MYRTLE GROVE CHIROPRACTIC & ACUPUNCTURE CENTER

For Office Use Only

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TODAY'S DATE: _____

PURPOSE OF APPOINTMENT: CONSULT TREATMENT WEIGHT LOSS COGNITIVE TESTING

How did you hear about us? Google Social Media Friend/Family Other

Last Name: _____ First: _____Middle Initial:___ 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: _____

Email address: _____

Appointment Reminder Preference: Cell (text) Cell (voice) Home (voice) Email

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

Employer name: _____

Occupation: _____

May we contact you at work: YES NO

Person responsible for account: _____ DOB: _____

Address: _____

Phone number:_____ Relationship:_____

Emergency Contact:

Name: _____ Phone:_____ Relationship:_____

Please answer the following lifestyle questions thoroughly.

DIET: Do you follow a specific diet? YES NO

Breakfast: Time:_____ Contents:_____

Lunch: Time:_____ Contents: _____

Dinner: Time:_____ Contents:_____

Snacks: Time(s)_____ Contents:_____

How much of the following do you consume DAILY?

Water:_____ Coffee:_____ Alcohol:_____ Soda:_____ (un)sweet Tea:_____ Other:_____

SLEEP PATTERN:

Do you have a regular sleep schedule: YES NO

What time do you go to bed?_____ What time do you get up?_____

Do you awaken in the middle of the night? YES NO Do you have difficulty falling back asleep? YES NO

EXERCISE ROUTINE: Describe your exercise routine and how many days a week you participate in the activities: _____

_____

_____

Briefly describe the trauma your body has experienced during your life including sports injuries, falls accidents and surgeries: _____

_____

_____

Please circle if you have experienced any of the following

back pain hip pain leg pain foot pain numbness/tingling neck pain shoulder pain arm pain

hand pain headaches migraines jaw pain dizziness sinusitis allergies diabetes thyroid disorder

high cholesterol high blood pressure heart trouble heart murmur rheumatic fever anemia

pacemaker sleep apnea nervousness anxiety depression arthritis digestive disorders hepatitis

HIV/AIDS cancer tumor other

When was your last complete blood work? _____

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

Have you ever received chiropractic care? YES NO

Name of Chiropractor and last visit_____

Why did you discontinue care? _____

Have you seen any other doctors/therapists for this condition YES NO Did it help? YES NO

IS YOUR CONDITION A RESULT OF : Auto accident work sports repetive injury fall/injury activities of daily living emotional stress physical stres

CHIEF COMPLAINTS "0" IS NO PAIN AND "10" IS UNBEARABLE PAIN

1. Specific part of the body:_____
   Pain level now 0 1 2 3 4 5 6 7 8 9 10
   Average pain: 0 1 2 3 4 5 6 7 8 9 10
   Pain at its lowest: 0 1 2 3 4 5 6 7 8 9 10
   Pain at its highest: 0 1 2 3 4 5 6 7 8 9 10
   Feels like*:* Sharp – Dull – Stabbing – Deep - Throbbing – Pounding – Cramping – Burning – Achy Stiff – Locked – Wobbly – Weak – Localized – Radiating – Vague – Numbness – Tingling
   Things that help: Heat – Rest – Stretching – Exercise – Chiropractic – Acupuncture – Diet – Topical gels – massage – opiates – muscle relaxers – NSAIDS – Essential oils – Nothing
   Things that make it worse: Driving – Bending- Stooping – Leaning back – Lifting – Twisting Reaching – Gardening – Raking – Coughing – Sneezing – Bearing down – Sitting – Standing Prolonged sitting – Prolonged standing – Sitting on toilet – Walking – Prolonged walking Lying on back – Lying on stomach – Lying on side: L/R – Looking up – Looking down- Looking L/R Diet- Emotional Stress

2. Specific part of the body:_____
   Pain level now 0 1 2 3 4 5 6 7 8 9 10
   Average pain: 0 1 2 3 4 5 6 7 8 9 10
   Pain at its lowest: 0 1 2 3 4 5 6 7 8 9 10
   Pain at its highest: 0 1 2 3 4 5 6 7 8 9 10
   Feels like: Sharp – Dull – Stabbing – Deep - Throbbing – Pounding – Cramping – Burning – Achy Stiff – Locked – Wobbly – Weak – Localized – Radiating – Vague – Numbness – Tingling
   Things that help: Heat – Rest – Stretching – Exercise – Chiropractic – Acupuncture – Diet – Topical gels – massage – opiates – muscle relaxers – NSAIDS – Essential oils – Nothing
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Do other members of your family suffer from similar complaints? YES NO

CURRENT MEDICATION **CONDITION** **DOSAGE** **DATE BEGAN**

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

Please check all services of interest to you

Chiropractic Acupuncture Physiotherapy Nutritional Support Weight Loss

Stress reduction Weight Loss Cognitive Testing Mental Health Spinal Strengthening

Surgical Prevention Post Surgery Genetic Testing Smoking Cessation Allergies

Functional medicine Visual Problems Orthotics Balance improvement

Pregnancy Children's Health Teen Health

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 procedures.

I hereby request and consent to the performance of chiropractic adjustments and other 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 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 judgement 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 my questions have been answered fully and satisfactorily. Signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any further conditions for which I seek.

Patient Signature: _____ D.Signature_____ Date _____

HIPPA POLICY

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

Patient authorization for contract 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: _____