Chiropractic Care Center

Dr. Liz Hood

CONFIDENTIAL PATIENT HEALTH COMPLAINT FORM

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Company or Employer Name: _____

Work Phone: ( ) _____ Email _____

Age: _____ Birth date: _____/_____/_____ Social Security Number: _____/_____/_____

Gender: Male ___ Female ___ Height: _____ Weight: _____

Please Circle One: Left Handed Right Handed

Marital Status: Single ___ Married ___ Divorced ___ Widow ___

Number of Children: _____ Ages of Children: _____

Who should we contact in case of emergency: _____

Emergency Contact's Phone: ( ) _____

1.) What problem brings you here today: _____

2.) When did this problem begin: _____

3.) What makes it better: _____

_____

4.) What makes it worse: _____

_____

5.) Have you tried any home treatment or medical treatment for this problem?: _____

If yes, What treatment(s) have you tried? _____

_____

6.) Please check all activities which are difficult to perform:

__ Coughing	__ Sleeping	__Sexual activity	__ Standing
__ Sneezing	__ Stooping	__ Dressing self	__ Pulling
__ Bending forward	__ Climbing	__ Sitting at a table	__ Walking
__ Turning over in bed	__ Kneeling	__ Pushing	short distances

GENERAL HEALTH HABITS & BACKGROUND:

1.) Do you have any allergies: _____

2.) Have you seen any other doctor for your present condition? _____

3.) If yes, who did you see and when? _____

4.) Please list any medications that you are currently taking and what they are for (including any prescriptions that you are regularly taking, such as birth control pills, and any "over the counter" drugs:

_____

_____

_____

PAYMENT INFORMATION:

1.) Clinic policy requires payment arrangements to be made on the first visit if any balance is due.

How do you intend to handle this account?

__ Workers Compensation __ Personal Injury/Auto Insurance __ Medicare

__ Health Insurance: _____ __ Cash

Please give any insurance information you may have and a copy of your insurance card to our Front Desk Assistant. We will be happy to determine coverage for you.

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HEALTH HISTORY

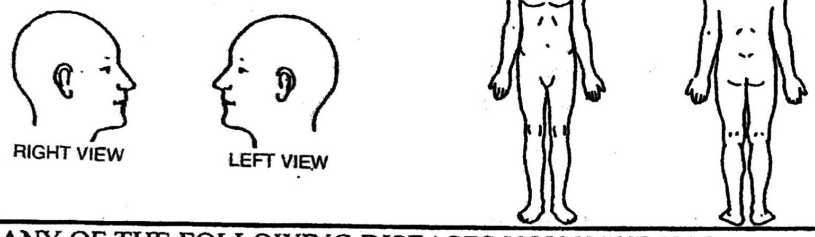
FAMILY HISTORY:

	DIABETES	HEART	KIDNEY	CANCER	BACK	STROKE	HIGH BP
Mother	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐

WOMEN ONLY:
Are you pregnant? Yes ☐ No ☐ Unsure/Possibly ☐

What was the first day of you last menstrual cycle? _____

CIRCLE AREAS OF PAIN OR DISCOMFORT:



HABITS:
Cigarettes: ___ packs/day
Alcohol: ____ drinks/day
Coffee: ___ cups/day
Soda: ____ cans/day

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

☐ Aids	☐ Chicken Pox	☐ Alcoholism	☐ Appendicitis	☐ Tuberculosis
☐ Diabetes	☐ Scarlet Fever	☐ Whooping Cough	☐ Cancer	☐ Arthritis
☐ Anemia	☐ Heart Disease	☐ Epilepsy	☐ Measles	☐ Pneumonia
☐ Mental Disorder	☐ Influenza	☐ Rheumatic Fever	☐ Pleurisy	☐ Eczema
☐ Polio				

CHECK ANY OF THE FOLLOWING PROBLEMS YOU HAVE OR HAD IN THE PAST 6 MONTHS:

MUSCLES & JOINTS
- ☐ Low Back Pain
- ☐ Pain between shoulders
- ☐ Neck Pain/Stiffness
- ☐ Arm/Elbow/Wrist Pain

WOMEN
- ☐ Menses Irregular
- ☐ Breast Lumps
- ☐ Pain during Sex
- ☐ Difficulty getting Pregnant

MEN
- ☐ Prostate Pain
- ☐ Impotence
- ☐ Infertility

EYE & EAR
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Hearing Difficulty
- ☐ Ringing in Ears

NERVOUS SYSTEM
- ☐ Nervousness
- ☐ Numbness
- ☐ Paralysis
- ☐ Confusion
- ☐ Cold/Tingling Extremities

KIDNEY/BLADDER
- ☐ Painful Urination
- ☐ Excessive Urine
- ☐ Discolored Urine

HEARTS & LUNGS
- ☐ Wheezing
- ☐ Chest Pain
- ☐ Asthma
- ☐ Short Breath
- ☐ High BP
- ☐ Low BP
- ☐ Irregular Heart Beat
- ☐ Heart Surgery
- ☐ Spitting Blood
- ☐ Bronchitis

STOMACH/INTESTINES
- ☐ Poor Appetite
- ☐ Excessive Appetite
- ☐ Excessive Thirst
- ☐ Liver Trouble
- ☐ Gall Bladder Problems
- ☐ Stomach Cramps
- ☐ Stomach Pain
- ☐ Black/Bloody Stool

GENERNAL PROBLEMS
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Loss of Sleep
- ☐ Headaches

Functional Rating Index

In order to properly access you condition, we must understand how much your condition has affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. PAIN INTENSITY

0	1	2	3	4
No Pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. SLEEPING

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. PERSONAL CARE (Washing, Dressing, Etc.)

0	1	2	3	4
No pain No restrictions	Mild pain No restrictions	Moderate pain Need to go slowly	Moderate pain Need some assistance	Severe pain Need 100% assistance

4. TRAVELING (Driving, Etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. WORK

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. RECREATION

0	1	2	3	4
Can so all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. FREQUENCY OF PAIN

0	1	2	3	4
No pain	Occasional pain 25% of the day	Intermittent pain 50% of the day	Frequent pain 75% of the day	Constant pain 100% of the day

8. LIFTING

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with heavy weight	Increased pain with light weight	Increased pain with any weight

9. WALKING

0	1	2	3	4
No pain any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. STANDING

0	1	2	3	4
No pain after several hours	Increased pain after several hrs.	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

NAME: _____ DATE: _____

Chiropractic Care Centers
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DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialities of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means and without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Physicians's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

ANALYSIS

A Chiropractic Physician conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found Chiropractic adjustments and aucillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no physician can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although Chiropractic Physicians are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he has any concern as to the nature of his total condition. Your Chirpractic Physician may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A Patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course will not give a chiropractic adjustment, or health care, if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Chiropractic Physician. The patient should look to

the correct specialist for the proper diagnostic and clinical procedures. The Chiropractic Physician provides a specialized non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similary conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond chiropractically may come under the control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

I HAVE READ THE FOREGOING AND UNDERSTAND IT:

_____ _____

DATE **SIGNATURE**

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Dr. Liz Hood

CONSENT TO TREAT

The primary treatment used by doctors of Chiropractic is the spinal adjustment. We will use primarily that procedure to treat you. The doctor may use his or her hands or a mechanical device upon our body in such a way as to move, adjust, your joints. By signing below, you state that you are willing to undergo a chiropractic examination, x-rays of your spine (if indicated), and chiropractic treatment as may be outlined by the doctor after the examination has been done.

Signature: _____ Date: _____

Consent to treat a minor child: _____ Relationship: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, you acknowledge that Chiropractic Care Center has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations.

Check all that are true:

☐ I have received Chiropractic Care Center's Privacy Notice.

☐ Chiropractic Care Center has given me the chance to discuss my concerns and question the privacy of my health information.

Patient Name: _____

Patient's Signature: _____