WESTSIDE
CHIROPRACTIC
Healthy By Choice

Personal History

Name (First, Middle, Last) ______________________________________ Date___________________

Preferred Nickname________________________________ Social Security Number ______-_______-_________

Mailing Address____ City ________ State_____ Zip__________

Home Phone Number_____________________________ Work Phone____________________________

Cell Phone Number ______________________________ Carrier: Alltel Verizon Sprint AT&T Other

Email Address__________________________________ Date of Birth_______________ Age_____

Business/Employer_______________________________ Type of Work_____________________________

Spouses 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__________

Family Physician____Office___________________________

Past Chiropractor____Office___________________________

Who is responsible for payment ☐ Self ☐Spouse ☐ Insurance ☐Other ________________________________

Insurance Company to be filed with ____

Who may we thank for referring you to our office ____

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 understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

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 ask your doctor.

I have read the HIPPA information presented to me by this office and understand my privacy rights with regard to HIPPA. Initial:_______________

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

Date: ________________________ Patient's Signature: ________________________________

Date: ________________________ Witness/Guardian: ________________________________

CURRENT HEALTH CONDITION

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

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

Where is your area of discomfort? ____________________

What started your discomfort: ____________________

Is your condition getting worse? Yes No

Is your condition interfering with: Work Sleep Daily Routine

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

What activities make it worse? ____________________

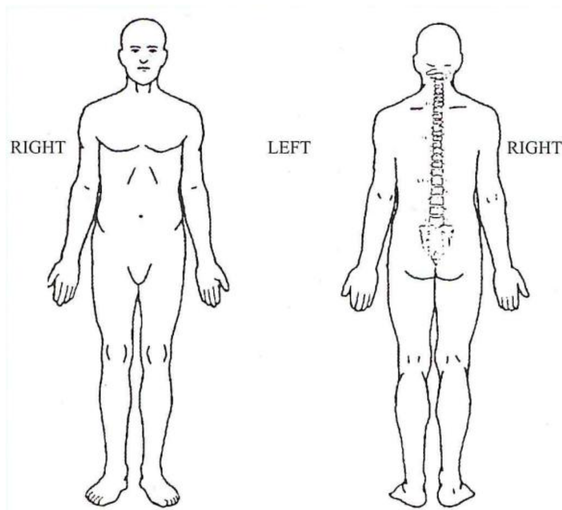
Does pain radiate to other body areas? Yes No Where? ____________________

Has this or something similar happened in the past? Yes No

Have you seen anyone else for this condition? Yes No Who? ____________________

Type of treatment: ____________________ Results? ____________________

PLEASE MARK AREAS OF DISCOMFORT



Current Medications: ____________________

____

Current Medical Conditions: ____________________

____

In addition to the main reason for your visit today, what additional health goals do you have?

____

____

PAST HEALTH HISTORY

Major Surgeries: Spine Joint Abdominal Heart Other____

Major Accidents or Falls: ____

____

Hospitalizations (other than above) ____

____

Do you exercise regularly? Yes No Do you smoke? Yes No

Do you drink alcohol? Yes No Occasionally Do you use recreational drugs? Yes No

How much water do you drink in a day? ______________________ Caffeine? ______________________

Allergies: ____

Have your ever had any of the following conditions?

- ❑ Heart Attack/ Stroke
- ❑ Heart Surgery/Pacemaker
- ❑ Congenital Heart Defect
- ❑ High/Low Blood Pressure
- ❑ Difficulty Breathing
- ❑ Shortness of Breath
- ❑ Asthma
- ❑ Emphysema
- ❑ Vision Changes
- ❑ Tuberculosis
- ❑ Glaucoma
- ❑ Cancer
- ❑ Arthritis
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Seizures/Epilepsy
- ❑ Shingles
- ❑ Depression/Anxiety
- ❑ Blood/Skin Disorders
- ❑ Kidney Problems
- ❑ Alcohol/Drug Abuse
- ❑ Heartburn/Nausea
- ❑ Weight Changes
- ❑ Dizziness
- ❑ Headaches
- ❑ Sinus problems

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:____

Additional Comments:____

____

____