

**GENERAL INFORMATION**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Past Chiropractic Care? Yes No  
When? \_\_\_\_\_

<p><b>PERSONAL INFORMATION</b></p> <p>Marital: Single Married Divorced Widow</p> <p>Spouse's Name: _____</p> <p>Names &amp; Ages of Your Children:</p> <p>name: _____ age: _____</p> <p>name: _____ age: _____</p> <p>name: _____ age: _____</p> <p>Your Age: _____</p> <p>Sex: Male Female</p>	<p><b>WORK INFORMATION</b></p> <p>Occupation: _____</p> <p>Employer: _____</p> <p>Work Phone: _____</p> <p><b>INSURANCE INFORMATION</b></p> <p>Insured's Name: _____</p> <p>Insured's SS#: _____</p> <p>Insured's Date of Birth: _____</p> <p>Insurance Co: _____</p>
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How did you find out about our office? \_\_\_\_\_

Who is responsible for your bill? Please check the best choice which applies

You and your:  spouse  worker's comp  auto ins.  medicare  health ins.

<p><b>HEALTH HABITS</b></p> <p><input type="checkbox"/> smoking packs/day _____</p> <p><input type="checkbox"/> drinking alcohol/day _____</p> <p><input type="checkbox"/> coffee cups/day _____</p> <p><input type="checkbox"/> water glasses/day _____</p> <p><input type="checkbox"/> pop cans/day _____</p> <p><input type="checkbox"/> sleep hours/night _____</p>	<p>Please check and fill in the appropriate boxes</p> <p>Exercise: <input type="checkbox"/> none <input type="checkbox"/> moderate <input type="checkbox"/> daily</p> <p>Type: _____</p> <p>Do you take vitamins or minerals? Yes No</p> <p>Please list _____</p> <p>Which best describes your stress level?</p> <p>None Minimal Moderate Tremendous</p>
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<p><b>FAMILY HISTORY</b></p> <p>MOTHER diabetes heart back problems headaches</p> <p>FATHER diabetes heart back problems headaches</p> <p>BROTHER, # of _____ diabetes heart back problems headaches</p> <p>SISTER, #of _____ diabetes heart back problems headaches</p>	<p>Please circle all that apply</p>
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**OPERATIONS & PROCEDURES**

Please list all of the operations, procedures, broken bones, fractures, dislocated joints and spinal taps you have had over the years: \_\_\_\_\_

\_\_\_\_\_



# ORR CHIROPRACTIC CENTER

## CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I, \_\_\_\_\_ (*print patient name*), understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Health Information Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent, in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and ***accept*** the terms of this consent.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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- Dental Visits:      Every 6 months      Yearly      Toothache/Emergency Only      None
- List the brand names of the prescriptions and over-the-counter medication that you take regularly:

\_\_\_\_\_

- Please list ALL recreation accidents, sports injuries, auto accidents, etc. and the year in which they occurred:

\_\_\_\_\_

On your second visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reach all of your health goals.

- As a result of my chiropractic care, I would like to: (please check all that apply)  
\_\_\_\_ feel better quickly      \_\_\_\_ have a healthier body by keeping my nervous system healthy  
\_\_\_\_ have a healthier spine      \_\_\_\_ live a healthier lifestyle & have a better quality of life

# ORR CHIROPRACTIC CENTER

If you have had the following, or if you suffer from the following, please check the appropriate box.

<b>General Symptoms</b>	Constantly/ Frequently	Sometimes/ Occasionally
allergies		
cold/heat intolerance		
dizziness/fainting		
depression/moodiness		
fatigue		
headache		
loss or difficulty sleeping		
weight change (+/-)		
nervousness		
night sweats		
numbness in arms/legs/hands		
pain in arms/legs/hands		
crave sweets/salts		
cold/tingling extremities		
leg cramps		

<b>Gastro-Intestinal</b>	Constantly/ Frequently	Sometimes/ Occasionally
belching or gas		
constipation		
diarrhea		
hemorrhoids		
nausea		
abdominal pain		
appetite increase/decrease		
vomiting		
excessive thirst		
heartburn/indigestion		
black/bloody stool		
ulcers		
difficult chewing/clicking		
acid reflux		
craving sweet/salty foods		
tired after meals		

<b>Eye/Ear/Nose/Throat</b>	Constantly/ Frequently	Sometimes/ Occasionally
mouth sores		
earache		
ear ringing		
enlarged thyroid/goiter		
frequent colds		
hoarseness		
nasal obstruction		
absence of taste		
nose bleeds		
absence of smell		
vision trouble/eye fatigue		
sinusitis		
sore throat/tonsillitis		
dental problems		
hearing difficulties		
deafness		

<b>Respiratory</b>	Constantly/ Frequently	Sometimes/ Occasionally
chest pain		
asthma		
chronic cough		
difficult breathing		
frequent clearing throat		

<b>Skin or Allergies</b>	Constantly/ Frequently	Sometimes/ Occasionally
boils or skin eruptions		
bruising easily		
dryness/eczema		
hives or itching		

Patient Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

# ORR CHIROPRACTIC CENTER

If you have had the following, or if you suffer from the following, please check the appropriate box.

<b>Cardio-Vascular</b>	Constantly/ Frequently	Sometimes/ Occasionally
high blood pressure		
low blood pressure		
pain over heart		
poor circulation		
rapid heart		
slow heart		
swelling ankles/feet/legs		
varicose veins		
pacemaker		

<b>Genito-Urinary</b>	Constantly/ Frequently	Sometimes/ Occasionally
bed wetting		
blood in urine		
frequent/painful urination		
inability to control urine		
bladder/kidney infection		
prostate trouble		
infertility		
sexual dysfunction		

<b>For Women Only</b>	Constantly/ Frequently	Sometimes/ Occasionally
excessive flow		
hot flashes		
irregular cycle		
painful periods		
breast pain		
breast lumps		
vaginal discharge		

Circle all that apply to you or have applied to you at any time in your life.

- |                    |                     |
|--------------------|---------------------|
| appendicitis       | arthritis           |
| epilepsy           | mumps               |
| polio              | HIV positive        |
| alcoholism         | cancer              |
| osteoporosis       | spinal disc disease |
| anemia             | measles             |
| rheumatic fever    | influenza           |
| chicken pox        | tuberculosis        |
| eczema             | venereal disease    |
| scoliosis          | goiter(thyroid)     |
| heart disease      | mental disorder     |
| pneumonia          | diabetes            |
| pleurisy           | stroke              |
| whooping cough     | heart attack        |
| multiple sclerosis | hernia              |

Please use the scale for the following activities of daily living:

- U**=unable    **L**=limited    **N**=normal
- |                                 |                  |
|---------------------------------|------------------|
| _____ walking                   | _____ lifting    |
| _____ standing                  | _____ running    |
| _____ sitting                   | _____ sleeping   |
| _____ housework                 | _____ exercising |
| _____ bending                   | _____ gripping   |
| _____ stair climbing            | _____ reaching   |
| _____ stooping/kneeling         |                  |
| _____ getting in & out of a car |                  |
| _____ personal grooming         |                  |
| _____ pushing/pulling           |                  |

Have past pregnancies been normal?    yes            no            n/a  
 Pregnant at this time?                    yes            no  
 Age of 1st menses                            \_\_\_\_\_  
 Date of last menses                         \_\_\_\_\_  
 Miscarriage Number                         \_\_\_\_\_



# **INFORMED CONSENT**

## **DOCTOR – PATIENT RELATIONSHIP IN CHIROPRACTIC**

### **CHIROPRACTIC**

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

### **ANALYSIS**

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use this inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative power of the body.

### **DIAGNOSIS**

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and the VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

### **INFORMED CONSENT FOR CHIROPRACTIC CARE**

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provider is licensed in a special practice and is available to work with other types of providers in your health care regime.

### **RESULTS**

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or the VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

### **TO THE PATIENT**

Please discuss any questions or problems with the doctor **BEFORE** signing this statement of policy.

I have read and understand the above information:

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Patient/Guardian Signature

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Date