CUMMING CHIROPRACTIC CENTER

PATIENT INTRODUCTION CARD

Date_____

Name_____Social Security#_____
Last First Middle

Address_____City_____State_____Zip_____

Home #_____ Cell #_____ Work #_____

Which would you prefer, email reminders or a text message for future appointments? (Circle one) Email Text message

Email address_____

Age_____Birthdate_____#Children/Ages_____ Marital Status M S W D

Occupation_____ Employer_____

Spouse's Name_____DOB_____SS#_____

Emergency Contact Name_____Phone_____ Relation_____

Do you have health insurance?_____ What company?_____

Describe health concerns in detail, how it happened and your pain level (mild 1 2 3 4 5 6 7 8 9 10 severe)

_____

_____

How has this affected your Activites of Daily Living?_____

_____

Date symptoms occurred?_____ Ever had similar symptoms? ❑ Yes ❑ No

Is condition related to auto accident? ❑ Yes ❑ No Employment? ❑ Yes ❑ No Referred by_____

What aggravates condition?_____What makes condition better? _____

Describe care received before coming to this office and results_____

_____

Have you had chiropractic before?_____ Where?_____When?_____

Do you wish spinal correction or temporary relief of your condition? ❑ Correction ❑ Temporary Relief

Have you ever had surgery? ❑ Yes ❑ No If yes, please explain (give month & year) _____

_____

Are you presently taking any medication? ❑ Yes ❑ No If yes, please give type, dosage and what it is for _____

_____

Have you ever had any falls, accidents or injuries? ❑ Yes ❑ No If yes, please explain (give month & year)_____

_____

Describe injured area(s)_____

_____

HEALTH REVIEW

Name_____ Date of Birth_____ Today's Date_____

Please check all symptoms you have experienced.

CARDIOVASCULAR
- ☐ general swelling
- ☐ swelling in legs
- ☐ swelling in face / eyes
- ☐ chest pain
- ☐ heart "jumps"/ pounds
- ☐ rapid heart beat/ irreg
- ☐ hypertension
- ☐ heart attack
- ☐ harden of arteries
- ☐ pain over the heart
- ☐ blood vessel disease (phlebitis, etc.)
- ☐ any family member had stroke

VERTEBROBASILAR
- ☐ double vision / blurred
- ☐ loss of coordination
- ☐ irregular muscle movement
- ☐ ringing in ears
- ☐ high blood pressure
- ☐ areas of muscle weakness
- ☐ dizziness with nausea
- ☐ dizziness without nausea
- ☐ fainting spells
- ☐ loss of memory
- ☐ inability to form words
- ☐ had a stroke
- ☐ periods of blindness

WOMEN ONLY
- ☐ painful period
- ☐ spotting
- ☐ vaginal discharge
- ☐ premenstrual symptoms
- ☐ irregular periods
- ☐ birth control
- ☐ lumps in breast

pregnancies _____
deliveries _____
Are you pregnant?
☐ YES ☐ NO

MUSCULOSKELETAL

HEAD
- ☐ frequent headache
- ☐ severe headache
- ☐ head feels heavy
- ☐ vertigo
- ☐ light headedness
- ☐ loss of smell
- ☐ loss of taste
- ☐ loss of balance
- ☐ dizziness

10/12

NECK
- ☐ neck pain / stiffness
- ☐ neck pain w/ movement
- ☐ swelling in neck
- ☐ pinched nerve in neck
- ☐ neck feels out of place
- ☐ muscle spasms in neck
- ☐ grinding sounds in neck
- ☐ popping sounds in neck

SHOULDERS
- ☐ pain in shoulder R-L-Both
- ☐ pain across shoulders
- ☐ tension in shoulders
- ☐ muscle spasms in shoulders
- ☐ can't raise arm Rt / Lt
  - ☐ above shoulder level
  - ☐ over head

ARMS & HANDS
- ☐ pain in upper arm R-L-Both
- ☐ pain in forearm
- ☐ pain in hand R-L-Both
- ☐ pain in fingers R-L-Both
- ☐ sensation of pins & needles
  - ☐ arms
  - ☐ in fingers
- ☐ fingers go to sleep
- ☐ cold hands
- ☐ swollen joints in fingers
- ☐ sore joints in finger
- ☐ loss of grip strength R - L- Both

MIDBACK
- ☐ mid back pain
- ☐ sharp stabbing pain
- ☐ dull ache
- ☐ pain front to back
- ☐ pain kidney area
- ☐ muscle spasms in mid back area

LOWBACK
- ☐ low back pain
- ☐ back feels out of place
- ☐ muscle strains

HIPS, LEGS & FEET
- ☐ pain in buttocks
- ☐ pain down leg R-L-Both
- ☐ knee pain R-L-Both
- ☐ leg cramps R-L-Both
- ☐ pins &needles in legs
- ☐ numbness in legs /toes
- ☐ cold feet
- ☐ swollen ankles / feet

SKIN/NAILS/HAIR
- ☐ eczema
- ☐ itchy / dry skin
- ☐ dry scalp
- ☐ psoriasis
- ☐ yellow skin
- ☐ bruise easily
- ☐ pale skin

EYES
- ☐ blurring of vision
- ☐ double vision
- ☐ eyes fatigue easily
- ☐ excessive tearing
- ☐ lack of tearing
- ☐ light bothers eyes
- ☐ excessive itching
- ☐ pain in eyeball

EARS
- ☐ loss of hearing
- ☐ pain in ears
- ☐ ear infections
- ☐ discharge from ears
- ☐ vertigo
- ☐ ringing in ears

NOSE NASOPHARYNX SINUSES
- ☐ unusual nasal discharge
- ☐ nose bleeds
- ☐ pressure over eyes
- ☐ pressure under eyes
- ☐ obstruction of nose
- ☐ frequent colds
- ☐ sinusitis
- ☐ nasal allergies
- ☐ loss of sense of smell

MOUTH AND THROAT
- ☐ pain in mouth
- ☐ pain of throat
- ☐ bleeding gums
- ☐ cavities
- ☐ abscessed teeth
- ☐ difficulty swallowing
- ☐ changes in voice

VENERAL DISEASE
- ☐ AIDS
- ☐ syphilis
- ☐ gonorrhea
- ☐ other

RESPIRATORY
- ☐ shortness of breath
- ☐ can't breath while lying down
- ☐ can't sleep while lying down
- ☐ dry cough
- ☐ productive cough
- ☐ coughing up blood
- ☐ wheezing
- ☐ asthma / bronchitis

GASTROINTESTINAL
- ☐ poor appetite
- ☐ indigestion / heartburn
- ☐ can't eat some foods
- ☐ nausea & vomiting
- ☐ jaundice
- ☐ abdominal pain
- ☐ change in bowel habit
- ☐ diarrhea
- ☐ constipation
- ☐ hemorrhoids

GENITOURINARY
Urination is: ☐ frequent ☐ normal ☐ infrequent
Urine amount is: ☐ high ☐ normal ☐ low
- ☐ need to get up at night to urinate
- ☐ abnormal intense desire to urinate
- ☐ difficulty starting urination
- ☐ decreased output
- ☐ pain urinating
- ☐ dribbling
- ☐ blood in urine
- ☐ cloudy urine
- ☐ lack of bladder control
- ☐ prostate problems (male)

SOCIAL HISTORY
- ☐ smoking / tobacco use
- ☐ alcohol use

Diet is: ☐ balanced ☐ not balanced
Sleep is: ☐ sufficient ☐ insufficient
Exercise is: ☐ sufficient ☐ insufficient
My family stress is: ☐ severe ☐ moderate ☐ minimal
How do you like your work? ☐ very much ☐ ok ☐ hate it
My job stress is: ☐ severe ☐ moderate ☐ minimal

- ☐ nervousness
- ☐ fatigue
- ☐ depression
- ☐ generally feel run-down

Employment, Activities of Daily Living (ADL's) and Recreation Information

Patient Name: _____ Date: _____

Description of Work: _____

Condition's Effect On Job Performance:

☐ No Effect ☐ Mild Painful (Can do) ☐ Mod Painful (Limited) ☐ Severe (Unable to Perform)

Daily Activities: Effects of Current Condition on Performance

Bending:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Care- Infirm Family:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Carrying Groceries:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Change Pstn Sit to Stand:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Climb Stairs:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Driving:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Extended Computer Use:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Feeding:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Household Chores:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Kneeling:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Lift Children:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Lifting:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Pet Care:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Reading (Concentration):	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Self Care Bathing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Self Care Dressing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Self Care Shaving:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Sexual Activities:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Sleep:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Static Sitting:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Static Standing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Walking:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Yard Work:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)

Recreational Activity: Effects of Current Condition on Performance

_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)

(Examples: running, golfing, bowling, tennis, shopping, water sports, cycling, football, basketball, weight train, aerobics, biking, swimming, hunting, fishing, gardening, etc.)

Cumming Chiropractic Center

Authorizations and Release

Name: _____ Birthdate_____

Financial Agreement

Before the Doctor(s) of Cumming Chiropractic Center can provide you with their services, it is important that all financial arrangements be clearly understood. Our agreement for your health care is with you alone. Your insurance is not a part of this agreement. Policy benefits vary from company to company and from policy to policy within each company, you are advised that you may or may not be fully compensated under the provisions of your own insurance policy. Please note that the carrying of insurance by us is done as a courtesy to our patients. While insurance claims are being processed, your co-insurance/payment is due at the time of service.

However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient's Signature_____ Date ____/____/_____ Witness_____

Medical Information Authorization to Release

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature_____ Date ____/____/_____ Witness_____

Request for Payment of Benefits to Provider of Care

I hereby authorize the _____Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to *Cumming Chiropractic Center* the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature_____ Date ____/____/_____ Witness_____

Acknowledgement of Receipt of Notice of Patient Privacy Practices

I have read or been provided with a Notice of Patient Privacy Practices that provides a description of healthcare information uses and disclosures, I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

Patient's Signature_____ Date ____/____/_____ Witness_____

No Accident or Work Injury / No Secondary Insurance

I, the undersigned, state that I was not involved in any auto accident or personal injury caused by any other party. I further state that my diagnostic test or treatment is not the result of any injury while on the job or by any other person related to my employment.

I, also, state that I am not insured under any additional (secondary) health insurance policies.

Patient's Signature_____ Date ____/____/_____ Witness_____

Consent for Treatment of Minor (under age 18)

I hereby authorize the Doctors of *Cumming Chiropractic Center* and whomever they may designate as their assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as they deem necessary to my _____ (indicate relationship to child) _____(Child's name).

Guardian's Signature_____ Date ____/____/_____ Witness_____

Cumming Chiropractic Center

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk is most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Cumming Chiropractic Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

Cumming Chiropractic Center **Medical Records Authorizations**

Name: _____ DOB_____

Medical Information Release Form (HIPAA Release Form)

I authorize to release my medical records to the person(s) or organization listed below:
I hereby request and authorize you, your employees and agents of Cumming Chiropractic Center to furnish to the person(s) listed below or anyone designated in writing by them, all copies of recrds and reports, including copies of x-rays and Photostat copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Name of person(s) medical record may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other _____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

MESSAGES

Please call my [ ] home [ ] work [ ] cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

Patient's Signature_____ Date ____/____/_____

Witness_____ Date _____/ _____/_____

Cumming Chiropractic Center

Photo Release

I give Cumming Chiropractic Center permission to photograph, film, or post details of my case (including one or more of the following: postural pictures, x-rays, adjustments, and or any comment or review that I may give) for the purpose of educating others about chiropractic care.

Signature: _____

Date: _____

I decline the right to photograph, film, or post details of my case (including one or more of the following: postural pictures, x-rays, adjustments, and or any comment or review that I may give) for the purpose of educating others about chiropractic care.

Signature: _____

Date: _____