Erickson Family Chiropractic

## Patient Information

Date:

First Name: Last Name: Initial

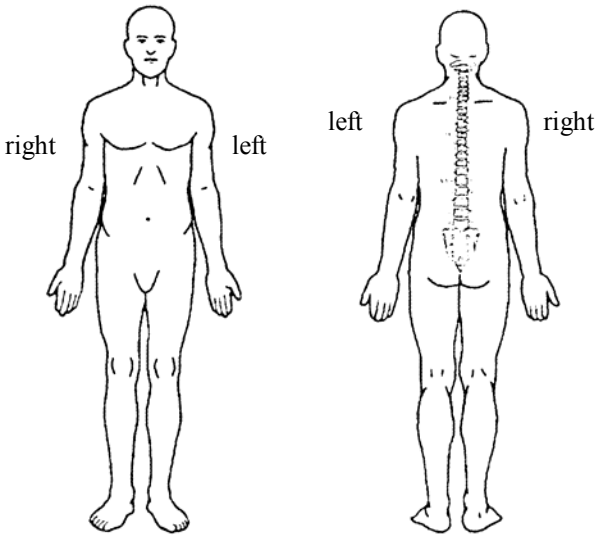
## Major Complaint Information

What is your major complaint(s)?

When did this symptom(s) begin?

If this is an injury, describe what happened?

Using the symbols provided in the Pain Index box, mark the areas on the illustrations below where you are experiencing pain, followed by a number from 1 to 10 indicating the extent of the pain. (1 being minor, 10 being severe)




### Pain Index

| | |
|---|---|
| **D** | Dull Nagging Ache |
| **B** | Burning |
| **S** | Sharp / Stabbing |
| **N** | Numbness / Tingling |

For example: if you are experiencing moderately Severe burning pain in back of your neck, you should note a "**B8**" on the neck of the illustration.

Have you experienced these symptoms before? ☐Yes ☐No When?

What aggravates this condition?

What decreases the symptoms / pain?

Have you seen another practitioner for this condition? ☐Yes ☐No Practitioner's Name

Date consulted: Diagnosis:

Does this condition interfere with your sleep? ☐Yes ☐No If so, how many times do you wake up in pain per night?

In what position do you sleep? ☐Back ☐Side ☐Stomach

Do you sleep with a pillow? ☐Yes ☐No How many?

Does heat affect the pain? ☐Yes ☐No If so, how?

Does cold affect the pain? ☐Yes ☐No Is so, how?

Do you wear a heel lift or orthotic? ☐Yes ☐No If so, which side(s)? ☐Right ☐Left

Does it cause pain to cough, bear down, or sneeze? ☐Yes ☐No If so, where is the pain?

## Check those activities below during which you experience difficulty or pain:

| | | | | |
|---|---|---|---|---|
| ☐ Lying on back | ☐ Getting in/out of car | ☐ Pulling | ☐ Sitting | ☐ Standing for long periods |
| ☐ Lying on side | ☐ Dressing Self | ☐ Reaching | ☐ Bending forward | ☐ Sneezing |
| ☐ Turning over in bed | ☐ Sexual Activity | ☐ Kneeling | ☐ Bending backward | ☐ Coughing |
| ☐ Lying flat on stomach | ☐ Pushing | ☐ Stooping | ☐ Walking | ☐ Other |

# FILL OUT THE NEXT THREE SECTIONS AS THEY APPLY TO YOU

## Lower Back Pain

Does pain radiate into the leg? ☐ Yes ☐ No Where: Does pain radiate to the abdomen? ☐ Yes ☐ No

Do you ever have impairment of bowl or urinary function? ☐ Yes ☐ No Explain:

Do you have numbness or tingling into the legs? ☐ Yes ☐ No Explain:

## Neck Pain

If you have a neck injury, does it affect: (Check all that apply) ☐ Hearing ☐ Vision ☐ Balance ☐ Cause ringing in ears

Do you hear grating sounds? ☐ Yes ☐ No Do you feel pressure behind your eyes? ☐ Yes ☐ No

Does pain radiate into the arm? ☐ Yes ☐ No Where:

Do you have difficulty lifting or turning your head: ☐ Yes ☐ No If so, in which direction ☐ Right ☐ Left ☐ Up ☐ Down

## Headaches

Do you get headaches? ☐ Yes ☐ No Frequency_ Do you have a family history of headaches? ☐ Yes ☐ No

Do you experience the following along with your headaches: Pain or cracking in your jaw? ☐ Yes ☐ No

Abnormal blood pressure? ☐ Yes ☐ No If yes: ☐ High ☐ Low Nausea, Vomiting, or Visual disturbances? ☐ Yes ☐ No

When was your last eye exam by a doctor? ☐ 1-6 months ☐ 6-12 months ☐ 1-2 years ☐ over 2 years Results

If female, are you pregnant? ☐ Yes ☐ No ☐ Not Sure Date of your last menstrual period:

List of all medications and/or supplements.

Have you ever had any surgeries or hospitalizations? ☐ Yes ☐ No Please list all Below:

| Type of Hospitalization/Surgery: | Date: | Type of Hospitalization/Surgery: | Date: |
|---|---|---|---|
| | | | |
| | | | |

Have you been x-rayed in the last 12 months? ☐ Yes ☐ No When?:

Have you ever been seen by a chiropractor before? ☐ Yes ☐ No Please list:

| Name of Chiropractor: | Dates: | Name of Chiropractor | Dates: |
|---|---|---|---|
| | | | |

Do you have a family physician? ☐ Yes ☐ No Name of physician: Phone:

Address:

City/State/Zip:

## Additional Complaints

Please check all additional complaints that you have at this time:

| | | | | |
|---|---|---|---|---|
| ☐ Loss of Concentration | ☐ Neck Stiffness | ☐ Shortness of Breath | ☐ Cold Hands | ☐ Arthritis |
| ☐ Eyes Sensitive to light | ☐ Neck Motion Restricted | ☐ Irritable | ☐ Cold Feet | ☐ HIV (Aids) |
| ☐ Memory Loss | ☐ Upper BackPain/ Stiffness | ☐ Anxiety | ☐ Jaw Pain | ☐ Other (Please List) |
| ☐ Heavy Feeling of Head | ☐ Mid Back Pain/ Stiffness | ☐ Depression | ☐ Hypertension | |
| ☐ Dizziness | ☐ Right/ Left Shoulder Pain | ☐ Insomnia | ☐ Diabetes | |
| ☐ Ringing in Ears | ☐ Right/ Left Arm Pain | ☐ Fatigue | ☐ Convulsions | |
| ☐ Loss of Balance | ☐ Pins & Needles Arms/ Legs | ☐ Excess Perspiration | ☐ Allergies (list) | Please Specify Location |
| ☐ Loss of Smell | ☐ Right/ Left Leg Pain | ☐ Digestive Trouble | | ☐ Numbness |
| ☐ Loss of Taste | ☐ Vision Problems | ☐ Nausea | | ☐ Swelling |
| ☐ Pain Behind Eyes | ☐ Sinus Trouble | ☐ Vomiting | | ☐ Cuts |
| ☐ Fainting | ☐ Nervousness | ☐ Diarrhea | ☐ Anemia | ☐ Brusing |
| ☐ Palpation | ☐ Chest Pain | ☐ Constipation | ☐ Heart Disease | |

Do you have, or have you ever had, any diseases or medical problems not listed? ☐ Yes ☐ No If so, please list:

Have you ever had? ☐ Motor Vehicle Injury ☐ Sports Injury ☐ Work Injury ☐ Slip and Fall Injury

If yes, please explain:

Any additional information you would like the doctor to know about before beginning care at Erickson Family Chiropractic:

## Personal Information

Address:

City / State / Zip:

Home Phone: ( ) Work Phone: ( )

Mobile Phone: ( ) Email:

Social Security #: Birth Date: Age: Sex: ☐ M ☐ F

Occupation: Employer's Name:

Work Address:

City / State / Zip:

Marital Status: ☐ **S** ☐ **M** ☐ **D** ☐ **W** Spouse's Name: # of Children:

Children's names:

How did you find out about our clinic?

## Emergency Contact

Name: Relation:

Home Phone: ( ) Work Phone: ( )

Address:

## Insurance Information

Insurance Company:

Phone #: Address:

Insured's Name: Insured's ID#: Group #:

Insured's Birth Date: Insured's Employer:

## IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS

## Personal Injury

Date of Accident: Hour AM ☐ PM ☐ Location

How did the accident occur? Auto Collision On-the-job-injury Other:

Please describe the accident:

If work related, did you report the injury to your foreman or employer? ☐ Yes ☐ No

If work related, name and phone number of foreman or authorized person:

If auto accident were you ☐ Driver ☐ Passenger ☐ Pedestrain

If auto collision, were you struck from ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto was parked

If auto accident, did your car strike the other(s) involved? ☐ Yes ☐ No

Or did the other car strike yours? ☐ Yes ☐ No ☐ Undetermined Did your vehicle's airbags deploy? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No Did You strike any objects in the car? ☐ Yes ☐ No (example: steering wheel)

List Object(s) struck: Lost work time ☐ Yes ☐ No If yes, date you returned to work

Do you have an attorney whe has advised you in this case? ☐ Yes ☐ No Attorney Name:

Attorney's Address:

## Authorization & Assignment

I authorize Erickson Family Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for services rendered at this office.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Erickson Family Chiropractic authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs that Erickson Family Chiropractic may incur to collect my bill.

Date: Patient's Signature: _____

## Informed Consent

I hereby authorize chiropractic doctors and staff at Erickson Family Chiropractic to treat my condition as deemed appropriate. The doctors and staff will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Erickson Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

**Specific Risk Possibilities Associated with Chiropractic Care:**

**Soreness–** Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort. Soreness will typically only last up to 24 hours after the treatment.

**Soft Tissue Injury–** Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft-tissue injury.

**Rib Injury–** Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays may be taken for cases considered at risk. Treatment is performed carefully and professionally accepted techniques will be used to minimize such risk.

**Physical Therapy Burns–** Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

**VBI–** VBI is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of VBI is 1 in every 5 million upper cervical adjustments and it has been noted that these are often caused by preexisting conditions. If at any time you notice dizziness, blurred vision, and/or ringing in your ears please notify staff.

**Other Problems–** There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly. I you have any question concerning this form or the above statements, please ask your doctor. Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Date: Patient's Signature: _____