FOR OFFICE USE ONLY

C BC/BS MC MD AA O

Myrtle Grove Chiropractic & Acupuncture Center

WELCOME TO YOUR HEALTH HAPPINESS & HOPE CLINIC

TODAY'S DATE:_____

PURPOSE OF APPOINTMENT: CONSULTATION TREATMENT OTHER_____

HOW WERE YOU REFERRED TO OUR OFFICE: _____

LAST NAME: _____FIRST: _____Middle Intial: _____ Nickname: _____

DOB: _____-_____-_____ AGE: _____ SEX: M F SOCIAL SECURITY #: _____-_____-_____

MARITAL STATUS: MARRIED SINGLE OTHER NUMBER OF CHILDREN: _____

HOME ADDRESS:_____

BILLING ADDRESS (if different) :_____

CITY: _____ STATE:_____ZIP:_____

HOME PHONE:_____ WORK PHONE: _____ CELL PHONE:_____

CAN YOU RECEIVE TEXTS? YES NO

EMAIL ADDRESS: _____

EMPLOYMENT STATUS: FT/PT SELF-EMPLOYED UNEMPLOYED RETIRED STUDENT FT/PT

Employer Name: _____

Occupation: _____

May we contact you at work: YES NO

Emergency Contact Information:

Name: _____Phone_____ Relationship_____

Name: _____Phone_____ Relationship_____

Person responsible for account: _____ DOB _____

Address: _____

Phone number:_____ Work Phone: _____

CHIEF COMPLAINT(S):

1. _____

2._____

3._____

4. _____

CONDITION RESULT OF:

AUTO ACCIDENT WORK SPORTS REPETITIVE INJURY ACTIVITIES OF DAILY LIVING

ONSET DATE: _____ SUDDEN GRADUAL UNKNOWN

AVERAGE DAILY STRESS : *INCLUDE EMOTIONAL PHYSICAL AND CHEMICAL (DIET& MEDICATION)*

NO STRESS 1 2 3 4 5 6 7 8 9 10 TREMENDOUS STRESS

QUALITY OF PAIN: SHARP DULL STABBING DEEP THROBBING POUNDING CRAMPING BURNING ACHY STIFF LOCKED WOBBLY WEAK LOCALIZED RADIATING VAGUE NUMBNESS TINGLING

TIMING: WORSE A.M. P.M. SAME THROUGHOUT DAY

WHAT HELPS YOUR CONDITION? NOTHING ICE HEAT REST STRETCHING EXERCISE CHIROPRACTIC ACUPUNCTURE DIET TOPICAL GELS MASSAGE OPIATES MUSCLE RELAXERS OTHER PAIN KILLERS NSAIDS

WHAT MAKES YOUR CONDITION WORSE? EVERYTHING NOTHING CHANGES THE PAIN DRIVING BENDING STOOPING LEANING BACK LIFTING TWISTING REACHING GARDENING RAKING COUGHING SNEEZING BEARING DOWN SITTING PROLONGED SITTING SITTING ON TOILET STANDING PROLONGED STANDING WALKING PROLONGED WALKING LYING ON BACK/SIDE / STOMACH L/R TURNING HEAD L/R LOOKING UP LOOKING DOWN

HAVE YOU EVER RECEIVED CHIROPRACTIC CARE? NAME OF DOCTOR AND LAST VISIT.

WHY DID YOU DISCONTINUE CARE?

_____

_____

HAVE YOU SEEN OTHER DOCTORS OR THERAPISTS FOR THIS CONDITION?

_____

DID IT HELP? YES NO

NAME OF
DOCTOR/FACILITY/TREATMENT:_____

_____

BRIEFLY DESCRIBE THE TRAUMA YOUR BODY HAS BEEN UNDER DURING YOUR LIFE. INCLUDING SPORTS INJURIES, FALLS, ACCIDENTS. SURGERIES AND LIFESTYLE. Please include dates.

_____

_____

_____

_____

CHECK THE BOX AND CIRCLE L/R IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING:

- o BACKACHES/PAIN L/R
- o HIP PAIN L/R
- o LEG PAIN L/R
- o FOOT PAIN L/R
- o NUMBNESS/TINGLING
- o NECKACHES/PAIN L/R
- o SHOULDER PAIN L/R
- o ARM PAIN L/R
- o HAND PAIN L/R
- o HEADACHES
- o MIGRAINES
- o JAW PAIN L/R
- o RINGING IN EARS
- o DIZZINESS
- o SINUSITIS
- o ALLERGIES
- o DIABETES
- o THYROID
- o HIGH CHOLESTEROL
- o HIGH BLOOD PRESSURE
- o HEART TROUBLE
- o HEART MURMUR
- o RHEUMATIC FEVER
- o ANEMIA
- o PACEMAKER
- o SLEEP APNEA
- o NERVOUSNESS
- o ANXIETY
- o ARTHRITIS
- o DIGESTIVE DISORDERS
- o HEPATITIS
- o HIV/AIDS
- o CANCER
- o TUMOR
- o OTHER

CHEMICAL STRESS:

When was your last complete blood work? _____

May we get a copy of the blood work results? _____

CURRENT MEDICATION	CONDITION	DOSAGE	DATE BEGAN

Patient Initials _____ **Date: _____**

CURRENT VITAMINS **BRAND** **DOSAGE** **DATE**

_____

_____

_____

_____

_____

_____

PLEASE DO NOT SKIP THE FOLLOWING:

WATER INTAKE: _____ **COFFEE**: _____**ALCOHOL:**_____**UN) SWEET TEA:**_____**SODA**_____

BREAKFAST: _____

LUNCH: _____

DINNER; _____

SNACKS: _____

THE HEALTHIEST FOOD I EAT IS: _____

THE MOST UNHEALTHY FOOD I EAT IS:_____

Patient Initials:_____ **Date:**_____

PATIENT NAME:_____ **DATE:** _____

1. **What is your pain right NOW?**

HEAD	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10
MIDBACK	0	1	2	3	4	5	6	7	8	9	10
LOW BACK	0	1	2	3	4	5	6	7	8	9	10
OTHER	0	1	2	3	4	5	6	7	8	9	10

2. **What is your TYPICAL or AVERAGE pain?**

HEAD	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10
MIDBACK	0	1	2	3	4	5	6	7	8	9	10
LOW BACK	0	1	2	3	4	5	6	7	8	9	10
OTHER	0	1	2	3	4	5	6	7	8	9	10

3 **What is your pain level at its BEST** (how close to zero does your pain get)?

HEAD	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10
MIDBACK	0	1	2	3	4	5	6	7	8	9	10
LOW BACK	0	1	2	3	4	5	6	7	8	9	10
OTHER	0	1	2	3	4	5	6	7	8	9	10

4.**What is your pain level at its WORST** (how close to 10 does your pain get)?

HEAD	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10
MIDBACK	0	1	2	3	4	5	6	7	8	9	10
LOW BACK	0	1	2	3	4	5	6	7	8	9	10
OTHER	0	1	2	3	4	5	6	7	8	9	10

Please check all services of interest to you:

- o Chiropractic
- o Acupuncture
- o Physiotherapy
- o Nutritional support
- o Functional medicine
- o Mental health
- o Stress reduction
- o Brain balance
- o Spinal strengthening
- o Pregnancy
- o Children's health
- o Teen health
- o Sports injuries
- o Auto accident injuries
- o Surgical prevention
- o Post surgical treatment
- o Allergies
- o Visual problems
- o Orthotics
- o Weight loss
- o Smoking cessation
- o Facial rejuvenation

DISCLOSURE AND CONSENT FOR CHIROPRACTIC CARE

To the patient: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the treatment after knowing the potential risks and hazards involved. The disclosure is not meant to alarm you; simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, acupuncture and diagnostic x-rays on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic treatments. I understand I am informed that, in the practice of chiropractic there are some risks to exam and treatment including but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and in my best interest. I further acknowledge that no guarantee or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions and all of my questions have been answered fully and satisfactorily. Signing below, I consent to the treatment plan. I intent this consent form to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek.

Patient Signature _____ Doctor Initial: _____ Date:_____

HIPPA POLICY

This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to the information.

- Patient authorization for contact regarding chiropractic care, related health services and/or related health products.
- Our promise of privacy and consent to patient records.
- Consent for purpose of treatment, payment and health care operations.

I acknowledge I have received and read a copy of the HIPAA Policy:

Signature: _____Date: _____

Your signature indicates your authorization of this activity and consent.

Personal Representative Name: _____

Description of the authority to act on behalf of patient:_____

I authorize the following person/persons to obtain information regarding my protected health information.

Name: _____ Relationship

Name: _____ Relationship

Name: _____ Relationship