Advanced Relief Chiropractic

Patient Information

Today's Date: _____ Date of Birth: _____ Gender: ( ) Male ( ) Female

Patient's Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Social Security: _____ Email Address: _____

Home Ph: _____ Cell Ph: _____ Work: _____

Occupation: _____ Employer: _____

Referred By: ( ) Self ( ) Insurance Carrier ( ) Friend/Other: _____

Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced

Emergency Contact: _____ Phone: _____

Insurance		
Policy Number		
Group Number		
Complete the following insured information if relation is other than self		
Insured's Name:		
Insured's Date of Birth		
Insured's Social Security Number		
Relationship to Insured	**( ) Spouse ( ) Child ( ) Step Child ( ) Other**	

Case History

Current medications or supplements taken: _____

Previous surgeries: _____

Family history of: ( ) Diabetes ( ) Heart Disease ( ) High BP ( ) Cancer _____ ( ) Other _____

Please check all symptoms that have occurred in the past 6 months

Head:

( ) Headaches	( ) Loss of memory	( ) Dizziness
( ) Fainting	( ) Loss of taste	( ) Change in vision
( ) Pain in ears ( ) R ( ) L	( ) Ringing in ears ( ) R ( ) L	( ) Loss of hearing ( ) R ( ) L

Neck:

( ) Pain in neck	( ) Neck pain with movement	( ) muscle spasms
( ) Grinding sounds in neck	( ) Pain radiating up to head	( ) Pain radiating to arm ( ) R ( ) L

Shoulders:

( ) Pain in joint ( ) R ( ) L	( ) Pain across shoulders	( ) Decreased range of motion

Chest:

( ) Chest pain	( ) Shortness of breath	( ) Rib pain ( ) R ( ) L

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Abdomen:

( ) Food sensitivity	( ) Nausea	( ) Gas
( ) Change in bowels	( ) IBS (D)	

Mid Back:

( ) Mid back pain	( ) Muscle spasms	

Low Back:

( ) Low back pain	( ) Muscle spasms	( ) Pain in kidneys ( ) R ( ) L

Hips, Knees, Feet & Legs

( ) Pain in buttocks ( ) R ( ) L	( ) Pain in hip ( ) R ( ) L	Pain down leg ( ) R ( ) L
( ) Knee pain ( ) R ( ) L	( ) Numbness/tingling ( ) R ( ) L	

Other conditions not listed: _____

What is your main complaint(s) currently : _____

How long have you had this condition? Have you had similar problems in the past? ( ) N ( ) Y

What makes the pain worse? _____ Please rate pain at its worst 1 – 10 _____

What helps relieve the pain? _____ Please rate pain at its best 1 – 10 _____

Does the pain interfere with any of the following? ( ) Daily Routine ( ) Work ( ) Sleep ( ) Other _____

Does the pain radiate? ( ) N ( ) Y If yes, where to? _____

Have you seen another Doctor for this condition? ( ) N ( ) Y

Doctor's Name: _____ Treatment Dates: _____

Diagnosis: _____

Any diagnostic imaging performed? ( ) N ( ) Y Any medications prescribed? ( ) N ( ) Y _____

Name of Primary Care Physician: _____ Date of last physical: _____

How would you rate your overall health? ( ) Excellent ( ) Very Good ( ) Good ( ) Fair ( ) Poor

How often do you exercise? ( ) Daily ( ) Weekly ( ) Monthly ( ) None

Current height? _____ Current weight? _____

Any major falls? (childhood & adult) _____

Auto Accidents? ( ) N ( ) Y (year & injuries) _____

Sports injuries? ( ) N ( ) Y (year & injuries) _____

Poor posture ( ) N ( ) Y Sleep on stomach ( ) N ( ) Y Sit for long periods ( ) N ( ) Y

Heavy lifting ( ) N ( ) Y Computer work ( ) N ( ) Y Repetitive bending ( ) N ( ) Y

Do you smoke? ( ) N ( ) Y per day _____ Exposed to 2nd hand smoke? ( ) N ( ) Y

How much alcohol do you consume? _____oz ( ) per day ( ) per week

How much caffeine do you consume? _____oz ( ) per day ( ) per week

Use of illicit drugs? ( ) N ( ) Y Type _____

Patient Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

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Informed Consent

I herby request and consent to the performance of chiropractic treatments and other chiropractic / medical procedures, including various forms of physio and physical therapy and x-rays by **Advanced Relief Chiropractic.** This consent is extended to other licensed chiropractors, chiropractic assistants and/or licensed massage therapists, who are now or in the future employed by working with or associated with this office.

I certify that I have had the opportunity to discuss with the doctor of chiropractic and/or other office personnel the nature and purpose of the care that is being provided. I understand that results are not guaranteed. Further, I have been informed and understand that in the practice of chiropractic there are some risks to treatments including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor who has explained all of these things to me is not expected to be able to anticipate and explain all the possible risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care based on the facts known at the time and what is in my best interest.

I give my consent to **Advanced Relief Chiropractic** staff to take and use photos for the purposes of treatment, education, professional journals, and/or advertisement.

My signature below certifies that I have read or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and treatment options have been explained. By signing this consent form I agree to the care being provided to me for the entire course of treatment for my present condition(s) or for any future condition(s) for which I seek treatment.

Printed Name: _____

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use the Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those that do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractor has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature: _____ Date: _____

CHIROPRACTIC APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your chiropractic care to Advanced Relief Chiropractic. When you schedule an appointment with us we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hour notice** will be considered a No Show and charged a $25 fee directly to the patient.

- This $25 fee will need to be paid in full before you will be able to schedule another appointment with Advanced Relief Chiropractic

- If you reschedule your appointment within 24 hours, we may waive the $25 fee as a courtesy.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact us and we may be able to waive this fee. You may contact us by email or by calling us and leaving a message if we are unable to answer. We do check our messages 7 days a week.

Advanced Relief Chiropractic (630)907-1300
drdanielpurdue@gmail.com

I have read and understand the Chiropractic Appointment Cancellation/No Show Policy and agree to its terms.

_____

Signature (Parent/Legal Guardian) Relationship to Patient

_____

Printed Name Date