

# Welcome to Elite Chiropractic!

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE FRONT DESK

## PATIENT INFORMATION

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

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

E-Mail: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Age: \_\_\_\_\_  Male  Female

Marital Status:  Married  Single  Separated  Other \_\_\_\_\_

Name of Spouse or Nearest Relative: \_\_\_\_\_ Phone: \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Your Employer: \_\_\_\_\_

Referred to this Office by:  Friend/Family Member – Name: \_\_\_\_\_

Online  Mail  Clinic Location  Other \_\_\_\_\_

Payment for Services will be by:  Cash  Check  Credit Card  Health Insurance  Automotive Insurance

Worker's Compensation

Name of Insurance Co.: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Are you covered by more than one insurance company?  No  Yes Name: \_\_\_\_\_

### MEDICAL/FAMILY HISTORY S=SELF M= MOTHER F=FATHER

(Please indicate which conditions you have been experiencing [using key above] by marking appropriate boxes.)

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	night sweats
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive trbl
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	spinal curvature
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	thyroid problem
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weakness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weight gain/loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other _____

Have you been treated by a physician or any health condition in the last year?  No  Yes

Describe Condition: \_\_\_\_\_ Date of Last Physical Exam: \_\_\_\_\_

**Primary Medical Doctor's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

### SURGICAL HISTORY:

1. \_\_\_\_\_ Date: \_\_\_\_\_

2. \_\_\_\_\_ Date: \_\_\_\_\_

3. \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever had a metal implant?  Yes  No

Any other implants? \_\_\_\_\_

ACCIDENT HISTORY:  Job  Auto  Other 1. \_\_\_\_\_ Date: \_\_\_\_\_

Job  Auto  Other 2. \_\_\_\_\_ Date: \_\_\_\_\_

Job  Auto  Other 3. \_\_\_\_\_ Date: \_\_\_\_\_

### PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

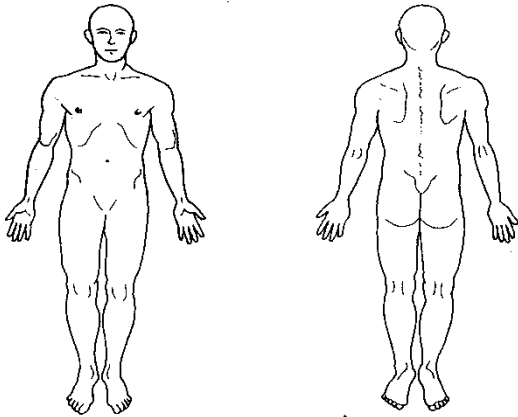
Please Rate Your Symptoms (1-10, with 1 being least serious)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Please mark the areas of concern on the diagram below. **N=Numbness T=Tingling P=Pain W=Weakness B=Burning A=Ache**



Symptoms are worse in the:  Morning  Afternoon  Night

When and how occurred? \_\_\_\_\_

Symptoms developed from:  Job Related Injury  Auto Accident  Other Accident  Illness  
 Unknown Cause  Gradual Onset  Date Occurred: \_\_\_\_\_

Symptoms have persisted for # \_\_\_\_\_ Hour(s) \_\_\_\_\_ Day(s) \_\_\_\_\_ Week(s) \_\_\_\_\_ Month(s) \_\_\_\_\_ Year(s)

Symptoms/Complaints:  Come & Go  Are Constant

Have you ever had this before:  No  Yes When? \_\_\_\_\_

If you were to guess, what do you think is causing your complaint(s)?  
\_\_\_\_\_

Name and location of doctors previously seen for present condition(s):  
\_\_\_\_\_

Are you taking any medication ?  No  Yes What Kind? \_\_\_\_\_  
Are you taking any supplements?  No  Yes What Kind? \_\_\_\_\_  
Are you Pregnant?  No  Yes Date of last menstrual period (*onset*) \_\_\_\_\_

**Please check the following activities that aggravate your condition:**

Bending  Coughing  Lifting  Lying down  Reaching  Standing  Sitting  Straining at stool  Turning head  Walking  Other \_\_\_\_\_

**Please check the following activities that relieve your condition:**

Bending  Lifting  Lying down  Reaching  Sitting  Standing  Turning Head  Walking  Other \_\_\_\_\_

**Please check any additional symptoms you may be experiencing:**

ankle swelling  blurred vision  buzzing in ears  cold hands  cold feet  chills  concentration loss/confusion  
 constipation  depression  diarrhea  difficulty breathing  face flushed  fainting  fever  frequent colds  gall bladder problems  insomnia  light bothers eyes  loss of balance  loss of smell  loss of taste  low back pain  
 muscles jerking  nausea  numbness in fingers  numbness in toes  pain between shoulders  pins and needles in arms  pins and needles in legs  shortness of breath  stiff neck  sore throat  stomach pain  tremors  
 wheezing

**Authorization:**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand the providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

**Patient’s Signature: (parent if minor)** \_\_\_\_\_ **Date:** \_\_\_\_\_

**HIPAA Notice:** I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is available for you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records please inform our office.

**Patient’s Signature: (parent if minor)** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Informed Consent for Chiropractic &/or Acupuncture Treatment:**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or of said minor) by Elite Chiropractic Health & Rehabilitation and/or its employees. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations and sprains. In the practice of acupuncture there are some risks to treatment, including but not limited to minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, and stuck or bent needles. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her, is in my best interest. I understand that results are not guaranteed. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**Patient’s Signature: (parent if minor)** \_\_\_\_\_ **Date:** \_\_\_\_\_