WESTSIDE CHIROPRACTIC

Healthy By Choice

Name (First, Middle, Last) _____ Date_____

Date of Birth_____ Age_____ Gender _____ Social Security Number _____-_____-_____

Mailing Address_____ City _____ State_____ Zip_____

Home Phone Number_____ Work Phone_____

Cell Phone Number _____ Email Address_____

Business/Employer_____ Type of work_____

Spouse Name and Business/Employer_____

Type of Work_____

Check One: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated No. of Children_____

Emergency Contact Name _____ **Relationship**_____ **Phone**_____

Street Address_____ City _____ State_____ Zip_____

Who may we thank for referring you to our office? _____

How can we help?_____

What are you passionate about?_____

Acknowledgements:

Initial ____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initial____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for any payment of any covered or non-covered services I receive.

Initial____ To the best of my ability, the information I have supplied is complete and truthful to the best of my recollection. I have not misrepresented the presence, severity or cause of my health concern.

HIPAA, Office Policies and Informed Consent

I authorize Westside Chiropractic, P.C. to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly Westside Chiropractic, P.C. such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason or any other bills that are due this office, and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, Workers Comp benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office. I hereby further give a lien to said office against any and all insurance benefits named herein, and any and all proceeds of any settle judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I, the undersigned do hereby appoint Westside Chiropractic, P.C. the authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charges directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill. I understand and agree to Westside Chiropractic's office policy and financial policy. Return check fee is $40.00. Balances over 30 days may be subject to 1.5% per month interest. All accounts not paid within 90 days will automatically be put through to an outside collection agency, which may affect your credit score.

Informed Consent

I hereby authorize doctors and staff at Westside Chiropractic, P.C. to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Westside Chiropractic, P.C. responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

- **Soreness** – Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.
- **Soft Tissue Injury** – Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft-tissue injury.
- **Rib Injury** – Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such s pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.
- **Physical Therapy Burns** – Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.
- **Stroke** – Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.
- **Other Problems** – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

*** If you have any questions concerning this form or the above statements, please talk with the doctor.**

I have carefully read and understand the above information. I hereby give my informed consent to have chiropractic treatment administered.

PRINT NAME _____ Patient's Signature: _____

DATE: _____ Witness/Guardian: _____

CURRENT HEALTH CONDITION

Reason for today's visit: Emergency New Injury Old Injury Chronic Pain Wellness

Where is your pain? _____

Are you in pain? Yes No Intensity right now? (mild) 1 2 3 4 5 6 7 8 9 10 (severe)

At it's worst? 1 2 3 4 5 6 7 8 9 10 At it's best? 1 2 3 4 5 6 7 8 9 10

Describe pain: Dull Sharp Achy Throbbing Shooting Frequent Constant Occasional

HOW did the pain start?: _____

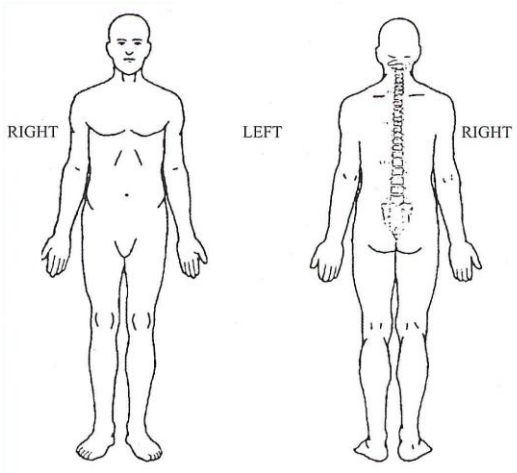
WHEN did it start? _____

What helps your condition? (ice, heat, medication) _____

What activities make it worse? _____

Does pain radiate to other body areas? Yes No Where? _____ Getting worse? Yes No

PLEASE MARK AREAS OF DISCOMFORT



Current Medications: _____

Current Medical Conditions: _____

Goals? _____

Past Surgeries: _____ Accidents: _____

Allergies: _____

Have you ever had any of the following conditions?

Depression Anxiety Headaches Dizziness High or Low Blood Pressure High Cholesterol Skin Disorders

Cancer Kidney stones Infertility Fainting Poor Appetite Fatigue Swollen Lymph Nodes

FAMILY HISTORY

Cancer	YES	NO	Family Member: _____
Diabetes	YES	NO	Family Member: _____
High Blood Pressure	YES	NO	Family Member: _____
Heart Disease	YES	NO	Family Member: _____
Stroke	YES	NO	Family Member: _____

NAME_____**DOB**_____

Ht. _____ Wt._____ Blood Pressure_____ Pulse_____

POSTURE (standing)

Head tilt L / R Shoulders: L / R Hip High L / R Anterior C S L / R

Thoracic Kyphosis: I D N Lumbar Lordosis: I D N

LUMBAR ROM: Normal / Mild / Moderate / Severe

Flexion (90) _____ Extension (30) _____

Left Lateral (30) _____ Right Lateral (30) _____

Left Rotation (35) _____ Right Rotation (35) _____

CERVICAL ROM: Mild / Moderate / Severe

Flexion (45)_____ Extension (55)_____

Left Lateral (40) _____ Right Lateral (40) _____

Left Rotation (70) _____ Right Rotation (70) _____

CERVICAL ORTHOPEDIC TESTS

Compression Distraction Foraminal Compression: L R Shoulder Depressor

LUMBAR ORTHOPEDIC TESTS

Kemps: L R Miner's Sign Bechterew's: L R Slump: C T L SLR: L R Well Leg:

Braggard's: L R Thomas: L R Milgrams Patrick's: L R Sit Up

Nachlas: L R Ely's: L R Hibb's: L R Yeoman's: L R