

# White Chiropractic

Date \_\_\_\_\_

## Patient Entrance Form

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M / F No. Children \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Separated  Divorced

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Policyholders SS # \_\_\_\_\_

Policyholder's date of birth \_\_\_\_\_ Employer of Policyholder \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Relationship \_\_\_\_\_

How did you hear about us? : Money Mailer Internet Yellow Pages Other (name of person) \_\_\_\_\_

Patient's Primary Care Physician (PCP) \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Date of Last Physical Exam \_\_\_\_\_

Are you pregnant?  Yes  No  Uncertain

Please describe your current problem \_\_\_\_\_

Is your current problem the result of: Auto Accident?  Yes  No Work Accident?  Yes  No Slip & Fall?  Yes  No

How did your problem begin \_\_\_\_\_

Date Problem began \_\_\_\_\_ Other doctors seen for this condition \_\_\_\_\_

List other treatments or tests you've had for this condition \_\_\_\_\_

Have you been treated for any other health condition by a physician in the last year?  Yes  No If yes, please explain: \_\_\_\_\_

How often are your symptoms present?  Constantly  Frequently  Occasionally  Intermittently

Describe your current pain/symptoms:  Sharp/Stabbing  Burning  Throbbing  Shooting  Tingling  Gripping  
 Dull  Numbness  Soreness  Aches  Weakness  Other \_\_\_\_\_

Since it began, is your problem:  Improving  Getting Worse  No Change

What makes the problem better?  Nothing  Lying Down  Standing  Walking  Sitting  Movement  
 Exercise  Inactivity/Rest  Other \_\_\_\_\_

What makes the problem worse?  Nothing  Lying Down  Standing  Walking  Sitting  Movement  
 Exercise  Inactivity/Rest  Other \_\_\_\_\_

Can you perform your daily home activities:  Yes  Only with help  Not at all

Do you exercise?  Yes, almost daily  Yes, occasionally  Not at all

Describe your job requirements:  Mainly Sitting  Light Labor  Heavy Labor

Can you perform your daily work activities:  Yes, all activities  Only some  Not at all

Describe your stress level:  None to mild  Moderate  High

EMAIL: \_\_\_\_\_

## Patient Health Questionnaire

Patient Name \_\_\_\_\_

Please check all that apply. Knowledge of these conditions may influence the type of treatment/therapy you receive.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Angina              | <input type="checkbox"/> Heartburn/Indigestion      | <input type="checkbox"/> Rheumatic Fever                         |
| <input type="checkbox"/> Anorexia            | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Pregnancies                             |
| <input type="checkbox"/> Aortic Aneurysm     | <input type="checkbox"/> Herniated Disk             | <input type="checkbox"/> Scoliosis                               |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Stroke                                  |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Jaw Pain                   | <input type="checkbox"/> Swelling, Stiffness of Joints           |
| <input type="checkbox"/> Bladder Infection   | <input type="checkbox"/> Liver/Gallbladder Problems | <input type="checkbox"/> Tinnitus (Ear Noises)                   |
| <input type="checkbox"/> Blood Disorder      | <input type="checkbox"/> Kidney Disorders           | <input type="checkbox"/> Tuberculosis                            |
| <input type="checkbox"/> Breast Lump         | <input type="checkbox"/> Loss of Bladder Control    | <input type="checkbox"/> Ulcer                                   |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Nervousness                | <input type="checkbox"/> Vision Disturbances                     |
| <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Pacemaker                  | <input type="checkbox"/> Venereal Disease                        |
| <input type="checkbox"/> Chronic Cough       | <input type="checkbox"/> Pain - Neck                | <input type="checkbox"/> Other _____                             |
| <input type="checkbox"/> Chronic Sinusitis   | <input type="checkbox"/> Pain - Mid Back            |  |
| <input type="checkbox"/> Colitis             | <input type="checkbox"/> Pain - Low Back            | Height: _____ feet _____ inches                                  |
| <input type="checkbox"/> Convulsions         | <input type="checkbox"/> Pain - Arm/Elbow           |  |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Pain - Hand                | Weight: _____ pounds   |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Pain - Wrist               |  |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Pain - Shoulder            |  |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Pain - Ankle or Foot       |  |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Pain - Leg                 | <input type="checkbox"/> Smoking - Packs/Day _____               |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Pain - Knee                | <input type="checkbox"/> Alcohol - Drinks/Week _____             |
| <input type="checkbox"/> Fainting            | <input type="checkbox"/> PMS                        | <input type="checkbox"/> Coffee/Caffeine Drinks - Cups/Day _____ |
| <input type="checkbox"/> Headache            | <input type="checkbox"/> Prostate Problems          | <input type="checkbox"/> Alcohol Dependence                      |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Rapid Heartbeat            | <input type="checkbox"/> Drug Dependence                         |

Please list all allergies including allergies to medications \_\_\_\_\_

List all medications you are presently taking (including vitamins & supplements) \_\_\_\_\_

List any bone and/or joint surgeries \_\_\_\_\_

List any recent Surgeries \_\_\_\_\_

### Family Health History:

If a family member has had any of the following, please mark the appropriate box:

- |                                     |                                   |   |  |   |
|-------------------------------------|-----------------------------------|---|--|---|
| <input type="checkbox"/> Cancer     | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Chronic Headaches    |
| <input type="checkbox"/> Epilepsy   | <input type="checkbox"/> Lupus    | <input type="checkbox"/> Lung Problems  | <input type="checkbox"/> Chronic Back Problems | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Alcoholism | Other _____                       |   |  |   |

I certify that all the above personal health information, on pages one and two, is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition in the future.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

\*  
**WHITE CHIROPRACTIC**

**HEALTH CARE AUTHORIZATION FORM**

Patient's Name \_\_\_\_\_ Patient's SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Please Print

Signature of Patient \_\_\_\_\_ Signature of Representative \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

THE PATIENT IDENTIFIED ABOVE AUTHORIZES WHITE CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

**SPECIFIC AUTHORIZATION**

- I give permission to White Chiropractic to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives or other health related information.
- If White Chiropractic contacts me by phone, I give them permission to leave a phone message with a member of my household, on my answering machine or voice mail. I give them permission to call my insurance company to verify my Chiropractic benefits.
- I give White Chiropractic permission to disclose my health information to another health care provider or a hospital if it is necessary to refer me to them for the diagnosis, assessment, or treatment of my health condition.
- I give White Chiropractic permission to disclose my health information and billing records to another party if they are potentially responsible for the payment of my services.
- By signing this form you are giving White Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

**EXPIRATION:** This notice is effective as of (today's date): \_\_\_\_\_. This Authorization shall expire seven years after the date on which you last received services from White Chiropractic.

**RIGHT TO REVOKE AUTHORIZATION:** You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. The written notice must contain the following information:

- Your name, Social Security number and date of birth
- A clear statement of your intent to revoke this AUTHORIZATION
- The date of your request
- Your signature

White Chiropractic requests this AUTHORIZATION for its own use/disclosure of Private Health Information. (Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, White Chiropractic will not refuse to provide you treatment. You have the right to inspect or copy the Private Health Information to be used/disclosed.

\* \* A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU \* \*

## Informed Consent to Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;
- b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;
- c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

\_\_\_\_\_  
**Patient Signature (or Legal Guardian)**

Patient Name: \_\_\_\_\_  
(please print)