PEAK Chiropractic

WELCOME

1640 E Capitol Avenue
Bismarck, ND 58501
701-751-0642

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)

_____

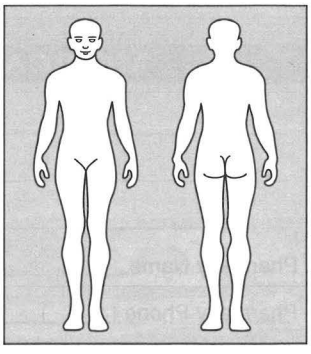
PATIENT CONDITION

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

- OVER -

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

PEAK Chiropractic

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:_____

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PEAK Chiropractic

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 accessed 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 for this reminder and any other text messages needed.

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: _____