Welcome

Please take a few moments to complete this form so that we can better serve you. If you have any questions along the way please do not hesitate to ask. Thank you.

Carson Chiropractic
community • family • health • strength • natural • prevention • balance

Date: _____

Patient Information

_____

Name: Last First M.I.

_____

Called Name Suffix

Address: _____

City: _____ State: _____ Zip: _____

Birth date: _____ ❑ Male ❑ Female

❑ Minor ❑ Single ❑ Married ❑ Partnered
❑ Separated ❑ Divorced ❑ Widowed

Primary Phone: _____ ❑ Cell ❑ Home

Secondary Phone: _____ ❑ Cell ❑ Home

E-Mail: _____

Occupation: _____

Employer: _____

Race/Ethnicity:

❑ American Indian
❑ Alaska Native
❑ Asian
❑ Black/African American
❑ Native Hawaiian
❑ Other/Pacific Islander
❑ White
❑ Declined To State

Are You Hispanic or Latino?: ❑ Yes ❑ No ❑ Decline to State

Primary Language: _____

Who may we thank for referring you?

_____

Emergency Contact:

Name: _____

Relationship to Patient: _____

Phone: _____

X-ray Policy

If deemed necessary by both patient and doctor, x-rays **may** be taken in the office.

I understand that in order to provide me with the best quality of care, it is **Carson Chiropractic's** policy to have any x-rays taken in the office interpreted by the board certified radiologists at **Gregerson Radiology Consults.**

I accept that I am responsible for any additional fees charged for x-ray readings. I release any medical information pertaining to my condition for billing purposes. I understand that I and/or **my insurance**, if applicable, may be billed directly by **Gregerson Radiology Consults** for their services and that I am responsible for any remaining balance.

Signature: _____

Financial Responsibility

❑ **Non-Insurance Patient:** I understand that I am financially responsible for all charges incurred at **Carson Chiropractic**, including, but not limited to, treatment cost, x-rays, products and/or other services. My account balance is to be paid in full at time of service, unless other financial arrangements have been made with the billing department.

Signature: _____

Insurance Patient:

❑ Medicare ❑ Medicaid
❑ Major Medical Insurance: _____

❑ I understand that I am financially responsible for any charges incurred from services rendered at **Carson Chiropractic,** including, but not limited to, deductible, co-pay, co-insurance, x-rays, and products or services not covered by my insurance policy. I agree to pay all balances due in a timely manner.

Signature: _____

Insurance Assignment and Release

❑ I certify that I, and/or my dependant(s), assign directly to **Carson Chiropractic** all insurance benefits, if any, otherwise payable to me for services rendered. I understand my financial responsibility for all charges, whether or not paid by insurance. I authorize **Carson Chiropractic** to disclose any health care information to my insurance company for the purpose of obtaining payment for services and determining insurance benefits.

_____

Signature of patient, parent or guardian. Date

_____

Print name Relationship to patient

Accident Patient:

Is condition the result of an auto or work accident?
❑ Yes ❑ No

If Yes, what type of account?
❑ Personal Injury ❑ Workers compensation

Manual Therapy/ Massage Cancellation Policy

I understand that if I am unable to make my scheduled manual therapy/massage appointment, that **24 hour notice** is required. Failure to show for a scheduled appointment will result in a **$25 fee** for each half hour missed, billed directly to me, the patient. I accept that I am personally responsible, and not insurance, for this cancellation fee.

Signature: _____

Patient Record of Disclosure

The **HIPPA** privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI) and provides the right to request confidential communications be made by alternative means indicated by you, the patient.

If you wish to be contacted by another means than already noted in this form, please let us know.

Medical Information

Primary care provider:

_____

_____

What treatments have you received for current condition?

❑ none ❑ chiropractic services ❑physical therapy

❑ medication: _____

_____

❑ surgery: _____

_____

other: _____

_____

What treatments, if any, did you find helpful and/or what treatments have aggravated your condition?

_____

_____

_____

Date of last:

Physical: _____ Spinal exam:_____

Chest x-ray: _____ Spinal x-ray: _____

MRI, CT-scan, bone scan: _____

_____

Name, address, phone and fax of any doctor(s) who have treated your condition:

_____

_____

_____

❑ I authorize **Carson Chiropractic** to request any/all medical records related to condition from other health care providers who have treated me.

Print Name: _____

Signature: _____

Injuries and Surgeries

(Date and Description)

Falls: _____

Head Injuries: _____

Broken Bones/fractures/Dislocations: _____

_____

_____

Surgeries: _____

_____

_____

_____

_____

Family Health History

(notate specific type and relation)

Arthritis: _____

_____

_____

Cancer: _____

_____

_____

_____

Diabetes: _____

_____

_____

_____

Heart Disease: _____

_____

_____

_____

Other: _____

_____

_____

_____

Medications and Dosages

_____

_____

_____

_____

_____

_____

_____

Habits

❑ smoking packs/day: _____

❑ former smoker when did you quit: _____

❑ alcohol drinks/week: _____

❑ coffee/caffeine cups/day: _____

❑ high stress level reason: _____

❑ Other:_____ frequency: _____

Vitamins/Supplements

_____

_____

_____

_____

_____

_____

_____

Allergies

_____

_____

_____

_____

_____

_____

_____

Patient Condition

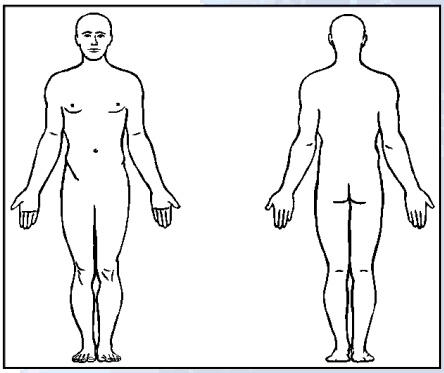
Reason for visit: _____

_____

When did symptoms first appear? _____

Is this condition getting progressively worse? ❑ Yes ❑ No

Please mark an **X** where you have pain:



Type of pain (mark all that apply):

❑sharp ❑dull ❑throbbing ❑numbness ❑tightness
❑shooting ❑burning ❑tingling ❑cramping ❑aching
❑stiffness ❑swelling ❑other:_____

How often does pain occur? _____

Is pain constant? ❑ -or- Does pain come and go? ❑

Does your pain interfere with...?

❑work ❑sleep ❑daily routine ❑recreation
❑other:_____

Activities or movements which are painful to perform:

❑sitting ❑standing ❑walking ❑bending ❑lying
❑other:_____

Pain Evaluation

Condition (Mark only those that apply)	Severity of pain (1=minimal/10=severe)									
Pain/Tension: neck	1	2	3	4	5	6	7	8	9	10
Pain/Tension: shoulder(s)	1	2	3	4	5	6	7	8	9	10
Pain/Tension: mid/upper back	1	2	3	4	5	6	7	8	9	10
Pain/Tension: low back	1	2	3	4	5	6	7	8	9	10
Pain/Tension: hip(s)	1	2	3	4	5	6	7	8	9	10
Extremities: _____	1	2	3	4	5	6	7	8	9	10
Headaches	1	2	3	4	5	6	7	8	9	10
Migraines	1	2	3	4	5	6	7	8	9	10
Fatigue	1	2	3	4	5	6	7	8	9	10
Difficulty sleeping	1	2	3	4	5	6	7	8	9	10
Sinus/allergy issues	1	2	3	4	5	6	7	8	9	10
Irritability/mood swings	1	2	3	4	5	6	7	8	9	10
Poor Digestion	1	2	3	4	5	6	7	8	9	10
Other: _____	1	2	3	4	5	6	7	8	9	10

Work Activity

❑ sitting ❑standing ❑light labor ❑ heavy labor
❑ other_____

Exercise

❑ none ❑ moderate ❑ daily ❑ heavy
❑other: _____
Type of exercise: _____

_____

Health History

(If "yes" please notate dates and treatments)

ADD/ADHD:	❑Yes	❑No
AIDS/HIV:	❑Yes	❑No
Alcoholism:	❑Yes	❑No
Allergy shots:	❑Yes	❑No
Anemia:	❑Yes	❑No
Appendicitis:	❑Yes	❑No
Arthritis:	❑Yes	❑No
Asthma:	❑Yes	❑No
Bi-Polar disorder:	❑Yes	❑No
Bleeding Disorder:	❑Yes	❑No
Breast lump:	❑Yes	❑No
Bronchitis:	❑Yes	❑No
Cancer:	❑Yes	❑No
Cataracts:	❑Yes	❑No
Chemical Dependency:	❑Yes	❑No
Chicken pox:	❑Yes	❑No
Depression:	❑Yes	❑No
Diabetes:	❑Yes	❑No
Eating Disorder:	❑Yes	❑No
Emphysema:	❑Yes	❑No
Epilepsy:	❑Yes	❑No
Glaucoma:	❑Yes	❑No
Gout:	❑Yes	❑No
Heart Disease:	❑Yes	❑No
Hepatitis:	❑Yes	❑No
Hernia:	❑Yes	❑No
Herniated Disc:	❑Yes	❑No
High Cholesterol:	❑Yes	❑No
Hypertension/high blood pressure:	❑Yes	❑No
Kidney Disease:	❑Yes	❑No
Liver Disease:	❑Yes	❑No
Migraine Headaches:	❑Yes	❑No
Miscarriage:	❑Yes	❑No
Mononucleosis:	❑Yes	❑No
Multiple Sclerosis:	❑Yes	❑No
Osteoporosis:	❑Yes	❑No
Pacemaker:	❑Yes	❑No
Parkinson's disease:	❑Yes	❑No
Pinched Nerve:	❑Yes	❑No
Pneumonia:	❑Yes	❑No
Prostate Problems:	❑Yes	❑No
Prosthesis:	❑Yes	❑No
Psychiatric Care:	❑Yes	❑No
Rheumatoid Arthritis:	❑Yes	❑No
Scoliosis:	❑Yes	❑No
Shingles:	❑Yes	❑No
Stroke:	❑Yes	❑No
Suicide Attempt:	❑Yes	❑No
Thyroid Problems:	❑Yes	❑No
Ulcers:	❑Yes	❑No
VD/STD:	❑Yes	❑No
Are you pregnant?	❑Yes	❑No

Weeks pregnant: _____ Due date: _____

Other: _____

Treatments: _____

_____

_____

Vitals

Height _____ Weight _____

B P _____ (doctor will take if unknown)

Examination

(doctor's use only)

Patient name: _____

Posture Analysis

	Left	Right
Weight Distribution		
Head Tilt		
Ear High On		
High Shoulder		
High Ilium		
High Scapula		
Hip height		

Cervical Range of Motion

	Norm	Range	Pain
Flexion	45		
Extension	55		
Lt. Lat. Flexion	40		
Rt. Lat. Flexion	40		
Lt. Rotation	70		
Rt. Rotation	70		

Dorso-Lumbar Range of Motion

	Norm	Range	Pain
Flexion	75-90		
Extension	30		
Lt. Lat. Flexion	35		
Rt. Lat. Flexion	35		
Lt. Rotation	30		
Rt. Rotation	30		

Orthopedic Tests

Valsalvas + -

Foramina Compression

Lt._____ St._____ Rt._____

Shoulder Depression

Lt._____ Rt._____

Strait Leg Raiser

Lt._____ Rt._____

Laseques Sign

Lt._____ Rt._____

Fabere's

Lt._____ Rt._____

Trigger Points

Trapezius	L	R
Rhomboids	L	R
Rotator cuff	L	R
Biceps	L	R
Forearms	L	R
QL	L	R
Gluteal	L	R
Hamstrings	L	R
IT/TFL	L	R
Plantar Fascia	L	R

Dermatome Findings

C2		T1	
C3		L1	
C4		L2	
C5		L3	
C6		L4	
C7		L5	
C8		S1	

Reflexes

	Left	Right
Triceps		
Biceps		
Radial		
Brach/rad		
Patellar		
Achilles		

Posture: Good Fair Poor

Gait: Good Limp Halting

Notes:

Office Use Only

- ❑ Welcome Form/Consent completed and signed
- ❑ Medicare: ABN form signed
- ❑ Personal Injury Account: PI intake form has been completed
- ❑ EZ BIS: patient information entered (INCLUDING PHONE #)
- ❑ EHR: entered in EZ BIS and noted on travel card
- ❑ Insurance: Entered into EZ BIS and noted on travel card
- ❑ First visit has been billed