

PATIENT INFORMATION – Please Print

GENERAL INFORMATION

Patient Last Name _____ First Name _____

(Legal Name on Lic. ID or Insurance Card)

Address _____ APT. _____ Care of _____

(Parent or Financially responsible person)

City _____ State _____ Zip _____ Phone (Work) _____

Driver's Lic # _____ No. Children _____ Phone (Cell) _____

Cell Phone Carrier for Text Reminders: _____

Email Address _____

Spouse's Name _____ Spouse's Daytime Ph# _____

Sex M F	Married Widowed	Single Divorced	Date of Birth / /	Social Security Number - -
Patient's Employer's Name _____ Address _____ City _____ State _____ Zip _____ Phone _____ Occupation _____				Employed Full Time Part Time Retired Not Employed Student Full Time Part Time

HOW DID YOU FIND US? _____

DO YOU HAVE INSURANCE? YES / NO

Insurance Company _____ Ins. Phone No. _____

Member ID _____ Group No. _____

PAST CHIROPRACTIC CARE? YES / NO

Clinic/Doctor Name? _____ Phone # _____

Address _____

X-rays Taken? YES / NO

Are your present problems due to an injury? YES / NO (ONLY COMPLETE IF YOU ANSWERED YES)

_____ On The Job _____ Auto Accident _____ Personal Injury _____ Other _____

Have you reported the Accident? YES / NO To Employer _____ Auto Carrier _____ Other _____

Have you retained an Attorney? YES / NO

AUTOMOBILE ACCIDENT/WORKER'S COMPENSATION ONLY

Insurance Company _____	Claim # _____	Policy # _____
Address _____	Phone # _____	
City _____ State _____ Zip _____	Adjustor's Name _____	
Attorney's Name _____	Contact Name _____	
Address _____	Phone # _____	

POLICIES

- All first visit charges are payable when services rendered.
- The fee paid for treatment x-rays is for analysis only. **The film itself is the property of this office.**
- We use your email to send you appointment reminders, office updates, monthly newsletter, etc.. **Please Opt Me Out ____ Yes**

____ (INITIAL) I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand Elite Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Elite Chiropractic will be credited to my account upon receipt. *However*, 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 at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.

I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account.

RELEASE AND ASSIGNMENT

____ (INITIAL) I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

CONSENT TO EXAMINATION AND DIAGNOSTIC PROCEDURES

____ (INITIAL) I do hereby authorize the Elite Chiropractic Doctors, Chiropractic Assistants, or Staff to perform upon me examination and diagnostic procedures arising from any current or presently unforeseen conditions, which the Elite Chiropractic Doctors may consider necessary or advisable in the course of my care.

I understand and agree that Elite Chiropractic Doctors have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and conducting of a physical examination are not considered treatment, but is a part of the process of information gathering so that the doctors of Elite Chiropractic can determine whether to accept me as a patient.

CONSENT TO X-RAY

____ (INITIAL) I do hereby authorize the Elite Chiropractic Doctors to take x-rays of myself (or said minor).

CONSENT TO OPEN DOOR ADJUSTING ENVIRONMENT

____ (INITIAL) Elite Chiropractic has an open door adjusting area. If you require privacy, it will be provided if your request is in writing. This office utilizes an "open-adjusting" environment for ongoing patient care. "Open-adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is not the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment then other arrangements will be made for you.

(WOMEN ONLY) PREGNANCY RELEASE*

Date of onset of patient's last menstrual period (LMP):_____.

____ (INITIAL) I do hereby release Elite Chiropractic; it's doctors, and staff from any and all liability. I hereby affirm that I am not pregnant nor am I attempting to get pregnant as of this date and the doctor has my permission to perform a x-ray evaluation. I have been informed adequately of the potential effects of radiation on a developing fetus. If a pregnancy test has been performed, I am also aware that this test is not 100% accurate and may yield false results.

I have read everything provided to me and by signing below I consent to everything that has been explained to me above.

Printed Name of Patient

Date

Printed Name of Witness

Signature Name of Patient or (Parent or Guardian) Date

Signature of Witness

CHIEF COMPLAINT

Please Circle Location of Your Pain

What is your 1st Major Complaint _____

Do you have any other health problems that concern you?

2nd Complaint: 2. _____

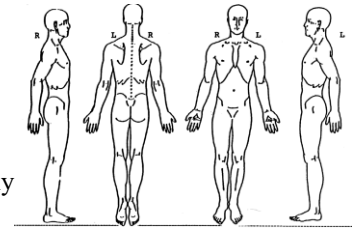
3rd Complaint: 3. _____ 4th Complaint: 4. _____

Onset

When did the complaint **recently flare up** start? Date _____ Gradually or Suddenly

Did anything cause or contribute to the onset? **YES / NO**

If yes please explain: _____



Provoking & Palliative (Please place the corresponding number of your complaint next to any provoking or palliative action)

What makes your condition worse? ☐ Nothing ☐ Lifting ☐ Trying to Stand ☐ Standing ☐ Walking ☐ Sitting ☐ Movement
☐ Exercise ☐ Inactivity ☐ Work Activities Other _____

What makes your condition better? ☐ Nothing ☐ Standing ☐ Walking ☐ Sitting ☐ Movement ☐ Exercise ☐ Inactivity ☐ Lying
Down ☐ Sleep ☐ Stretching ☐ Ice ☐ Heat ☐ Pain Meds ☐ OTC's Other _____

Quality (Please place the corresponding number of your complaint next to any sensation you are feeling)

Describe the sensation you feel ☐ Sharp, ☐ Dull, ☐ Burning, ☐ Throbbing, ☐ Achy, ☐ Sore, ☐ Shooting

Please rate your Pain.

1. 1st Complaint _____	No pain	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	Extreme Pain
2. 2nd Complaint _____	No pain	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	Extreme Pain
3. 3rd Complaint _____	No pain	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	Extreme Pain
4. 4th Complaint _____	No pain	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	Extreme Pain

Radiating

Does your pain radiate to any other part of your body? **YES/NO** Do you experience Numbness/Tingling? **Y/N**

If yes please explain: _____

Timing

Is your pain Constant? **YES / NO** Constant since when? _____

Is your pain Intermittent? **YES / NO**

1. 1st Complaint - Frequency _____	Times Per Week _____	Hrs/Days _____
2. 2nd Complaint - Frequency _____	Times Per Week _____	Hrs/Days _____
3. 3rd Complaint - Frequency _____	Times Per Week _____	Hrs/Days _____
4. 4th Complaint - Frequency _____	Times Per Week _____	Hrs/Days _____

Have you ever had anything like this before? **YES / NO** If yes when? _____

Has your condition affected your daily activities? **YES / NO** If yes, how? _____

Have you lost work days? **YES / NO** If yes, how many? _____

Has there been any change in your bodily functions (urination, defecation, respiration, digestion, vision, sexual, other)? **YES / NO**

If yes, please explain: _____

Name other doctors you have seen for this condition: _____

What are your health goals? _____

Give the Most current Date: Leave blank if not applicable

Spinal Exam _____
X-ray Exam _____
MRI or CT Exam _____
Lab Exam _____
Last Physical _____
Bone Density _____

FEMALE ONLY

Pap Smear _____
Breast Exam _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

☐ Appendicitis	☐ Anemia	☐ Heart Disease
☐ Pneumonia	☐ Goiter	☐ Epilepsy
☐ Rheumatic Fever	☐ Influenza	☐ Mental Disorder
☐ Polio	☐ Pleurisy	☐ Low Back Pain
☐ Tuberculosis	☐ Diabetes	☐ Alcoholism
☐ Whooping Cough	☐ Cancer	☐ AIDS
☐ Stroke	☐ Whiplash	☐ Hypertension
☐ Osteoporosis		

Office Use Only:

ICD: _____

CPT: _____

Elite Chiropractic P.L.L.C.
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TERMS OF ACCEPTANCE/CONSENT TO TREAT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working towards for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be use to attain it. This will prevent any confusion or disappointment.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: The specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Potential Risks: *The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.* While rare, in the practice of chiropractic there are some risk to exam and treatment including, but not limited to: sprains/strains, increased symptoms and pain or no improvement of symptoms or pain, fractures, disc injuries, strokes, dislocations, and serious neurological impairment.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I do not expect the doctor to be able to anticipate and explain all risk and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the same time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I, _____ have read and fully understand the above statements. I have also had the opportunity to ask questions and all my questions have been answered fully and satisfactorily. By signing below, I consent to treatment. 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 care.

Patient Signature

Date

CONSENT TO EVALUATE AND TREAT A MINOR(TREATMENT OF A CHILD UNDER 18 YRS).

I, _____ being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Parent Signature

Date

Witness Signature

Date