



Date _____ **PATIENT INFORMATION** Case# _____
 Doctor _____

PLEASE FILL IN THE APPROPRIATE SPACES. (All information you give is confidential)

Patient Name (Last) _____ (First) _____
 Street Address _____ Apt # _____
 City _____ State _____ Zip _____ Email _____
 Phone (Home) _____ (Work) _____ (Cell) _____
 Sex M F Date of Birth _____ / _____ / _____ Social Security # _____ - _____ - _____
 Status Married Single Widowed Divorced Spouses Name _____ # of children _____
 Employed Full Time Part Time Retired Not Employed Student
 Occupation _____ Patient's Employer's Name _____
 Address _____
 City _____ State _____ Zip _____ Phone _____
 How did you hear about our office? _____ Referred by _____
 Emergency Contact: _____ Phone: _____ Relationship _____

INSURANCE INFORMATION (commercial insurance and Medicare only)

Primary Insurance Company _____ Type: Group Private
 ID/Policy # _____ Group Name _____ Group Number _____
 Insured's Name _____ Insured's Date of Birth _____ / _____ / _____
 Patient's Relationship to Insured Self Spouse Child Other Insured's Employer _____
 Secondary Insurance Company _____ Type: Group Private
 ID/Policy # _____ Group Name _____ Group Number _____
 Insured's Name _____ Insured's Date of Birth _____ / _____ / _____
 Patient's Relationship to Insured Self Spouse Child Other Insured's Employer _____

AUTOMOBILE ACCIDENT/ WORKER'S COMPENSATION ONLY

Insurance Company _____ Policy # _____ Claim # _____
 Adjusters Name _____ Address _____ MedPay? Yes No
 City _____ State _____ Zip _____ Phone _____
 Attorney's Name _____ Contact Name _____ Phone _____
 Address _____

RELEASE AND ASSIGNMENT: I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Patient Signature _____ Date _____

Date _____

PATIENT HISTORY

Case# _____

Doctor _____

PLEASE FILL IN THE APPROPRIATE SPACES. (All information you give is confidential)

MAJOR COMPLAINT: _____

How long have you had this condition? _____

Date of Onset? _____

Have you lost workdays? Yes No If yes, how many? _____

Have you had this same condition before? Yes No If yes, when? _____

Was the injury accident related? Auto accident Work accident If yes, when? _____

When was your last auto accident? _____ When was the one before that? _____

Previous Chiropractic Care? Yes No Chiropractor's Name _____

What was the reason for your initial visit? _____

What spinal maintenance programs were you given to follow to maximize the future stability of your spine? _____

Did you follow it? _____ If not, why? _____

Why are you changing chiropractors? _____

What surgeries have you had? _____

List drugs you now take (prescription and non-prescription) _____

Name other doctors you have seen for this condition: _____

What are your health goals? _____

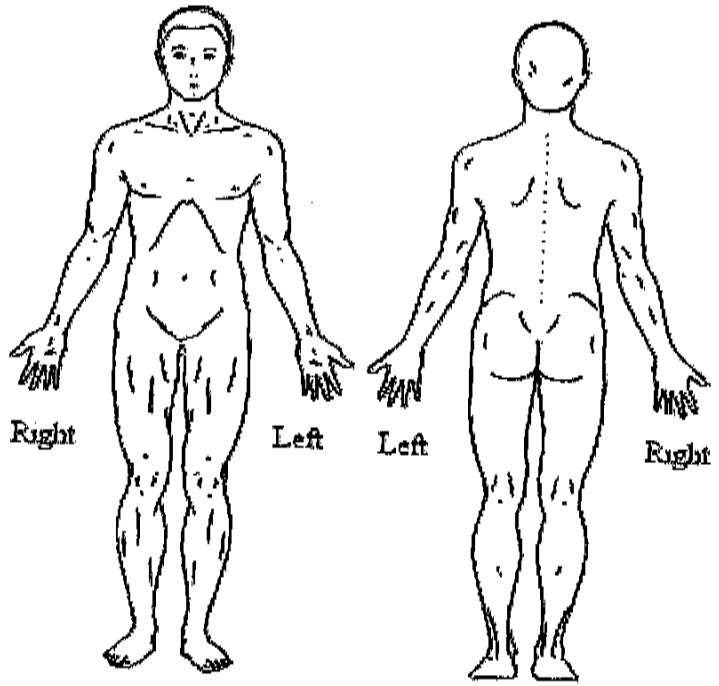
How do you expect to achieve these goals? _____

Please mark if you have had any of these symptoms in the last 12 months:

<input type="checkbox"/> Fractured bones <input type="checkbox"/> Auto accidents _____ 0-1 years ago _____ 2-5 years ago _____ 6 years or more <input type="checkbox"/> Other accidents, falls <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Convulsions, epilepsy <input type="checkbox"/> Skin problems <input type="checkbox"/> Cancer <input type="checkbox"/> Frequent colds, flu <input type="checkbox"/> Depressed <input type="checkbox"/> Irritable <input type="checkbox"/> Anemia <input type="checkbox"/> Allergy, sinus <input type="checkbox"/> Under stress <input type="checkbox"/> Eating disorders <input type="checkbox"/> Trouble sleeping <input type="checkbox"/> Trouble concentrating <input type="checkbox"/> Learning disability <input type="checkbox"/> Mood Changes	<input type="checkbox"/> Neck pain or stiffness R L <input type="checkbox"/> Numbness, tingling, pain in arms, hands, fingers R L <input type="checkbox"/> Jaw pain or click (TMJ) R L <input type="checkbox"/> Difficulty in excessive standing, sitting, riding bending, lifting, twisting <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Dizziness <input type="checkbox"/> Ringing in ears R L <input type="checkbox"/> Hearing loss <input type="checkbox"/> Blurred or double vision <input type="checkbox"/> Upper back pain, stiffness <input type="checkbox"/> Mid back pain, stiffness <input type="checkbox"/> Lower back pain, stiffness <input type="checkbox"/> Pain with cough, sneeze <input type="checkbox"/> Hip pain R L <input type="checkbox"/> Headaches <input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Numbness, tingling, pain in buttocks, legs, feet, toes R L <input type="checkbox"/> Foot trouble R L <input type="checkbox"/> Heart Problems <input type="checkbox"/> Stroke <input type="checkbox"/> High/low blood pressure <input type="checkbox"/> Chest pain, asthma <input type="checkbox"/> Liver trouble <input type="checkbox"/> Gall bladder problems <input type="checkbox"/> Digestive problems <input type="checkbox"/> Ulcers <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Prostate problems <input type="checkbox"/> Impotence <input type="checkbox"/> Kidney trouble <input type="checkbox"/> Menstrual problems, PMS <input type="checkbox"/> Pregnant (now) <input type="checkbox"/> Bedwetting <input type="checkbox"/> Ear infections <input type="checkbox"/> Varicose Veins <input type="checkbox"/> AIDS, HIV
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PLEASE MARK ON THE FIGURES BELOW, THE AREAS OF YOUR SYMPTOMS USING THE FOLLOWING SYMBOLS.

- Numbness** == =
- Dull Ache** 000
- Burning** XXX
- Sharp/Stabbing** ///
- Pins, Needles** +++
- Other** ^ ^ ^



MARK AN 'X' ON THE LINES:

HOW BAD ARE YOUR SYMPTOMS RIGHT NOW?

NONE SEVERE

HOW BAD HAVE THEY BEEN IN THE PAST?

NONE SEVERE



INFORMED CONSENT

- The information I have given this office is complete to the best of my knowledge. I authorize the doctors and staff of this clinic to administer such procedures and treatment as they deem necessary. They have implied no guarantees of cure.
- I consent to any examinations, x-rays, and spinal adjustments deemed necessary by the doctor. Further, I agree to any modality, therapy, or rehabilitation exercise that, in their opinion, is necessary in my case. I understand the staff is skilled in the use of many of the adjunctive therapies offered, although they might not be licensed or degreed as is provided and accepted by the Chiropractic Statutes of Georgia. I agree that under the guidance of my doctor the above mentioned properly trained staff may treat me directly.
- I am aware that x-rays taken of me and my clinical records are a permanent part of this clinic's permanent clinical record file, and as such, they may not be released from the office for a period of seven years. They are legally the property of this clinic.
- I understand that although rare, there may be certain risks inherent with the practice of chiropractic and rehabilitation. These risks include, but are not limited to, sprain/strain of area, spinal disc irritation and/or stroke.
- I understand that there are risks associated with the various adjunctive procedures offered in this office. These procedures include ice/heat therapy, flexion/distraction therapy, decompression therapy, myofascial release therapy, therapeutic exercises, and traction. Risks associated with these procedures include, but are not limited to, skin reactions, aggravations of the present condition, bruising, release of emboli, and deep vein thrombosis.
- I do not expect the doctor to anticipate, nor explain all of the risks, and/or complications that are possible, but I will rely on the doctors training and education to exercise professional judgment during the course of any procedure or protocol which he/she feels necessary based on the facts and diagnosis in my case.

Patient's Signature: _____ **Date:** _____
Witness Signature: _____ **Date:** _____

RELEASE OF RECORDS

- When necessary, and with this document acting as proper release thereof, I hereby give Duewest Chiropractic and Rehab Center permission to access and/or release my records to legal and/or other health care professionals, who present their request in a written and legal form.
- This consent noted herein will remain in effect throughout my active treatment in this office and for any future care.

Patient's Signature: _____ **Date:** _____
Witness Signature: _____ **Date:** _____

MALE



X-Ray Information

I give permission to DUEWEST CHIROPRACTIC & REHAB CENTER to take plain x-ray films for diagnostic purposes if necessary.

This form must be signed by a parent or guardian if the patient is a minor.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____



X-Ray/Pregnancy Information

I give permission to Duewest Chiropractic & Rehab Center to take plain x-ray films for diagnostic purposes if necessary.

I also acknowledge that I am not Pregnant.

Date last menstrual period started: _____

This form must be signed by a parent or guardian if the patient is a minor.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____

AMERICAN RADIOLOGICAL SERVICES

(419) 269-2140

(800) 442-1202

PATIENT _____ CLINIC _____ FILM DATE _____
 AGE _____ SEX M F SOCIAL SECURITY # _____ / _____ / _____ DATE OF BIRTH _____
 PATIENT ADDRESS _____ CITY _____ STATE _____ ZIP _____

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to American Radiological Services (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

SIGNATURE: _____ DATE: _____

WITNESS: _____

PATIENT HISTORY

PATIENT PRESENTATION _____

TRAUMA? YES NO EXPLAIN _____

PAST MEDICAL HISTORY _____

MALIGNANCY? YES NO DETAILS _____

DIAGNOSIS/CONCERNS/QUESTIONS [NO ICD CODES PLEASE] _____

PLEASE COMPLETE INSURANCE/BILLING INFO ON REVERSE SIDE