

PATIENT INFORMATION & CONDITION FORM

Patient Name: _____

Today's Date: ___/___/___

Social Security Number _____ Birth Date: ___/___/___ Age: ___ Gender: F M

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ___/___/___ Phone: (____) _____

Mother: _____ Date of Birth: ___/___/___ Phone: (____) _____

Guardian: _____ Date of Birth: ___/___/___ Phone: (____) _____

Who do you normally live with? Mother and Father Father Mother Legal Guardian None of these

Marital Status: Married Separated Widowed Single How many children? _____

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Phone (____) _____

OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street _____

City _____ State _____ Zip _____

Phone (____) _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (____) _____

Student at _____ FULL-TIME PART-TIME

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Work Address _____ Work Phone (____) _____

Spouse is a student at _____ FULL-TIME PART-TIME

Who should we contact in the event of an emergency? _____ Phone (____) _____

Address of contact person _____

How did you learn about us? _____

Is your condition or injury due to an accident or work-related cause? YES NO Please check ALL that apply.

Did the condition or injury result from *automobile* accident? YES NO

Did it result from a *work-related* accident or cause? YES NO (briefly describe): _____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? _____

Approximately, when did your injury or condition occur? ___/___/___

Describe your condition, symptoms, or the purpose of this appointment: _____

Have you ever had the same or similar condition? YES NO If yes, when and describe: _____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/___

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Date of last physical examination? _____

What surgery have you had? _____ When? _____

Serious illnesses or conditions? _____ When? _____

Have you been treated for any health condition by a physician in the last year? YES NO

Describe: _____

What medications or drugs are you taking? _____

Have you ever suffered from:

- Dizziness
- Backaches
- Heart Trouble
- Diabetes
- Hernia
- Arthritis
- Headaches
- Numbness
- Asthma
- Neuritis
- Digestive Disorders
- Nervousness
- Sinus Trouble
- Anemia
- Cancer

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? YES NO UNCERTAIN

Do you have health insurance? YES NO Not Sure Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/___ Does the policy holder

have the insurance through his/her employer? YES NO If yes, who is the employer? _____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorneys who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/___

Patient Questionnaire – Non-Accident

Patient Name: _____

Today's Date: ___/___/___

Date of Exam: ___/___/___

Provider: _____

New Patient Yes No

General Information Related to the Condition:

Approximately when did the conditions or symptoms begin to occur? ___/___/___

No particular condition or symptoms -- Just seeking general good health

Describe the conditions, symptoms or purpose of the appointment:

Additional Information Related to the Condition:

Describe your pain: Burning Sharp Dull Ache

What caused it?

What aggravates it?

What relieves it?

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? Yes No

When? ___/___/___

Describe:

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Please check any of the following symptoms you are now experiencing:

- | | | | | | |
|--|--|--|--|---|--------------------------|
| <input type="checkbox"/> Headache
Neck Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> |
| <input type="checkbox"/> Loss of Memory
Ears Ring | <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Tingling in arms/hands | <input type="checkbox"/> |
| <input type="checkbox"/> Hands Cold
Back Pain | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Tingling in legs/feet | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Nausea | <input type="checkbox"/> |
| <input type="checkbox"/> Numbness in arms/hands
Loss of Balance | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Constipation | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in legs/feet | <input type="checkbox"/> |
| <input type="checkbox"/> Cold Sweats
Fatigue | <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever | <input type="checkbox"/> |
| <input type="checkbox"/> Irritability
Jaw pain | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Chest pain/rib pain | <input type="checkbox"/> Pain in arms/hands | <input type="checkbox"/> Pain in legs/feet | <input type="checkbox"/> |
| <input type="checkbox"/> Loss of strength - arms | <input type="checkbox"/> Burning muscle pain | <input type="checkbox"/> Loss of strength - legs | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Sharp/shooting pain | |
- Other _____

Have you experienced changes to:

- | | | | | |
|---------------------------------------|---|---------------------------------------|--|----------------------------------|
| <input type="checkbox"/> Eyes (sight) | <input type="checkbox"/> Ears (hearing) | <input type="checkbox"/> Nose (smell) | <input type="checkbox"/> Mouth (taste) | <input type="checkbox"/> Bladder |
| <input type="checkbox"/> Bowels | <input type="checkbox"/> Sleep | <input type="checkbox"/> Emotion | <input type="checkbox"/> Appetite | |

Please Explain: _____

Have you missed work or school due to your injuries? Yes No

Do you smoke? Yes No Number of packs: _____

Do you drink alcohol? Yes No Number of Drinks _____

Notes:

Medical History:

Have you ever been in our office before? Yes No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

- 1) _____ / /
- 2) _____ / /
- 3) _____ / /

Surgeries/Hospitalizations:

Allergies (please list all):

Do you now or have you ever had:

Heart Disease
Thyroid Problems

Diabetes

Cancer

Stroke

High Blood Pressure

Tuberculosis
Seizure Disorder

Prostate Disorder

Kidney Problems

Asthma

Ulcer

Other: _____

Informed Consent -- Chiropractic Care

Dr. Jennifer R. DeGaray, D.C.

Patient's Name: _____

Date of Care Plan: __/__/__

***Instructions: This document relates to your Informed Consent for care.
Please read carefully before signing.***

General. I, the below-signed patient/individuals, have read this document in its entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that while this lists you as the "Rendering Provider," at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of the Care; Alternatives

Chiropractic manipulation / adjustment. As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

X-Rays. I have been advised that x-rays can be hazardous to an unborn child. To the best of my knowledge. I am not pregnant.

Other Potential Alternatives. I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; and surgery.

Contraindications to Manipulation / Adjustment. I understand that you will not give me an adjustment / manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Definitions. "You" and "office" refer to any provider who renders care to me at the Location above. "Care" includes all care outlined

in my Care Plan as well as any other care I receive from you in the future, including care related to other conditions.

Patient's Consent. I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my condition, and also all of the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all of the questions that I have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care.

Patient's Name: _____

Patient's Signature: _____

Date of Signature: ___/___/___

Name of Parent / Guardian / Authorized Representative: _____

Signature: _____

Date of Signature: ___/___/___