

# Welcome to Summit Chiropractic and Wellness Center!

The information you supply is strictly confidential. Please answer the questionnaire fully, your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible chiropractic care.

## Personal Information:

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_  
Email address: \_\_\_\_\_ What is the best way to contact you? \_\_\_\_\_  
Date of birth: \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
What type of physical duties does your job require? \_\_\_\_\_  
Have you been treated by a chiropractor before? Yes \_\_\_ No \_\_\_ If so, Whom and when? \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Spouse's/Partner's Name: \_\_\_\_\_  
Emergency Contact (Name & Number): \_\_\_\_\_

## Insurance/Payment Information:

Please let our staff know if you are consulting our office due to an auto accident or work related injury.

How do you plan to pay for care? Personal Insurance \_\_\_ Third Party Insurance \_\_\_ Self pay, no Insurance \_\_\_  
Primary Insurance:  
Insurance Name: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_  
Policy/ID #: \_\_\_\_\_ Group#: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_ Relation to Insured: Self \_\_\_ Spouse \_\_\_ Parent \_\_\_  
Secondary Insurance (if applicable):  
Insurance Name: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_  
Policy/ID #: \_\_\_\_\_ Group#: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_ Relation to Insured: Self \_\_\_ Spouse \_\_\_ Parent \_\_\_

**Present Condition:**

Give a brief detailed description of the problem you are currently experiencing:

\_\_\_\_\_

\_\_\_\_\_

Date symptoms/injury occurred: \_\_\_\_\_ Have you ever had the same or similar condition? \_\_\_\_\_

If yes, please describe how and when you experienced the same condition: \_\_\_\_\_

\_\_\_\_\_

What does this prevent you from doing? \_\_\_\_\_

Has it gotten worse recently? Yes \_\_\_ No \_\_\_ Same \_\_\_ Better \_\_\_ Gradually worse \_\_\_

How frequent are you experiencing the pain? Constantly \_\_\_ Intermittently \_\_\_ Daily \_\_\_ Night only \_\_\_

How long does it last? All day \_\_\_ Few hours \_\_\_ Minutes \_\_\_

Describe the type of pain: Sharp \_\_\_ Dull \_\_\_ Aching \_\_\_ Burning \_\_\_ Stabbing \_\_\_ Throbbing \_\_\_

Numbness \_\_\_ Nagging \_\_\_ Deep \_\_\_ Numbness \_\_\_ Tingling \_\_\_ Other: \_\_\_\_\_

Does this pain radiate or travel (shoot) to any other areas of your body? Yes \_\_\_ No \_\_\_ If yes, where? \_\_\_\_\_

Are you experiencing numbness and/or tingling in your body? Yes \_\_\_ No \_\_\_ If yes, where? \_\_\_\_\_

Is there anything you can do to relieve the problem? \_\_\_\_\_

What types of things have you tried to relieve the problem? \_\_\_\_\_

What makes the problem worse? Standing \_\_\_ Sitting \_\_\_ Lying \_\_\_ Bending \_\_\_ Lifting \_\_\_ Twisting \_\_\_

Have you lost days from work due to this condition? Yes \_\_\_ No \_\_\_ if yes, how many days? \_\_\_\_\_

Does this condition interfere with: Sleep? \_\_\_ Daily routine? \_\_\_ Other: \_\_\_\_\_

Have you sought any other treatment for this condition anywhere else? \_\_\_\_\_

Please indicate where you are feeling your symptoms. Indicate the level of pain on the number chart.

10 Worst possible pain

9

8

7

6

5 Moderate pain

4

3

2

1

0 No pain

**Past Health History:**

Please list any illnesses you have or had in the past: \_\_\_\_\_

Please list any previous trauma or injuries, broken bones, sprains/strains, etc.: \_\_\_\_\_

Have you been hospitalized within the last 5 years? Yes \_\_\_ No \_\_\_ If yes, explain: \_\_\_\_\_

Please list any surgeries and the date performed: \_\_\_\_\_

Do you have any known allergies? \_\_\_\_\_

List any medications you are currently taking and reason for taking it:

List any vitamin, mineral, or herb supplements you are currently taking: \_\_\_\_\_

**Habits:**

	None	Light	Moderate	Heavy	Explain
Alcohol					
Coffee					
Soft drinks					
Water					
Tobacco					
Recreational Drugs					
Exercise					
Sleep					
Salty foods					
Sugar					

**Other Symptoms/Conditions:**

Please mark any of the following that you have now or have ever experienced:

- Headaches
- Neck pain
- Chest pain
- Nausea
- Convulsions
- Low back pain
- High blood pressure
- Abdominal pain
- Dizziness
- Painful joints
- Heart attack/disease
- Poor appetite
- Fainting
- Weak muscles
- Stroke
- Black stools
- Fatigue
- Walking problems
- Poor circulation
- Wheezing
- Nervousness
- Sinus issues
- Swelling ankles
- Coughing
- Eye disorders
- Shortness of breath
- Enlarged thyroid
- Kidney stones
- Pain between shoulders
- Asthma
- Frequent colds
- Painful urination
- Depression
- Allergies
- Excessive hunger/thirst
- Prostate issues
- Loss of memory
- Broken bones
- Osteoporosis
- Diabetes
- Loss of balance
- Weight loss/gain
- Liver/gallbladder
- Cancer
- Skin rashes
- High cholesterol
- Loss of bladder control
- Menstrual cramps

**Family Health History:**

Do/did any members of your immediate family (mother, father, sister, brother) have any serious health conditions? Examples include, but are not limited to, Cancer, Heart disease, Diabetes, Arthritis, etc.

No \_\_\_\_\_

Yes \_\_\_\_\_ Please explain: \_\_\_\_\_

Do you have any children? Yes \_\_\_\_\_ No \_\_\_\_\_ How many? \_\_\_\_\_

For Women: Are you or could you be pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ Uncertain \_\_\_\_\_ Date of last cycle? \_\_\_\_\_

**One last thing...**

Is there anything else that you want the Doctor to know about concerning your health that was not covered in this form? Please let us know of any concerns or questions! \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**We want you to know your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to 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.**

**Authorization and release:** I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I understand and agree to allow this chiropractic office to use their Patient Health information for the purpose of treatment, payment, healthcare operations, and coordination of care.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

## Informed Consent

Please read over this material before your consultation. Do not sign until after the doctor has discussed it with you and has answered all of your questions.

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

- While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment
- There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustments. Although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
- There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasions, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be a highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal 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 the following with my healthcare provider:

- The condition that the treatment is to address
- The nature of the treatment
- The risks and benefits of that treatment
- Any alternatives to that treatment

I have had the opportunity to ask questions and receive answers regarding the treatment

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with Dr. Kimberly Chitwood and staff at Summit Chiropractic and Wellness Center.

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Patient Signature (or Legal Guardian)

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Date