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 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 _____ Primary care provider (medical doctor)_____ phone _____

Please indicate method of payment

☐ Cash ☐ Health insurance (including HMO's) ☐ Medicare
☐ Auto accident ☐ Worker's Compensation

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_____

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)

Chiropractic Sports & Injury Center - Bruce Humphries D.C.
1399 W. Colton Ave Dte #9, Redlands CA 92374 (909)793-9787

Informed Consent To Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or test conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure, as with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one I one million to one in two million cervical adjustments. It is also reported that the percent of stokes is the same if a person sees a medical doctor or a chiropractor.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measure and rest, medical care with prescription drugs, physical therapy, bracing, injections and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask question about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as deemed appropriate for my circumstance, I intend this consent to cover the entire course of care from all provider in this office for my present condition and for any future condition(s) for which I seek chiropractic care form this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

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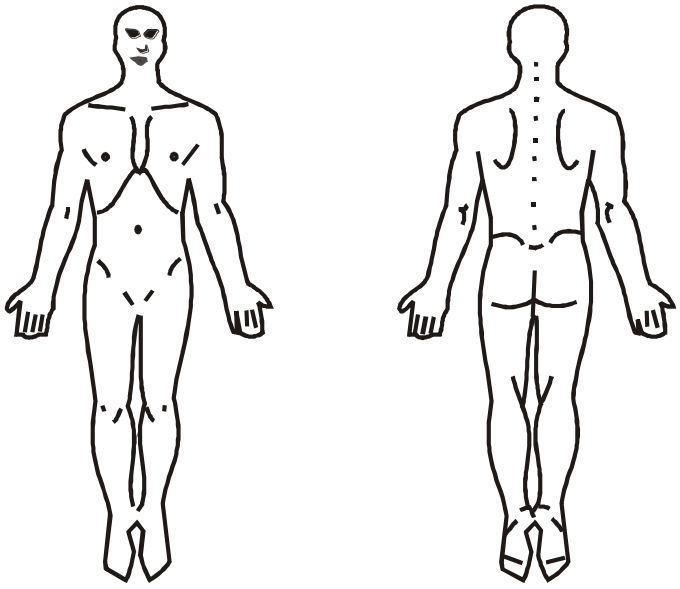
Present Complaints

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

Circle or underline your answers

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 Inactivity Movement/Exercise Other_____

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

How bad is your ache or pain? 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 be active? No effect Some physical restrictions Need Limited assistance with common tasks Need assistance often Totally impaired

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

Physical activity at work: Sedentary Light manual labor Manual labor Heavy manual labor

List past traumas or accidents_____

_____

_____

Patient Health Questionnaire

Name _____

Please mark Past and Present Symptoms. **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 Joints(s)
☐	☐	Fainting
☐	☐	Visual disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Abdominal pain
☐	☐	Muscular Incoordination
☐	☐	Tinnitus (Ear Noises)
☐	☐	Rapid Heart Beat
☐	☐	Chest pains
☐	☐	Excessive Thirst
☐	☐	Chromic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue
☐	☐	Constipation/irregular bowel habits
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Eczema/rash
☐	☐	Loss of appetite
☐	☐	Frequent urination
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Abnormal Weight ❑ Gain ❑ Loss
☐	☐	Shortness of Breath
☐	☐	Pain that wakes you up at night
☐	☐	Bumps or thickening moles or warts
☐	☐	Difficulty in Swallowing/Digestion
☐	☐	Persistent Cough or Hoarseness
☐	☐	♀ Irregular Menstrual Flow
☐	☐	Profuse Menstrual Flow
☐	☐	Brest ❑ Soreness ❑ Lumps
☐	☐	Endometriosis

Past	Present	Condition
☐	☐	Depression
☐	☐	Sleep Apnea
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attach (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 _____

Has a family member had any of the following:

☐ 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 % _____

Present Weight _____lbs Height _____ft ____in

Past	Present	
☐	☐	♀ Pregnancy, # births _____
☐	☐	Birth Control Pills, type_____
☐	☐	Medications _____

_____

_____

Past	Present	
☐	☐	Tobacco
☐	☐	Alcohol
☐	☐	Drug or Alcohol Dependence
☐	☐	Coffee/Tea/Caffeinated Soft Drinks: cups/can per day _____

☐ ☐ Hospitalizations/Surgical Procedures (list if not described elsewhere) _____

I certify that he 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 _____