

## PATIENT INFORMATION

Date \_\_\_\_\_

Last 4 No's of SS# \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birth Date \_\_\_\_\_

Married  Single

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No

Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?  
 Auto Insurance  Employer  Worker Comp.  Other

Auto Insurance Name (if applicable)  
 \_\_\_\_\_

## PATIENT CONDITION

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

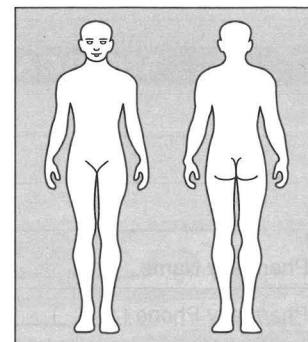
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down



# HEALTH HISTORY

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy

Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
				Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

## EXERCISE

- None
- Moderate
- Daily
- Heavy

## WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

## HABITS

- Smoking \_\_\_\_\_ Packs/Day \_\_\_\_\_
- Alcohol \_\_\_\_\_ Drinks/Week \_\_\_\_\_
- Coffee/Caffeine Drinks \_\_\_\_\_ Cups/Day \_\_\_\_\_
- High Stress Level \_\_\_\_\_ Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

## MEDICATIONS

## ALLERGIES

## VITAMINS/HERBS/MINERALS

_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
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## Informed Consent

To the Patient: Please read document and sign. It is important that you understand the information contained in this document:

**The nature of the chiropractic adjustment:** The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The doctor will use that procedure to treat you. She may use her hands or mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

**Analysis/Examination/Treatment:** As part of the analysis, examination and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpitation, trigger point massage, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, ultrasound, cold therapy, biofreeze application, electric muscle therapy, and traction therapy.

**The risks inherent in chiropractic adjustment:** As with any other healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy such as fractures or minor muscle pulls. It is common to feel stiffness or soreness following the first few days of treatment. Fractures are rare occurrences and generally result from some underlying weakness of the bone. Stroke or vertebral artery dissection caused by chiropractic manipulation of the neck has not been officially proven but continues to be anecdotal. The doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would not come to the doctor's obvious attention, it is your responsibility to inform the doctor.

**Authorization for the release of patient information:** I hereby authorize PEAK Chiropractic to provide other health care providers with information regarding my healthcare as deemed appropriate, give my permission for the use of medical records, including x-rays and information shared during the process of examinations and treatment to be released to insurance companies, other doctors, health consultants and or staff involved in my care.

Do not sign until you have read and understand the above.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have had all my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to under the treatment recommended. I hereby give my consent to chiropractic treatment and authorize any pertinent medical records exchange. I understand the consent to be effective until I am notified otherwise.

Patient's Signature: \_\_\_\_\_

Signature of parent/guardian (if minor) \_\_\_\_\_

Date: \_\_\_\_\_



## No Cancellation / No Show Policy

Here at PEAK Chiropractic, we strive to provide you with the very best care and attention that we can. Our patients are very important to us and we want to provide the highest standard of care possible.

We understand that unanticipated events occur in everyone's lives. However, out of respect for our practitioner and other patients, we ask that you try your best to be on time for scheduled appointments. We ask for a **minimum of 2 hour** notice if you are unable to make your scheduled appointment.

We are implementing a "No Cancellation / No Show" policy that is effective immediately.

### No Cancellation / No Show Policy

If a patient does not show for a scheduled appointment and does not provide a cancellation notice at least two hours prior to the appointment, the patient will be assessed a \$25.00 fee. Emergency situations will be handled on a case by case basis.

We have patients that are on a waiting list for any daily appointments that open up. When appointments are not canceled in a timely matter, we are not able to assist those patients on the wait list.

### Appointment Reminders

To assist our patients in this policy implementation, we are subscribing to a service that will send out both e-mail reminders and text message reminders **24 hours prior** to your scheduled appointment. Please respond to the text messages as to your appointment confirmation.

With this implementation, we want to make sure we have the best e-mail address and cell phone number on file for you. Please provide that below.

E-Mail: \_\_\_\_\_

Cell Phone No. (for text messages): \_\_\_\_\_

I, the undersigned, have been informed about PEAK Chiropractic's No cancellation / No show policy.

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_