

Patient Information

Today's Date	Date of Birth	Age	Gender
			M/F
Name			
Address			
Phone	Cell phone	Email	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered	Partners Name:		
Emergency contact:		How did you hear about us?	
What is your main complaint?			
When & how did it start?			
What treatment have you already received for your condition?	<input type="checkbox"/> Medications <input type="checkbox"/> Surgery <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Chiropractic <input type="checkbox"/> Acupuncture <input type="checkbox"/> Massage <input type="checkbox"/> None <input type="checkbox"/> Other _____		
Other physicians seen for this condition:			

Describe the pain:			
<input type="checkbox"/> Sharp	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Dull	<input type="checkbox"/> Stiff
<input type="checkbox"/> Constant	<input type="checkbox"/> Intermittent	<input type="checkbox"/> Burning	<input type="checkbox"/> Shooting
<input type="checkbox"/> Electrical	<input type="checkbox"/> Tingling	<input type="checkbox"/> Superficial	<input type="checkbox"/> Cramps
<input type="checkbox"/> Numb	<input type="checkbox"/> Sudden	<input type="checkbox"/> Deep	<input type="checkbox"/> Swollen

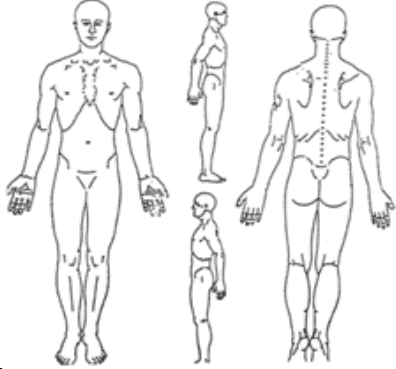
What makes the pain worse?:			
<input type="checkbox"/> Sitting	<input type="checkbox"/> Walking	<input type="checkbox"/> Bending	<input type="checkbox"/> Cold
<input type="checkbox"/> Lying down	<input type="checkbox"/> Coughing	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Heat
<input type="checkbox"/> Standing up	<input type="checkbox"/> Lifting	<input type="checkbox"/> Standing	<input type="checkbox"/> Other

What makes it feel better?:			
<input type="checkbox"/> Sitting	<input type="checkbox"/> Walking	<input type="checkbox"/> Bending	<input type="checkbox"/> Cold
<input type="checkbox"/> Lying down	<input type="checkbox"/> Coughing	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Heat
<input type="checkbox"/> Standing up	<input type="checkbox"/> Lifting	<input type="checkbox"/> Standing	<input type="checkbox"/> Other
<input type="checkbox"/> Medicines	<input type="checkbox"/> Massage	<input type="checkbox"/> Chiropractic	

Does it interfere with your:			
<input type="checkbox"/> Work	<input type="checkbox"/> Sleep	<input type="checkbox"/> Daily routine	<input type="checkbox"/> Recreation

Health History		
<p>General</p> <input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Allergies <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding <input type="checkbox"/> Bronchitis <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fractures <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Migraines <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pacemaker <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Tumors <input type="checkbox"/> Other _____ <p>Are you pregnant? Yes / No complications? Yes / No</p> <p>MusculoSkeletal System</p> <input type="checkbox"/> Low back pain <input type="checkbox"/> Mid back pain <input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Neck pain <input type="checkbox"/> Arm problems <input type="checkbox"/> Leg problems <input type="checkbox"/> Swollen joints <input type="checkbox"/> Painful joints <input type="checkbox"/> Stiff joints <input type="checkbox"/> Sore muscles <input type="checkbox"/> Weak muscles <input type="checkbox"/> Walking Problems <input type="checkbox"/> Spasms <input type="checkbox"/> Broken bones <input type="checkbox"/> Shoulder pain	<p>Genito-Urinary System</p> <input type="checkbox"/> Bladder trouble <input type="checkbox"/> Excessive urination <input type="checkbox"/> Scanty urination <input type="checkbox"/> Painful urination <input type="checkbox"/> Discolored urine <p>Female</p> <input type="checkbox"/> Vaginal discharge or pain <input type="checkbox"/> Breast pain <input type="checkbox"/> Lumps on breast <p>Gastro-Intestinal System</p> <input type="checkbox"/> Poor appetite <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Difficult chewing <input type="checkbox"/> Difficult Swallowing <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting Blood <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Black stool <input type="checkbox"/> Bloody stool <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Liver trouble <input type="checkbox"/> Gall bladder problems <input type="checkbox"/> Weight trouble <p>Nervous System</p> <input type="checkbox"/> Numbness <input type="checkbox"/> Loss of feeling <input type="checkbox"/> Paralysis <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Headaches <input type="checkbox"/> Muscle jerking <input type="checkbox"/> Convulsions <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Confusion <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia	<p>Cardio-Vascular Respiratory</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> Pain over heart <input type="checkbox"/> Difficult breathing <input type="checkbox"/> Persistent cough <input type="checkbox"/> Coughing phlegm <input type="checkbox"/> Coughing blood <input type="checkbox"/> Rapid heartbeat <input type="checkbox"/> Blood pressure problems <input type="checkbox"/> Heart problems <input type="checkbox"/> Lung problems <input type="checkbox"/> Varicose veins <p>Eye, Ear, Nose, Throat</p> <input type="checkbox"/> Eye strain <input type="checkbox"/> Eye inflammation <input type="checkbox"/> Vision problems <input type="checkbox"/> Ear pain <input type="checkbox"/> Ear noises <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hearing loss <input type="checkbox"/> Nose pain <input type="checkbox"/> Nose bleeding <input type="checkbox"/> Nose discharge <input type="checkbox"/> Difficult nose breathing <input type="checkbox"/> Sore gums <input type="checkbox"/> Dental problems <input type="checkbox"/> Sore mouth <input type="checkbox"/> Sore throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Difficult speech <input type="checkbox"/> Sinus <input type="checkbox"/> Allergy <input type="checkbox"/> Jaw pain <p>Habits</p> <input type="checkbox"/> Cigarettes <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Coffee or tea <input type="checkbox"/> Drug abuse <input type="checkbox"/> _____

Patient Information

Exercise	None	Moderate	Daily	Heavy
Work	Sitting	Standing	Light	Heavy
<p><u>Injuries/Surgeries/Hospitalizations</u> Please describe and give the dates of any significant falls, head injuries, broken bones, dislocations, surgeries, or hospitalizations.</p>				
<p>Mark your discomfort and describe, Please be specific.</p> <div style="text-align: center;">  </div>				
<p>Informed Consent I verify that the information given above is accurate and truthful to the best of my knowledge. I also give my consent to Dr. Joshua Jameson to examine and treat me.</p> <p>I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.</p> <p>I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive. I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.</p>				
<p>Office Financial Policy Payment is expected at time of service.</p>				
<p>Missed appointments/ cancellation Policy Please provide 24 hours notice when cancelling an appointment. Failure to show up for a scheduled appointment, or canceling an appointment with less than 24 hours notice will result in a charge of \$20.</p>				
Name:		Signature		Date

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Name _____ Phone _____

The effective date of this Notice of Information Practices is _____.

Thank you.