CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

PATIENT INFORMATION

FULL NAME_____ DATE OF BIRTH____/____/____ AGE____ MALE □ FEMALE □

ADDRESS_____ APT#____ SSN_____-_____-_____

CITY_____ STATE____ ZIP CODE _____ CELL PHONE (____)_____

ALTERNATE PHONE (____)_____ EMAIL ADDRESS _____

EMPLOYER'S NAME_____ OCCUPATION_____

WORK ADDRESS_____ CITY_____ STATE ____ZIP CODE_____

WORK PHONE (____)_____ EXT_____ MARITAL STATUS: SINGLE □ MARRIED □ WIDOWED □

EMERGENCY CONTACT _____ PHONE_____

DATE SYMPTOMPS BEGAN___/___/___ HOW DID YOU HEAR ABOUT US? _____

PRIMARY CARE PHYSICIAN _____PHONE_____

CLAIM INFORMATION

IS YOUR CONDITION DUE TO: AN AUTO ACCIDENT □ A PERSONAL INJURY □ A WORK INJURY □ OTHER □

TYPE OF CLAIM: CASH □ GROUP HEALTH INS □ PERSONAL INJURY □ WORKER'S COMP □ MEDICARE □

I WILL BE PAYING BY: CASH □ CHECK □ VISA □ MASTERCARD □ AMEX □ DISCOVER □ OTHER □

INSURANCE INFORMATION

RELATIONSHIP TO INSURED? SELF □ SPOUSE □ OTHER □ CHILD □ SPOUSE:_____

INSURED'S EMPLOYER: SAME AS ABOVE □ _____

INSURED'S SSN: SAME AS ABOVE □ SSN____-____-____ INSURED'S DOB: SAME AS ABOVE □ ____/____/____

PRIMARY INSURANCE CO. _____ ADDRESS _____

CITY_____ STATE____ ZIP CODE _____ PHONE _____

POLICY NUMBER _____ GROUP NUMBER_____

SECONDARY INSURANCE CO. _____ ADDRESS _____

CITY_____ STATE____ ZIP CODE _____ PHONE _____

POLICY NUMBER _____ GROUP NUMBER_____

AUTHORIZATIONS

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefit submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient/Guardian's Signature:_____Date:_____

Chief Complaint

What brings you in the office? _____

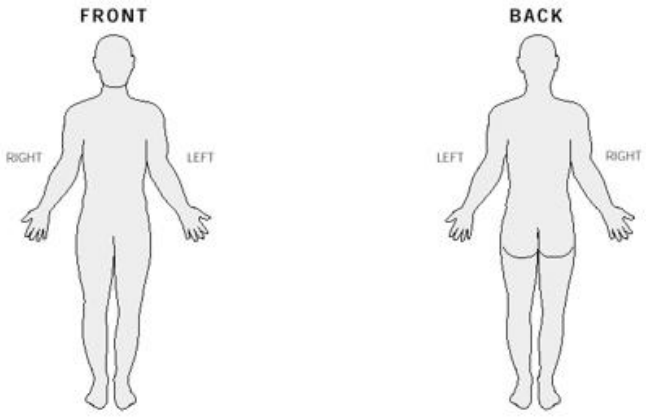
Present Illness

Onset: What was the date of injury? Or when did you become aware of the symptoms? _____

Mechanism: How did the injury occur? _____

Recurrence: Have you had this pain before? YES or NO Describe _____

Location: Mark the areas on the diagram where you feel discomfort.



Radiation: Does the symptoms radiate into the arms or legs? □ YES □ NO

Quality: Describe the type of pain.

□Sharp □Shooting □Throbbing □Stiffness □Dull □Aching
□Burning □Tingling □Numbness □Cramps □Swelling □ Other

Severity: Please mark a line on the scale to describe your level of discomfort. If you are describing more than one symptom, indicate the level of pain for each symptom.

No Pain | _____ | **Worst possible pain**

Duration/Freq: How long do your symptoms last? _____How often do you experience your symptoms? _____

Temporal: Is your pain worst during any particular part of day or night? _____

Provocative: What activities or conditions seem to make your symptoms worse? _____

Palliative: What tends to make you feel better? _____

Other Provider: Name and phone number of any health care provider who has seen you for this condition. Including X-rays/MRI.

Past Medical History

Please circle to indicate if you have any of the following:

AIDS/HIV	Cancer	Gout	Multiple Sclerosis	Stroke
Alcoholism	Cataracts	Heart Disease	Mumps	Suicide Attempt
Anemia	Chicken Pox	Hepatitis	Osteoporosis	Thyroid Problems
Anorexia	Diabetes	Hernia	Pacemaker	Tonsillitis
Appendicitis	Drug Abuse	Herpes	Pneumonia	Tuberculosis
Arthritis	Emphysema	High Cholesterol	Polio	Tumors
Asthma	Epilepsy	Kidney Disease	Prostate Problem	Ulcers
Blood Disorders	Fractures	Liver Disease	Psychiatric Care	Vaginal Infections
Breast Lump	Glaucoma	Measles	Rheumatic Arthritis	Venereal Disease
Bronchitis	Goiter	Migraines	Rheumatic Fever	Whooping Cough
Bulimia	Gonorrhea	Mononucleosis	Scarlet Fever	High blood pressure
				Other

Surgeries	**Description**	**Date**

Medications	**Allergies**	**Vitamins/Herbs/Minerals**

Family History

Please circle if you have your immediate family members that have any of the following:

Emphysema	Diabetes	Stomach	Mental Illness	Osteoporosis
Headaches	Circulation Problems	Ulcers	Alcoholism	Liver Disease
Heart Disease	AIDS/HIV	Back Problems	Arthritis	Cancer
High Blood Pressure	Seizures-Convulsions	Kidney Disease	Stroke	Thyroid Disease

What was the cause of death? _____

Activities of Daily Life

Please rate your difficulties in performing the activities below. (0 No difficulties – 5 Cannot perform due to pain)

Difficulties with self care and personal hygiene	0	1	2	3	4	5
Difficulties with physical activities (standing/sitting/bending)	0	1	2	3	4	5
Difficulties with functional activities (lifting/pushing)	0	1	2	3	4	5
Difficulties with social or recreational activities	0	1	2	3	4	5
Difficulties with traveling (driving/flying)	0	1	2	3	4	5

Please rate how your condition has affected your senses below. (0 No change – 5 Loss of ability)

Difficulty with different forms of communication (reading/writing)	0	1	2	3	4	5
Difficulty with senses (smell/touch/taste/hearing/seeing)	0	1	2	3	4	5
Difficulty with hand function (grasping)	0	1	2	3	4	5
Difficulty with sleep and sexual function	0	1	2	3	4	5

Do you have or have you ever had:

- Any generalized changes in general health such as weakness, fatigue, fever, chills, night sweats, fainting, changes in sleep pattern, unexplained weight loss, unexplained weight gain or others?
  YES OR NO If yes, please explain_____
- Any skin problems such as rashes, itching, dryness, sores, changes in color, changes in moles, changes in hairs, changes in fingernails or others?
  YES OR NO If yes, please explain_____
- Any eye, ear, nose or throat problems such as blurred vision, double vision, eye pain, hearing loss, ringing in the ear, vertigo, sinus problems, loss of smell, hoarseness, difficulty swallowing or others?
  YES OR NO If yes, please explain_____
- Any heart problems such as a murmur, palpitations, rapid heartbeat, extremity swelling, chest pain cold extremities, high/lo blood pressure or others?
  YES OR NO If yes, please explain_____
- Any lung problems such as coughing, phlegm, shortness of breath, difficulty breathing, wheezing, congestion, coughing blood or others?
  YES OR NO If yes, please explain_____
- Any gastrointestinal problems such as stomach pain, nausea/vomiting, diarrhea, gas/bloating, constipation, rectal bleeding, changes in appetite/thirst, changes in stools or other?
  YES OR NO If yes, please explain_____
- Any genitourinary problems such as painful urination, blood in urine, frequent urination, incontinence, urgency, change in urine appearance or others?
  YES OR NO If yes, please explain_____
- Any musculoskeletal problems such as muscle pain, muscle weakness, muscle twitching, joint stiffness, joint pain, joint swelling, hot joints or others?
  YES OR NO If yes, please explain_____
- Any neurological problems such as numbness, tingling, weakness, paralysis, loss of memory, loss of sensation, difficulty with coordination, dizziness, difficulty with speech or others?
  YES OR NO If yes, please explain_____
- Any psychiatric problems such as depression, anxiousness, hallucination, drug addiction, suicidal thoughts, difficulty sleeping or others?
  YES OR NO If yes, please explain_____
- Any endocrine problems such as severe intolerance to heat or cold, changes in thirst, excessive sweating or others?
  YES OR NO If yes, please explain_____
- Any hematological problems such as anemia, diabetes, hepatitis, autoimmune disease or others?
  YES OR NO If yes, please explain_____

Is there anything else you think the doctor should know about your medical history?

GREATER NORWICH CHIROPRACTIC

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care involves the diagnosis and treatment of musculoskeletal conditions, primarily those involving the spine and related structures, through use of manual adjustments and other non-invasive techniques. The purpose of this form is to obtain your informed consent for chiropractic treatment.

RISKS OF CHIROPRACTIC CARE Although chiropractic care is generally safe, there are potential risks associated with any medical treatment. These risks may include:

- Soreness, discomfort, or bruising following the treatment
- Aggravation of existing conditions or injuries
- Fracture or dislocation of bones or joints
- Nerve damage or compression
- Stroke, heart attack, or other serious medical conditions (very rare)

BENEFITS OF CHIROPRACTIC CARE The goal of chiropractic care is to improve the functioning of the musculoskeletal and nervous systems, relieve pain, and improve overall health and well-being. The potential benefits of chiropractic care may include:

- Reduced pain and discomfort
- Improved mobility and range of motion
- Improved posture and balance
- Enhanced athletic performance
- Better sleep and relaxation

ALTERNATIVE TO CHIROPRACTIC CARE There may be alternative treatments available for your condition, including medical, surgical, or physical therapy interventions. Your chiropractor may recommend a referral to a different healthcare provider if they believe that another treatment would be more appropriate for your needs.

CONFIDENTIALITY AND RELEASE OF INFORMATION The chiropractor will maintain confidentiality of your health information in accordance with applicable laws and regulations. They may release your health information to other healthcare providers for the purpose of coordinating your care.

FINANCIAL RESPONSIBILITY You are responsible for payment of all charges for chiropractic care, regardless of insurance coverage.

I have read and understand the contents of this informed consent form. I have had the opportunity to ask any questions that I may have had, and I voluntarily consent to the proposed chiropractic care.

Signature of Patient _____ Date _____

Print Name _____ Date _____