Elite Chiropractic & Wellness Centers

It's your Future...

...be there Healthy

Confidential Patient Information

Date _____

First Name: _____ Last Name: _____ Initial _____

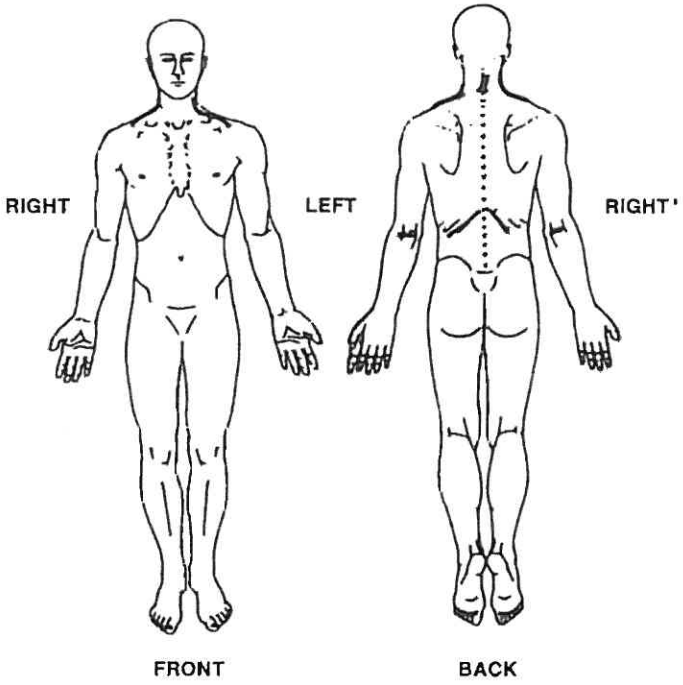
Major Complaint Information

What is your major complaint(s) _____

_____

When did this symptom(s) begin? _____

Using the symbols provided in the Pain Index, mark the areas on the illustrations below where you are experiencing pain.



Pain Index

D	Dull Nagging Ache
B	Burning
S	Sharp / Stabbing
N	Numbness / Tingling
M	Muscle Spasm / Pulling

For example; if you are experiencing moderately severe burning pain in back of your neck, you should note a B8 on the neck of the illustration.

If this is an injury, describe what happened:

_____

_____

_____

_____

On a scale of 1 - 10, how do you feel now? (1 being best, 10 being the worst)

1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before? ❒ Yes ❒ No When? _____

What aggravates this condition? _____

What decreases the symptoms / pain? _____

Have you seen another doctor for this condition? ❒ Yes ❒ No Doctor's Name: _____

Date consulted: _____ Diagnosis: _____

Does this condition interfere with your sleep? ❒ Yes ❒ No If so, how many times do you wake up in pain per night? _____

In what position do you sleep? ❒ Back ❒ Side ❒ Stomach

Do you sleep with a pillow? ❒ Yes ❒ No How many? _____

Does heat affect the pain? ❒ Yes ❒ No If so, how? _____

Does cold affect the pain? ❒ Yes ❒ No If so, how? _____

Do you wear a heel lift? ❒ Yes ❒ No If so, which side? ❒ Right ❒ Left

Does it cause pain to cough, grunt, or sneeze? ❒ Yes ❒ No If so, where? _____

Check those activities below during which you experience difficulty or pain:

○ Lying on back	○ Lying flat on stomach	○ Pushing	○ Stooping	○ Walking
○ Lying on side	○ Getting in/out of car	○ Pulling	○ Sitting	○ Sneezing
○ Standing for long periods	○ Dressing Self	○ Reaching	○ Bending forward	○ Coughing
○ Turning over in bed	○ Sexual Activity	○ Kneeling	○ Bending backward	○ Other: _____

FILL OUT THE NEXT THREE SECTIONS AS THEY APPLY TO YOU -

Lower Back Pain

Does pain radiate into the leg? ☐ Yes ☐ No Does pain radiate to the abdomen? ☐ Yes ☐ No

Do you have numbness or tingling into the legs? ☐ Yes ☐ No Explain: _____

Do you ever have impairment of bowel or urinary function? ☐ Yes ☐ No Explain: _____

Neck Pain

If you have a neck injury, does it affect: (Check all that apply) ☐ Hearing ☐ Vision ☐ Balance ☐ Cause ringing in your ears

Do you hear grating sounds? ☐ Yes ☐ No Do you feel pressure or pain behind your eyes? ☐ Yes ☐ No

Does pain radiate into the arm? ☐ Yes ☐ No Where? _____

Do you have difficulty lifting or turning your head? ☐ Yes ☐ No If so, in which direction? ☐ Right ☐ Left ☐ Up ☐ Down

Headaches

Do you get headaches? ☐ Yes ☐ No Frequency _____ Do you have a family history of headaches? ☐ Yes ☐ No

Do you experience the following along with your headaches: Pain or cracking in your jaw? ☐ Yes ☐ No

Abnormal blood pressure? ☐ Yes ☐ No ☐ High ☐ Low Nausea, Vomiting or Visual disturbances? ☐ Yes ☐ No

When was your last eye exam by a doctor? ☐ 1 - 6 months ☐ 6 - 12 months ☐ 1 - 2 years ☐ over 2 years Results: _____

If female, are you pregnant? ☐ Yes ☐ No ☐ Not Sure If yes, what is your due date? _____

List all medications you are taking now, including over the counter medication: _____

Have you ever had any surgeries or hospitalizations? ☐ Yes ☐ No Please list:

Type of Hospitalization / Surgery	Date:	Type of Hospitalization / Surgery	Date:

Have you been x-rayed in the last 12 months? ☐ Yes ☐ No When? _____

Have you ever been seen by a chiropractor before? ☐ Yes ☐ No Please list:

Name of chiropractor:	Date:	Name of chiropractor:	Date:

Do you have a family physician? ☐ Yes ☐ No Name of physician: _____ Phone: _____

Address: _____

PLEASE CHECK ALL ADDITIONAL COMPLAINTS YOU HAVE AT THIS TIME:

Additional Complaints

- ○ Loss of Concentration
- ○ Eyes Sensitive to Light
- ○ Memory Loss
- ○ Heavy Feeling of Head
- ○ Dizziness
- ○ Ringing in Ears
- ○ Loss of Balance
- ○ Loss of Smell
- ○ Loss of Taste
- ○ Pain Behind Eyes
- ○ Fainting
- ○ Palpitation
- ○ Neck Stiffness
- ○ Neck Motion Restricted
- ○ Upper Back Pain / Stiffness
- ○ Mid Back Pain / Stiffness
- ○ Right / Left Shoulder Pain
- ○ Right / Left Arm Pain
- ○ Right / Left Leg Pain
- ○ Pins & Needles Arms / Legs
- ○ Vision Problems
- ○ Sinus Trouble
- ○ Nervousness
- ○ Chest Pain
- ○ Shortness of Breath
- ○ Irritable
- ○ Anxiety
- ○ Depression
- ○ Insomnia
- ○ Fatigue
- ○ Excess Perspiration
- ○ Digestive Trouble
- ○ Nausea
- ○ Vomiting
- ○ Diarrhea
- ○ Constipation
- ○ Cold Hands
- ○ Cold Feet
- ○ Jaw Pain
- ○ Hypertension
- ○ Diabetes
- ○ Convulsions
- ○ Allergies (Please List)

_____

_____

- ○ Anemia
- ○ Heart Disease
- ○ Arthritis
- ○ HIV (Aids)
- ○ Other (Please List)

_____

_____

_____

Please Specify Location:

- ○ Numbness _____
- ○ Swelling _____
- ○ Cuts _____
- ○ Bruising _____

Do you have, or have you ever had, any diseases or medical problems not listed? ❒ Yes ❒ No If so, please list: _____

_____

Have you ever had? ❒ Motor Vehicle Injury ❒ Sports Injury ❒ Work Injury ❒ Slip and Fall Injury

If yes, please explain: _____

Any additional information you would like the doctor to know about before beginning care at **Elite Chiropractic & Wellness Center:** _____

_____

Personal Information

Address: _____

City / State / Zip _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Mobile Phone: _____ E-mail: _____

Social Security #: _____ Birth Date: _____ Age: _____ Sex: ❒ M ❒ F

Driver's License #: _____

Occupation: _____ Employer's Name: _____

Work Address: _____

City / State / Zip: _____

Marital Status: ❒ S ❒ M ❒ D ❒ W Spouse's Name: _____ # of Children: _____

How were you referred to **Elite Chiropractic & Wellness Center?** _____

Emergency Contact

Name: _____ Relation: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Address: _____

Insurance Information

Insurance Company: _____ Phone # _____

Address: _____

Insured's Name _____ Insured's SS# _____ Group # _____

Insured's Birth Date: _____ Insured's Employer: _____

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS

Personal Injury

Date of Accident:_____ Hour _____ AM _____ PM _____ Location: _____

How did accident occur? _____ Auto Collision _____ On-the-job injury _____ Other:_____

Please describe the accident or injury _____

_____

If work related, did you report the injury to your foreman or employer? ❒ Yes ❒ No

If work related, name and phone number of foreman or authorized person_____

If auto accident were you ❒ Driver ❒ Passenger ❒ Pedestrian

If auto collision, were you struck from ❒ Behind ❒ Right Side ❒ Left Side ❒ Front ❒ Auto was parked

If auto accident, did your car strike the other(s) involved? ❒ Yes ❒ No Or did the other car strike yours? ❒ Yes ❒ No ❒ Undetermined

Did you require post-accident hospitalization? ❒ Yes ❒ No

Lost work time ❒ Yes ❒ No If yes, date you returned to work _____

Do you have an attorney who has advised you in this case? ❒ Yes ❒ No Attorney Name: _____

Address: _____ Phone #: (_____) _____

Authorization & Assignment

I authorize **Elite Chiropractic & Wellness Center** to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint **Elite Chiropractic & Wellness Center** authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Informed Consent

I hereby authorize physicians and staff at **Elite Chiropractic & Wellness Centers** to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of **Elite Chiropractic & Wellness Centers** responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care.

Soreness: Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury- Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft-tissue injury.

Rib Injury - Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns - Heat generated by physical therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

Stroke - Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems - There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

_____ _____ _____

Date Patient's Signature Witness

Elite Chiropractic & Wellness Centers

Consent for Use of Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.
There are several circumstances in which we may have to use or disclose your health care information.

1. We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
3. We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.S20). Please feel free to contact us at any time for a copy of our privacy notices, or you may download a copy from our website at **www.elitewellnesscenters.com**.

Promotional Activities

From time to time our practice sends out information to make you aware of products, services, events and special promotions. The doctors and staff at Elite Chiropractic and Wellness may need to use your health information including your name, address, phone number, e-mail and your clinical records for the purpose of marketing health information, products and services to you. You have the right to refuse to give us this authorization. If you do not give us permission, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect the information that we use to contact you for marketing purposes at any time (164.524). Our practice and staff may receive direct or indirect remuneration from our marketing activities.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing.

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I authorized you to use or disclose my health information in the manner described above. I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of the consent and authorization form.

_____	_____
Printed Name	Date
_____	_____
Signature	Guardian/Representative