MAPLEWOOD
Chiropractic Health Center

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

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

E-mail Address: _____ Cell/Home Phone: _____

Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No Insurance Provider: _____

Employer: _____ Occupation: _____

Name & Number of Emergency Contact: _____Relationship: _____

PLEASE CIRCLE YOUR ANSWERS AND ALSO ELABORATE IF NECESSARY

PLEASE KEEP IT 1 SYMPTOM PER LINE OF QUESTIONS

Symptom #1: (Neck pain, Upper back pain, Lower back pain, Hip pain, Headache, Shoulder pain, Knee pain, Foot pain, other)?

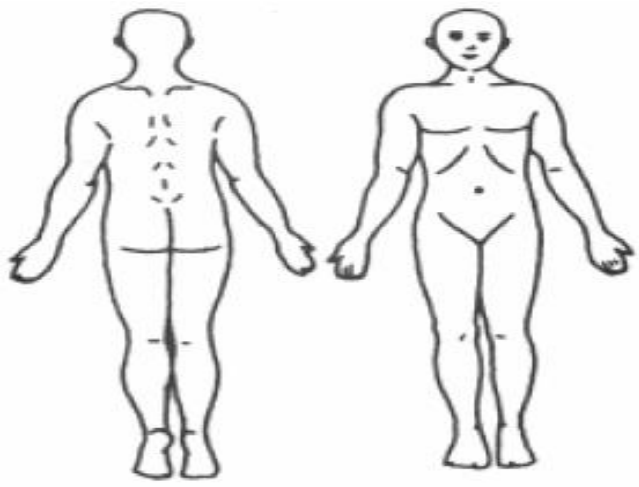
Where is the pain located (Left side, Right side, Both left and right sides)?

Frequency of pain (Constant, Frequent, Intermittent, Occasional)?

Pain character (Aching, Burning, Dull, Sharp, Stabbing, Throbbing)?

Weakness? Stiffness? Radiation/referral pain? Numbness/tingling?

On a scale of 0-10 (0 = No Pain/ 10 = Worst Pain Possible)
how would you rate the severity of your pain:
Right Now: _____ Average: _____ At Best: _____ At Worst: _____



Complaint aggravated by (Light activity, Moderate activity, Heavy activity, Bending, Lifting, Standing, Stress, Temperature changes, Twisting, other)?

Complaint relieved by (Cold, Heat, Increased activity, Lying down, Over the counter medications, Prescribed medications, Rest, Postural changes, Stretching, Support brace, other)?

Symptom #2: (Neck pain, Upper back pain, Lower back pain, Hip pain, Headache, Shoulder pain, Knee pain, Foot pain, other)?

Where is the pain located (Left side, Right side, Both left and right sides)?

Frequency of pain (Constant, Frequent, Intermittent, Occasional)?

Pain character (Aching, Burning, Dull, Sharp, Stabbing, Throbbing)?

Weakness? Stiffness? Radiation/referral pain? Numbness/tingling?

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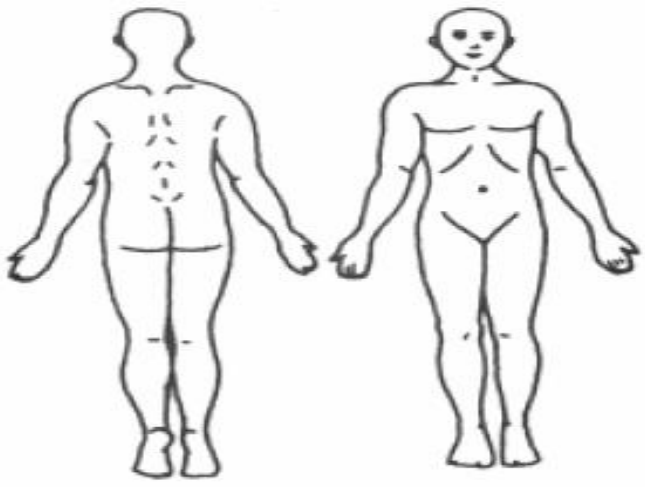

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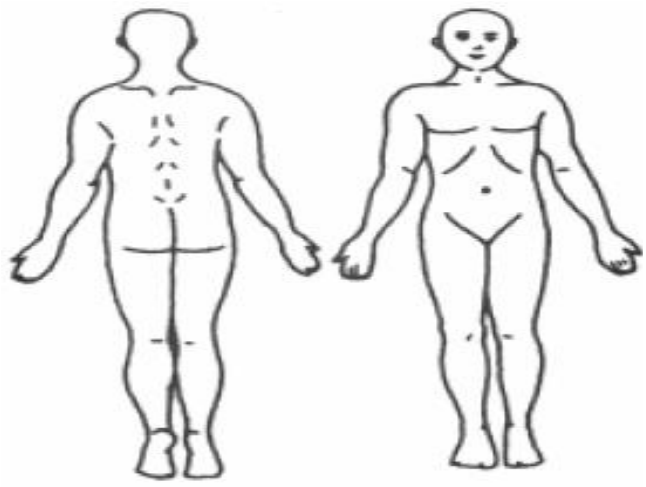
Complaint relieved by (Cold, Heat, Increased activity, Lying down, Over the counter medications, Prescribed medications, Rest, Postural changes, Stretching, Support brace, other)?

Symptom #3: (Neck pain, Upper back pain, Lower back pain, Hip pain, Headache, Shoulder pain, Knee pain, Foot pain, other)?

Where is the pain located (Left side, Right side, Both left and right sides)?



Frequency of pain (Constant, Frequent, Intermittent, Occasional)?

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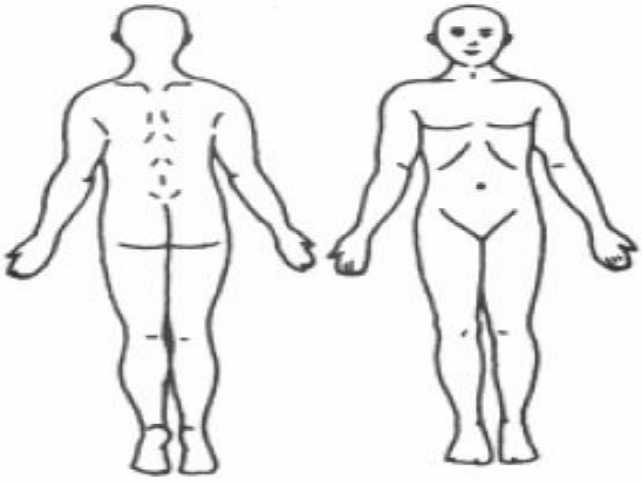
Complaint relieved by (Cold, Heat, Increased activity, Lying down, Over the counter medications, Prescribed medications, Rest, Postural changes, Stretching, Support brace, other)?

Symptom #4: (Neck pain, Upper back pain, Lower back pain, Hip pain, Headache, Shoulder pain, Knee pain, Foot pain, other)?

Where is the pain located (Left side, Right side, Both left and right sides)?



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If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have and **N** for *N**ever** have had*:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer

___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ Yes ❑ No

If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)

Have they ever been treated for their condition? ❑ Yes ❑ No ❑ I don't know

2. Any other hereditary conditions the doctor should be aware of. ❑ Yes ❑No: _____

I hereby authorize payment to be made directly to Maplewood Chiropractic Health Center, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Maplewood Chiropractic Health Center for any and all services I receive at this office.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

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HIPAA: Consent for Use and Disclosure of Health Information

I was offered/received a copy of Maplewood Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____ _____
Patient's Name DOB HR#

_____ _____
Patient signature Date

_____ _____
Witness Date

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided Maplewood Chiropractic Health Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ 🗀*Witness Initials*
Patient or Authorized person's Signature Date

Regarding X-ray/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ 🗀 *Witness Initials*
Patient or Authorized person's Signature Date