Patient Information

NAME ______________________________ GENDER M___F___AGE_____BIRTHDATE______________

ADDRESS ______________________________ CITY ____________________ STATE______ZIP__________

HOME PHONE ________________CELL PHONE________________ E-MAIL ______________________________

DL#/STATE____________________ SOCIAL SECURITY #________________OCCUPATION____________________

EMPLOYER NAME ____________________EMPLOYER ADDRESS____________________WORK PHONE________________

MARITAL STATUS_______SPOUSES NAME________________SPOUSE'S BIRTHDATE___________SPOUSE'S EMPLOYER______________

SPOUSE'S WORK PHONE ____________________ I WAS REFERRED TO THIS OFFICE BY?______________________________

EMERGENCY CONTACT INFO – Person not living at your address

CONTACT PERSONS NAME________________ADDRESS ______________________________CITY/STATE/ZIP____________________

PHONE__________CELL ___________ PRIMARY CARE PROVIDER (YOUR MEDICAL DOCTOR) ____________________PHONE _________

PLEASE INDICATE METHOD OF PAYMENT

☐ CASH ☐ HEALTH INSURANCE (INCLUDING HMO'S) ☐ AUTO ACCIDENT WITH AUTO INSURANCE

☐ MEDICARE ☐ MEDI-CAL ☐ WORKER'S COMPENSATION ☐ AUTO ACCIDENT - OTHER PARTY PAY

IS THERE A SECONDARY INSURANCE? ____________________ATTORNEY INFORMATION______________________________

INSURANCE CO____________ADDRESS______________________________CITY____________________STATE ______ZIP __________

PHONE______________________POLICY HOLDERS NAME__________________________POLICY NUMBER______________________

GROUP NUMBER____________PLAN NUMBER_________CLAIM NUMBER__________________CONTACT PERSON______________________

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below including those working at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor of chiropractic or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

RELEASE OF INFORMATION: To the extent necessary to determine liability for payment and to obtain reimbursement, this clinic may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable for all or any portion of the clinic's charge including but not limited to insurance companies, health care service plans or worker's compensation carriers.

FINANCIAL AGREEMENT: The undersigned agrees that in consideration of the services to be rendered to the patient he/she hereby individually obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collection, the undersigned shall pay actual attorney's fee and collection expense. All delinquent accounts shall bear interest at the legal rate.

ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the clinic any insurance benefits otherwise payable to or on behalf of the undersigned for treatment rendered at a rate not to exceed the clinic's regular charges. It is agreed that payment to the clinic, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is responsible for any charges not covered by this assignment.

____ DATE______________________

PATIENTS SIGNATURE (OR PATIENTS REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED)

____ DATE______________________

WITNESS

Chiropractic Sports Center - Bruce Humphries D.C.

1399 W. Colton Ave Ste #9, Redlands CA 92374 (909)793-9787

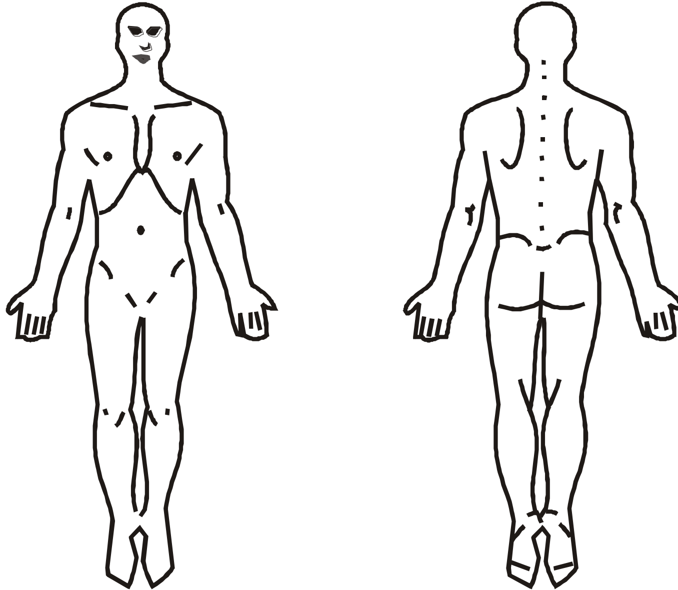
Present Complaints

Name____ Date____________

Present Complaints____

____

Mark an “X” on the picture where you have pain or other symptoms. Include symptoms of pain, numbness, or tingling.



Please describe the pain. You may mark more than one:

- ☐ Sharp/Stabbing
- ☐ Sharp/Dull
- ☐ Aches
- ☐ Dull
- ☐ Soreness
- ☐ Weakness
- ☐ Throbbing/Gnawing
- ☐ Numbness
- ☐ Shooting
- ☐ Gripping/Constricting
- ☐ Burning
- ☐ Tingling/ pins & needles

Did your problem begin: • Immediately after a specific incident • Multiple incidents • Gradually developed over time

Describe how your problem began: ____

____

When did your problem begin: Days____ Weeks____ Months____ Specific Date if possible?___________________________

What makes your problem better? • Nothing • Laying down • Walking • Standing • Sitting • Movement/Exercise
• Inactivity • Other____

What makes your problem worse? • Nothing • Laying down • Walking • Standing • Sitting • Movement/Exercise.
• Inactivity • Other____

How bad is your ache? Please circle a number: 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable pain

Is your pain worse in the: • Morning • Day • Evening • After specific event_____________________________________

Since your problem began, is the pain: • Increasing • Decreasing • Not changing

How often are the complaints present?
• constant (76-100%) • Frequent (51-75%) • Occasional (26-50%) • Intermittent (25% or less)

What treatment have you received for this condition?____

Are your complaints affecting your ability to work or otherwise be active? • No effect • Some physical restrictions
• Need Limited assistance with common tasks • Need assistance often • Need significant assistance • Totally impaired

How is your general stress level? • No stress • Minimal stress • Moderate stress • Greatly stressed

Physical activity at work:
• Sedentary more than 50 % of workday • Light manual labor • Manual labor • Heavy manual labor

List past traumas or accidents____

____

____

____

PATIENT HEALTH QUESTIONNAIRE

Patient Name ______________________________________

If you have *ever* had a listed symptom in the *past*, please check that symptom in the *Past Column*. If you are *presently* troubled by a particular symptom, check that symptom in the *Present column*. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

Past	Present	Condition
☐	☐	Neck Pain
☐	☐	Shoulder Pain (R_____ L_____)
☐	☐	Pain in Upper Arm or Elbow (R_____ L_____)
☐	☐	Hand Pain (R_____ L_____)
☐	☐	Wrist Pain (R_____ L_____)
☐	☐	Upper Back Pain
☐	☐	Low Back Pain
☐	☐	Pain in Upper Leg or Hip (R_____ L_____)
☐	☐	Pain in Lower Leg or Knee (R_____ L_____)
☐	☐	Pain in Ankle or Foot (R_____ L_____)
☐	☐	Jaw Pain
☐	☐	Swelling, Stiffness of Joint(s)
☐	☐	Fainting
☐	☐	Visual Disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Muscular Incoordination
☐	☐	Tinnitus (Ear Noises)
☐	☐	Rapid Heart Beat
☐	☐	Chest Pains
☐	☐	Loss of Appetite
☐	☐	Anorexia
☐	☐	Abnormal Weight ☐Gain ☐Loss
☐	☐	Excessive Thirst
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue
☐	☐	Irregular Menstral Flow
☐	☐	Profuse Menstral Flow
☐	☐	Breast ☐Soreness ☐Lumps
☐	☐	Endometriosis
☐	☐	PMS
☐	☐	Loss of Bladder Control
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/irregular bowel habits
☐	☐	Difficulty in Swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Eczema/Rash

Past	Present	Condition
☐	☐	Depression
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack (date) __________
☐	☐	Stroke (date) __________
☐	☐	Asthma
☐	☐	Cancer, Explain__________
☐	☐	Tumor, Explain__________
☐	☐	Prostate Problems
☐	☐	Blood Disorder
☐	☐	Emphysema (chronic lung disorders)
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Ulcer
☐	☐	Liver / Gallbladder problems
☐	☐	Kidney Stones
☐	☐	Hepatitis
☐	☐	Bladder Infection
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	HIV/AIDS
☐	☐	Other__________

If a family member has had any of the following, please mark the appropriate box:

☐ Cancer	☐ Epilepsy
☐ Rheumatoid Arthritis	☐ Chronic Back Problems
☐ Diabetes	☐ Chronic Headaches
☐ Heart Problems	☐ Lupus
☐ Lung Problems	☐ Other__________
☐ High Blood Pressure	__________

Yes	No	
☐	☐	Do you have a permanent disability rating? Location __________
☐	☐	Date rating received ____/____/____
☐	☐	Rating Percentage__________%

Present Weight _______pounds **Height** _______feet _______inches

Please check any of the following that apply to you

Past	Present	
☐	☐	Pregnancy, # births__________
☐	☐	Birth Control Pills, type__________
☐	☐	Medications (list if not listed elsewhere) __________ __________
☐	☐	Hospitalizations/Surgical Procedures (list if not described elsewhere)__________

Past	Present	
☐	☐	Tobacco
☐	☐	Alcohol
☐	☐	Drug or Alcohol Dependence
☐	☐	Coffee/Tea/Caffinated Soft drinks: cups/cans per day__________

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverages in the future.

Patient's Signature: ______________________________ Date: __________