Lawn
Going to Bathroom	Lifting Objects	Picking Up Kids
Doing Laundry	Reaching	Playing Sports
Preparing Meals	Standing	Raking Leaves
Putting on Pants	Stair Stepping	Shoveling Snow
Putting on Shirt	Sitting	Sleeping
Putting on Shoes	Twisting	Swimming
Taking Out Trash	Walking	Yard Work

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Past Health History

Have you ever…

Yes	No	
___	___	Been Knocked Unconscious?
___	___	Been in a car accident?
___	___	Been treated for a spine problem/nerve disorder?
___	___	Had any significant falls, slips, or injuries?
___	___	Fractured/broken a bone?
___	___	Had surgery?
___	___	Been hospitalized for other than surgery?

Do you currently use tobacco of any kind? Yes - Former smoker - Never been a smoker
If yes, how often do you smoke: Current, every day – Current, sometimes
Packs per day____

If yes, what is your level of interest in quitting smoking? 0 1 2 3 4 5 6 7 8 9 10

Do you consume alcohol? Yes No # Drinks per week____
Do you consume caffeine? Coffee – Soda – Tea - Energy Drinks, # Drinks per day____
Do you exercise? No - Infrequent - Occasional – Regular - Avoid due to pain

Please mark any you currently have or have had previously:

AIDS	Cramps	Kidney Infection	Sciatica
Alcoholism	Depression	Kidney Stone	Shortness of Breath
Allergies	Diabetes	Loss of Memory	Sinus Infection
Amenia	Digestion Problems	Loss of Balance	Sleep Problems
Arteriosclerosis	Dizziness	Loss of Smell	Spinal Curvatures
Arthritis	Excessive Menstruation	Loss of Taste	Stroke
Asthma	Eye Pain/Difficulties	Migraine Headache	Swelling in Ankles
Back Pain	Fatigue	Neck Pain/Stiffness	Swollen Joints
Breast Lump	Frequent Urination	Nervousness	Thyroid Condition
Bronchitis	Headache	Nosebleeds	Tuberculosis
Bruise Easily	Hemorrhoids	Pacemakers	Ulcers
Cancer	High Blood Pressure	Polio	Varicose Veins
Chest Pain	Hot Flashes	Poor Posture _____	
Cold Extremities	Irregular Heart Beat	Prostate Issues _____	
Constipation	Irregular Cycles	Ringing in Ears _____	

Is there a family history of…? (Include relationship)

Heart Disease _____
Cancer _____
Stroke _____
Arthritis _____
Diabetes _____
High Blood Pressure _____
Other _____

Notice of Privacy Practices

Our practice is dedicated to maintain the privacy of your health information according to the guidelines set forth by federal and state law. These laws also require us to provide you with notice of privacy practices, and to inform you of your rights and our obligations concerning your health information. The undersigned hereby acknowledges that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of East Valley Chiropractic Clinic, which describes the practice's policies and procedures regarding the use and disclosure of any of the Protected Health Information created, received or maintained by East Valley Chiropractic Clinic.

Initial

Patient's Rights and Responsibilities

Health care involves a partnership between patients, families, and health care providers, each of whom have certain right and responsibilities. When you are well-informed, participate in treatment decisions, and communicate openly with your doctor and other health professionals, you help make your care as effective as possible. This clinic encourages respect for the personal preferences and values of each individual. The undersigned hereby acknowledges that I have received, reviewed, and understand my right and responsibilities.

Initial

Statement of Informed Consent

Chiropractic adjustments are performed in our office by skilled doctors of chiropractic who have successfully completed advanced educational requirements, national board examinations, and state board examinations. As with any healthcare procedure, there are some inherent risks that exist. Whenever possible this risk is minimized to its lowest level. Our doctors and staff make every effort possible to provide the safest chiropractic care available. The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and that any/all treatments have risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from the doctor.

Initial

Assignment of Benefits

Assignment of benefits is simply authorizing East Valley Chiropractic Clinic to file charges directly to your insurance company, saving you time and effort of filling claims yourself. The undersigned hereby authorizes East Valley Chiropractic Clinic to submit my insurance claims to my insurance company. By having my signature on file, I need not sign each claim submitted by their office. I understand that I may withdraw my signature at any time. I also understand that I an ultimately responsible for all charges for which my insurance does not pay.

Initial

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any preexisting medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services are rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that East Valley Chiropractic will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to East Valley Chiropractic will be credited to my account on receipt.

I have read and understand you Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used or disclosed.

The information I have provided above is accurate to the best of my knowledge and will be used to determine appropriate chiropractic care.

Please Sign and Date:

_____ Date _____ / _____ / _____

Parent or Guardian if Patient is under 18 years of age