

WELCOME

PATIENT INFORMATION

Please Print Please allow our staff to photocopy your insurance card and all available insurance information.

FULL NAME _____	GENDER: M F _____	HOME PHONE _____
ADDRESS _____	CITY, STATE, ZIP _____	
WORK PHONE _____	CELL PHONE _____	E-MAIL _____
AGE _____	DATE OF BIRTH ___/___/___	MARITAL STATUS: S M W D Sep NO. of Children _____
SS# _____	Driver's License # _____	State of License _____

Your Employer _____	Your Occupation _____	Years on Job _____
Employer Address _____	City, State, Zip _____	
Work Phone _____		

Name of Spouse, Parent or Guardian _____	Age _____	Date of Birth ___/___/___
Spouse/Parent Employer _____	Spouse/Parent Occupation _____	SS# _____
Employer's Address _____	City, State, Zip _____	
Work Phone _____		

EMERGENCY CONTACT INFORMATION		
Name _____	Relationship to you _____	Phone Number _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

DESCRIBE THE MAJOR COMPLAINTS THAT BRING YOU TO OUR OFFICE: _____

IS THIS A WORK RELATED INJURY, CAR ACCIDENT OR FALL? YES NO
DATE OF ACCIDENT _____ CLAIM # _____
INSURANCE COMPANY _____ PHONE NUMBER _____

Payment Options (Please Indicate): Cash Check MasterCard Visa

Would you like to receive educational e-mails from our office? Yes No

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing the doctor. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photocopy of this agreement shall serve as the original.

We file your primary insurance at no charge to you. Filings for policies in addition to your primary coverage are completed for a fee and as time permits.

Patient's Signature _____ Date _____

Spouse/Guardian's Signature _____ Date _____

CASE HISTORY

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past and present.

An understanding of your health history will help us to determine appropriate care.

FULL NAME _____ **DATE** _____
AGE _____ **RACE** _____ **GENDER** _____ **HEIGHT** _____ **WEIGHT** _____

Review of Systems

1. Do you have skin, hair or nail problems? Yes No _____
 2. Do you have mouth and/or throat problems? Yes No _____
 3. Do you have nose and/or sinus problems? Yes No _____
 4. Do you have ear problems? Yes No _____
 5. Do you have eye problems? Yes No _____
 6. Do you have chest or lung (breathing) problems? Yes No _____
 7. Do you smoke? Yes No Amount per day _____ How long? _____
 8. Do you have heart and/or blood vessel problems? Yes No _____
 9. Do you have blood or lymph node problems? Yes No _____
 10. Do you have digestive problems? Yes No _____
 11. Do you have genital problems (e.g. prostate, testicular, vaginal)? Yes No _____
 12. Do you have urinary (including kidney or bladder) problems? Yes No _____
 13. **Females**, have you had menstrual problems? Yes No _____
Have you ever taken birth control? Yes No For how long? _____
Is there any chance that you are currently pregnant? Yes No _____
Do you have any breast problems? Yes No _____
 14. Do you have any nervous system diseases and/or mental health problems? Yes No _____
 15. Do you have any gland and/or hormone problems? Yes No _____
 16. Do you have allergy or immunity problems? Yes No _____
 17. Do you have any muscle, tendon or ligament problems? Yes No _____
 18. Do you have any bone or joint disease (examples: bone=osteoporosis, joint=arthritis)? Yes No _____
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Past History

19. List any diseases which you have had in the past, including childhood diseases: _____
20. Tell us if you have ever been diagnosed as having a particular condition such as diabetes, cancer, AIDS, etc.: _____
21. Have you suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones? Yes No _____
22. List any surgeries you have had (don't forget appendix tonsils, ear tubes, wisdom teeth):

Date _____

Date _____

Date _____

Date _____
23. Have you ever been hospitalized for any reason other than surgery? Yes No _____
24. **Medications:** Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis: _____
25. Your diet is: Balanced Fair Poor Excessive Restricted

(OVER PLEASE)

CASE HISTORY (CONTINUED)

FULL NAME _____

DATE _____

Family History

26. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)? Yes No _____

Social History

27. In what position do you usually sleep, and how well? _____

28. Do you exercise on a regular basis? Yes No How? _____

29. How do you spend your spare time (hobbies, etc)? _____

30. Do you use: Caffeine? Tobacco? Nicotine? Recreational Drugs? Alcohol? _____

31. Please describe your work:

Type:	Professional	Physical Labor	Driver	Clerical	Factory	Homemaker
Physical Demands:	Heavy	Moderate	Mild	Sedentary		
Stress Level:	High	Medium	Low			

Additional Questions

32. Do you have problems with recurring headaches? Yes No _____

33. Are you losing weight without trying? Yes No _____

34. Does your pain wake you up at night? Yes No _____

35. Have you had a change in bowel or bladder habits? Yes No _____

36. Have you had a sore that doesn't heal? Yes No _____

37. Have you recently had any unusual bleeding or discharge? Yes No _____

38. Do you have a thickening/lump in the breast or elsewhere? Yes No _____

39. Do you have indigestion or difficulty swallowing? Yes No _____

40. Have you had an obvious change in a wart or mole? Yes No _____

41. Do you have a nagging cough or hoarseness? Yes No _____

42. In the space below, please explain or give additional details regarding the information n you have given above. Also, if there is any information about your health history which was not requested, please fill it in below.

43. Please describe your current complaint. In other words, what brought you here? _____

44. Who is your: _____

Medical Doctor? _____

OB/GYN? _____

Dentist? _____

SYSTEM/SYMPTOM REVIEW

FULL NAME _____

AGE _____

DATE _____

Do you currently have any of the following?

Integument System

Skin rash	Y	N
Skin lesion	Y	N
Changes in skin color	Y	N
Itching (pruritus)	Y	N
Hair changes	Y	N
Nail changes	Y	N

Endocrine System

Hormone problems	Y	N
Hot flashes	Y	N
Thyroid problems	Y	N
Hormone therapy	Y	N
Growth abnormalities	Y	N
Metabolism changes	Y	N

Digestive System

Abdominal pain	Y	N	Rectal bleeding	Y	N
Nausea	Y	N	Jaundice	Y	N
Vomiting	Y	N	Abdominal distention	Y	N
Constipation	Y	N	Cramping	Y	N
Diarrhea	Y	N	Lump/mass	Y	N

Cardiovascular System

Chest pain	Y	N	Changes in skin color	Y	N
Irregular heartbeat	Y	N	Stroke (full or pin)	Y	N
Shortness of breath	Y	N	Dizziness	Y	N
Fainting	Y	N	Cool hands or feet	Y	N
Fatigue	Y	N	Varicose veins	Y	N
Swelling of legs	Y	N	Mitral valve problems	Y	N

Pulmonary System

Coughing	Y	N
Phlegm/expectorant	Y	N
Coughing up blood	Y	N
Shortness of breath	Y	N
Wheezing	Y	N
Blue skin (cyanosis)	Y	N
Chest pain	Y	N

Musculoskeletal System

Stiffness	Y	N
Popping noises	Y	N
Joint pain	Y	N
Weakness	Y	N
Limitation of movement	Y	N
Extremity deformities	Y	N
Difficulty walking	Y	N

Nervous System

Partial paralysis	Y	N	Lack of coordination	Y	N
Complete paralysis	Y	N	Psychiatric disorders	Y	N
Headache	Y	N	Speech abnormalities	Y	N
Are you right-handed?	Y	N	Visual disturbances	Y	N
Loss of consciousness	Y	N	Are you left-handed?	Y	N
Dizziness	Y	N	Gait disorders	Y	N
Memory loss	Y	N	Tremors	Y	N
Numbness	Y	N	Tics (spasms)	Y	N
Weakness	Y	N	Sensory changes	Y	N
Depression	Y	N	Mood changes	Y	N

SYSTEM/SYMPTOM REVIEW (CONTINUED)

FULL NAME _____

AGE _____

DATE _____

Do you currently have any of the following?

Genital/Urinary System

Special Senses

Pain during urination	Y	N
Changes in urine flow	Y	N
Lump or mass in groin	Y	N
Kidney stones	Y	N
Chronic bladder infections	Y	N
Genital itching	Y	N
Changes in urination frequency	Y	N
Change in urine color	Y	N

Visual problems	Y	N
Hearing loss	Y	N
Loss of balance	Y	N
Loss of taste	Y	N
Loss of smell	Y	N
Loss of touch sensation	Y	N
Temporary vision loss in one eye	Y	N

Reproductive System

MALE ONLY			FEMALE ONLY		
Testicular pain	Y	N	Abnormal vaginal bleeding	Y	N
Prostate problems	Y	N	Painful menstruation	Y	N
Infertility	Y	N	Breast lump/mass	Y	N
Impotence	Y	N	Vaginal discharge/itching	Y	N
Discharge	Y	N	Nipple discharge	Y	N
Lump or mass	Y	N	Infertility	Y	N
			Abnormal periods	Y	N
			Male pattern baldness	Y	N

Head and Neck Region

Headaches	Y	N	Ringling in ears	Y	N
Neck stiffness	Y	N	Ear pain	Y	N
Neck lump/mass	Y	N	Ear discharge	Y	N
Eye pain	Y	N	Ear itching	Y	N
Eye redness	Y	N	Nasal discharge	Y	N
Eye discharge	Y	N	Sinus trouble	Y	N
Double vision	Y	N	Bad breath	Y	N
Dry eyes	Y	N	Nasal obstruction	Y	N
Excessive tearing	Y	N	Snoring	Y	N
Spinning sensation	Y	N			

Blood, Lymphatics, Immunology, Allergy

Anemia	Y	N	Frequent illness	Y	N
Iron deficiency	Y	N	Immunity problems	Y	N
Clotting problems	Y	N	Allergies	Y	N
Bruise easily	Y	N	Take allergy shots	Y	N
Swollen lymph nodes	Y	N			

PATIENT NAME: _____

Consent for treatment

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical table upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures: which will be prescribed and performed as indicated by the doctor.

- | | | |
|---|--|---|
| <input type="checkbox"/> spinal manipulative therapy | <input type="checkbox"/> palpation | <input type="checkbox"/> vital signs |
| <input type="checkbox"/> range of motion testing | <input type="checkbox"/> orthopedic testing | <input type="checkbox"/> basic neurological testing |
| <input type="checkbox"/> muscle strength testing | <input type="checkbox"/> postural analysis | <input type="checkbox"/> ultrasound |
| <input type="checkbox"/> hot/cold therapy | <input type="checkbox"/> EMS (electric muscle stimulation) | |
| <input type="checkbox"/> radiographic studies | <input type="checkbox"/> stretching | <input type="checkbox"/> deep tissue massage |
| <input type="checkbox"/> algometric/pressure testing | | |
| <input type="checkbox"/> Other (please explain) _____ | | |
-

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindication to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The nature of Acupuncture

Acupuncture involves the insertion of very fine needles in various locations on the body. Acupuncture has been shown to have an effect on circulation, blood pressure, production of blood cells, and release of hormones that help the body respond to injury and stress. Complications from acupuncture may include:

- a. **Bleeding and Bruising** – As with acupuncture in general, when a needle is removed some minor bleeding may occur. This is normal and usually will not leave a bruise. Occasionally a bruise or hematoma may appear. Topical and internal remedies will be discussed to address bruising. If swelling persists, call me immediately.

- b. **Infection** – Infection at the needle site is very rare after an acupuncture treatment because the needles are sterile. If you suspect infection at the needling site (i.e. Redness, swelling or warm to the touch) call me immediately. Additional treatment or referral to your General Practitioner may be necessary.
- c. **Needle Shock** – Needle shock is a rare complication that can happen during any acupuncture treatment. If you feel faint or shaky during treatment, please let me know immediately.

Allergic Reaction – In rare cases, local allergies to topical preparations have been reported. Systemic reactions that are more serious may occur to herbs used during treatment. Skin testing is done prior to application of any herbal preparations. Allergic reactions may require additional treatment or discontinuation of treatment

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW:

I have read [] or have read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Jeffrey Wong and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Dated: _____

Patient's Name

Doctor's Name

Signature

Signature

Signature of Parent or Guardian
(if a minor)