

CHIROFIT

Confidential Patient Information

3326 Aspen Grove Dr. Ste. 502

Franklin, TN 37067

Phone (615) 771-0722

Fax (615) 771-0734

Website: www.chirofitcoolsprings.com

Patient Information:

Date: ____/____/____

Patient's Full Name _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Date of Birth: ____/____/____ Male Female Spouse's Name: _____

Married Single Widowed Separated Divorced Number of Children/Ages _____

Social Security # _____ - _____ - _____ Referred by (Friend, Relative, Physician or Newspaper) : _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Family Physician: _____ City: _____ State: _____ Phone _____

Is Today's Visit Due To A Work Related Injury: Yes No Date Of Injury: _____

Please Describe How the Injury Occurred: _____

Employer Information:

Employer: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of employer/supervisor **who authorized my treatment at this facility:** _____

My employer and I have filed a worker's compensation claim: Yes No Claim Number: _____

Name of contact person for my worker's compensation claims: _____ Phone: _____

Attorney Information:

I have retained an attorney: Yes No Attorney's Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, **I personally owe to you.**
4. I am choosing to receive treatment at this facility for an illness or injury, which I sustained in the course of my employment. *I know that I am responsible for all fees incurred if my employer does not authorize care at this office.*
5. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you (CHIROFIT) are **paid in full.**

Patient Signature _____ Date ____/____/____

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Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Date: ____ / ____ / ____

Patient's Name: _____

Chief complaint _____

Secondary or related complaint(s) if any: _____

Date of Onset: _____ Was the Onset Gradual Sudden Since onset, has it gotten: Worse Better

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP EXPLAIN YOUR **CHIEF COMPLAINT**:

Describe the quality of the complaint/pain:

- sharp
- dull/ache
- throbbing
- tingling/numbness
- other: _____

Does any of the following make the pain worse:

- lifting/bending/pushing/pulling
- cough/sneeze/bowel movement
- driving/riding/sitting
- walking/running/standing
- other: _____

Describe if pain is in a single spot or does is spread out:

- radiating dull, deep ache
- pin point
- burning, sharp stabbing, tingling, numb
- other: _____

Does any of the following make it better:

- rest/laying down
- sitting
- walking/exercise
- other: _____

How often are you aware of the pain:

- intermittent (less than 25% of time when awake)
- occasional (25-50% of time when awake)
- frequent (50-75% of time when awake)
- constant (75-100% of time when awake)

Does it interfere with your daily activities:

- minimal (annoyance, no impairment)
- slight (tolerated, some impairment)
- moderate (marked impairment)
- marked (preclude any activity)

Have you detected any possible relationship of your current complaint with any of the following:

- Muscle Weakness
- Bowel/Bladder problems
- Digestion
- Cardiac/Respiratory
- Other: _____

Have you tried any self-treatment or taken any medication (over the counter or prescription): Yes No

If yes, explain; _____ Results: _____

Are you currently pregnant? Yes No Are you currently taking anti-coagulant or blood thinning medication? Yes No

What type of care are you interested in: Pain relief only Healing of current condition Optimizing your health All three

NP1 NP2 NP3 NP4 NP5 NP6 NP7 NP8 NP9 NP10 NP11 NP12 NP13 NP14 NP15 NP16 NP17 NP18 NP19 NP20 NP21 NP22 NP23 NP24 NP25 NP26 NP27 NP28 NP29 NP30 NP31 NP32 NP33 NP34 NP35 NP36 NP37 NP38 NP39 NP40 NP41 NP42 NP43 NP44 NP45 NP46 NP47 NP48 NP49 NP50 NP51 NP52 NP53 NP54 NP55 NP56 NP57 NP58 NP59 NP60 NP61 NP62 NP63 NP64 NP65 NP66 NP67 NP68 NP69 NP70 NP71 NP72 NP73 NP74 NP75 NP76 NP77 NP78 NP79 NP80 NP81 NP82 NP83 NP84 NP85 NP86 NP87 NP88 NP89 NP90 NP91 NP92 NP93 NP94 NP95 NP96 NP97 NP98 NP99 NP100

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Date: ____/____/____

Patient's Name: _____

In general, would you say your health is (check one): Excellent Very good Good Fair Poor

PAST HEALTH HISTORY:

1. Have you ever experienced your present problem before for which you are consulting us: Yes No If yes, When: _____

Was treatment provided: Yes No If yes, By whom: _____ Outcome: _____

2. Have you **ever** had a **stroke** or issues with **blood clotting**? Yes No If yes, explain _____

3. Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? Yes No If yes, explain: _____

4. Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries**? Yes No

Date	Injury/Fracture/Illness/Surgeries	Treatment	Results

Are you presently taking any **prescription drugs**, over-the-counter drugs, vitamins, or supplements? Yes No

Product/Drug	Reason	Dosage	Frequency

SYSTEMS REVIEW QUESTIONS:

Do you or have you ever had any problems with the following areas? (Please mark **Y** for yes or **N** for no in each of the following:)

- | | | |
|----------------------------------|-------------------------|--|
| 1. ___ Eyes | 7. ___ Muscles | 13. ___ Allergies |
| 2. ___ Ears, Nose, Mouth, Throat | 8. ___ Nerves | 14. ___ Psychological/Emotional |
| 3. ___ Heart | 9. ___ Joints/Bones | Females only: |
| 4. ___ Lungs/ Breathing | 10. ___ Skin | 15. ___ Gynecological/Menstrual/Breast |
| 5. ___ Intestines/Bowels | 11. ___ Internal Organs | Males Only: |
| 6. ___ Urinary | 12. ___ Blood | 17. ___ Prostate/Testicular/Penile |

Please explain any above **Yes** answers: _____

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Confidential Patient History**SOCIAL HISTORY:**Recreational Activities (Hobbies): _____
_____Your education level: Highschool Some college College Graduate Post Graduate Other: _____

- | | | | |
|--------------------------|--------------------------|-------------------------------------|---|
| Yes | No | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you exercise? _____ | times per week Type of Exercise: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke? _____ | packs per day
If you have quit smoking, when did you quit? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use other forms of tobacco? | What/How much per day? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you consume alcohol? | How many drinks per week? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you eat a balanced low fat diet? | If no, explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you get adequate sleep? | If no, explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is work stressful to you? | If yes, explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is family life stressful to you? | If yes, explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use recreational drugs? | If yes, explain: _____ |

FAMILY HISTORY AND HEALTH STATUS: list any diseases, disorders, or major illnesses. If deceased, from what?

- Mother: _____
- Father: _____
- Sisters: _____ How many? _____
- Brothers: _____ How many? _____
- Other: _____

OTHER INFORMATION:How do you sleep Back Side Stomach Do you use a pillow : Yes NoDo you wear orthotics or arch supports Yes No**Females:** Date of last gynecological and breast exam: _____For Purposes of X-Ray: Possible pregnancy? Yes No

Date of last menstrual cycle: _____

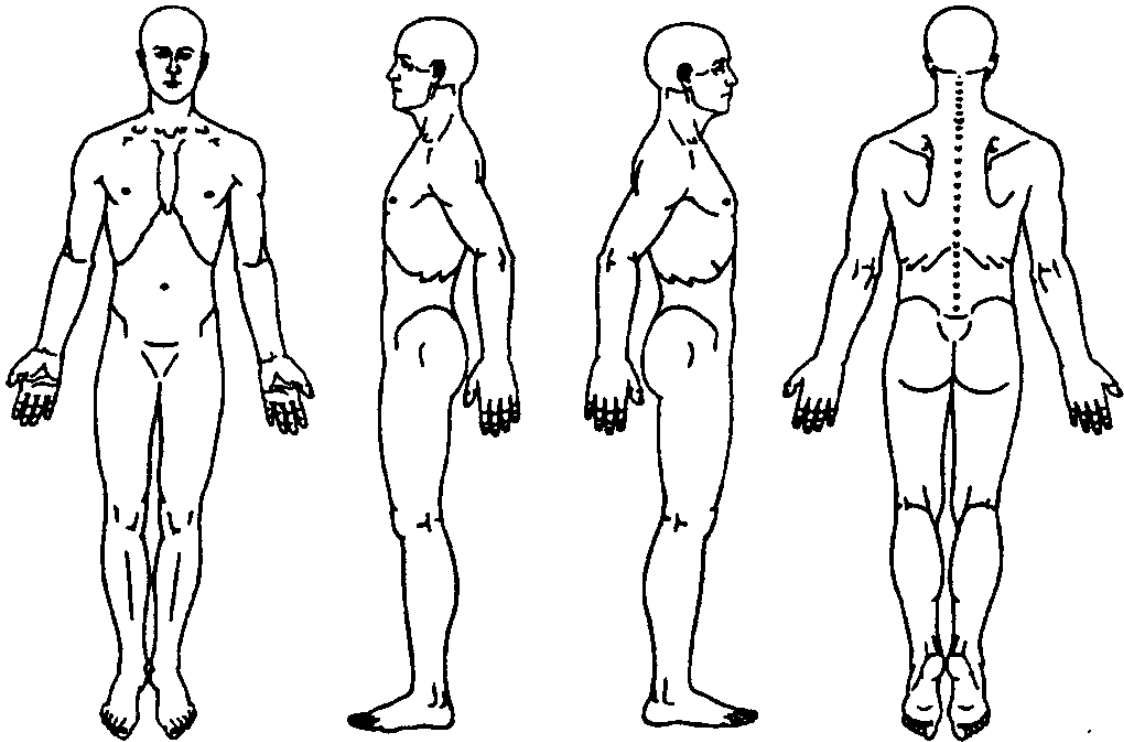
Please read and sign:

I hereby state that all information that I have provided CHIROFIT is complete and truthful and that I fully disclosed my health history.

SIGNED: _____ Date _____

Please Mark Area Of Pain on the Drawing Using The Codes Listed Be-

+++	Burning
###	Dull/Ache
***	Numbness/Tingling
===	Throbbing
000	Stabbing/Sharp



SEVERITY OF PAIN

List region of pain and circle the number which represents the intensity of your pain

Example:

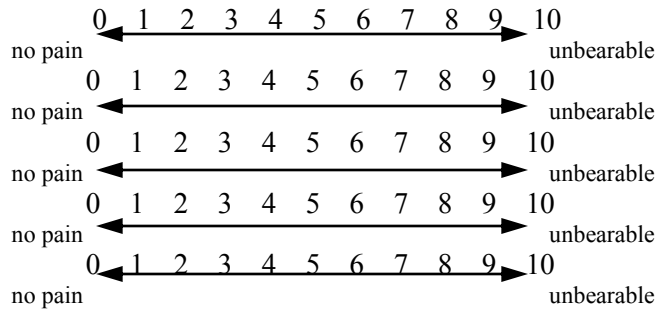
Ex. Complaint: low back pain

1. Complaint: _____

2. Complaint: _____

3. Complaint: _____

4. Complaint: _____



INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____	Signature of Patient	Date _____
_____	Signature of Parent or Guardian (if a minor)	Date _____
_____	Signature of Witness	Date _____

To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously because it can make a difference between responding to treatment or not. Usually your referring doctor and/or therapist have prescribed a set frequency of treatment. If you show up for treatment, it will enable you to get better. Other than that all you need to do is follow your doctor's instructions, and you should achieve your treatment goals.

We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get the full number of prescribed treatments that week whenever possible.

There is a **\$20 charge for a cancellation or no-show without proper notice.** This charge will not be covered by you insurance, but will have to be paid by you personally.

For **Workmen's Compensation and Personal Injury patients**, documentation of any missed appointments is forwarded to your case manager and primary physician. This could jeopardize your claim.

You may occasionally need to see another physician other than the one who normally sees you if you do need to re-arrange your appointment. All of our physicians are experienced professional and they will study your chart. You may return to your original physician at the next appointment.

Please understand that your pain will probably increase and decreases as your course of treatment progresses and before it is finally eliminated. Either condition should not be a reason not to come in: 1) Your pain is gone or 2) Your pain is worse. If the pain is gone, now is the time to really begin rehabilitating the injured area to prevent recurrence. If your pain is worse, we can do something to help.

When you don't show as scheduled, three people are hurt. 1) You, because you didn't get the treatment you need as prescribed by your doctor; 2) The doctor who now has a hole in their schedule; 3) The person that couldn't get in when you had your appointment scheduled.

Thank you for cooperating with us on this matter. We are looking forward to working with you.

patient signature

date