



Welcome To Our Office!

Today's Date ____/____/____

Patient Title: Mr. Mrs. Ms. Miss Dr.

Name _____ Preferred Name _____
First Middle Last

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Phone Provider: U.S. Cellular Verizon Sprint T-Mobil Other _____

Email Address _____

Preferred Contact Method Home Phone Work Phone Mobile Phone Email

Date of Birth ____/____/____ Age _____ Gender Male Female

Social Security # _____ - _____ - _____

Race White/Caucasian Black/African American Hispanic Other _____ I choose not to specify

Marital Status Single Married Other Spouse's Name _____ # of Children _____

Emergency Contact _____ Phone # _____ Relationship _____

Referred to our office by _____

Employment Status Employed Full-Time Student Part-Time Student Retired Other

Occupation _____ Employer _____

Health Information

Do you currently take any medications? Yes No

	<i>Medication Name</i>	<i>Frequency</i>	<i>Dosage</i>	<i>For What Condition?</i>
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____
4	_____	_____	_____	_____
5	_____	_____	_____	_____

Are you allergic to any medications? Yes No

If yes, please list known allergies to medications: _____

Current Problem

Reason for this visit? _____

What level of intensity would you rate your pain?
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Please CIRCLE all that apply:

-Dull -Sharp -Throbbing -Burning -Deep -Aching
-Tingling -Stabbing -Cramping - Numbness -Radiating -Stiffness

What is the frequency of your symptoms?
 Constant Frequent Occasional Intermittent

What makes your symptoms worse? _____

What makes your symptoms better? _____

When did the symptoms start? _____

How did you injure yourself? _____

Have you ever experienced this before? Yes No _____

How does this affect your personal life? (hobbies, sports, etc...) _____

How does this affect your job? (missed days, inability to lift, stand, sit, etc...) _____

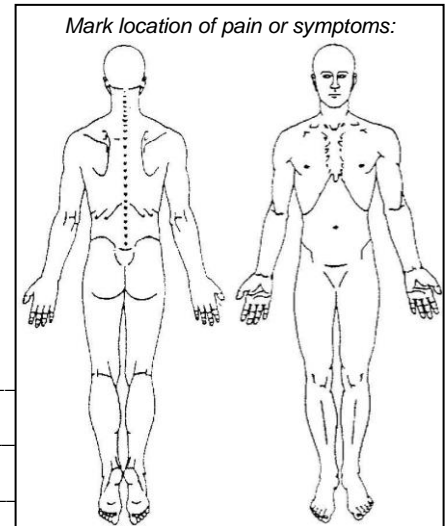
What home remedies have you tried? _____

Have you been to another doctor for this problem? Yes No _____

Have you ever been to a Chiropractor before? Yes No _____

Does this affect any of the following tasks? **SELECT the answers that apply to you.**

Bathing/Showering	Hobbies	Playing Sports
Bending Forward	Walking	Preparing Meals
Driving	Eating	Standing
Brushing Teeth	Kneeling	Putting on Pants
Bending to the side Left/Right	Getting In/Out of Bed	Stair Stepping
Twisting	Leaning Back	Putting on Shirt
Cleaning	Going to the Bathroom	Sitting
Carrying Objects	House Work	Putting on Shoes



FOR OFFICE USE ONLY:

Height: _____ Weight: _____ BPM: _____ BP: ____/____

Past Health History

Have you ever...

Yes No

Been Knocked Unconscious? _____

Been in a car accident? _____

Been treated for a spine problem/nerve disorder? _____

Had any significant falls, slips, or injuries? _____

Fractured/broken a bone? _____

Had surgery? _____

Been hospitalized for other than surgery? _____

Do you currently smoke tobacco of any kind? Yes Former smoker Never been a smoker

If yes, how often do you smoke: Current every day smoker Current sometimes smoker # Packs per day _____

If yes, what is your level of interest in quitting smoking? 0 1 2 3 4 5 6 7 8 9 10
No interest Very Interested

Do you consume alcohol? Yes No # Drinks per week _____

Do you consume caffeine? Coffee Soda Tea Energy Drinks # Drinks per day _____

Do you exercise? No Infrequent Occasional Regular Avoid due to pain

Please mark any you currently have or have had previously:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Cramps	<input type="checkbox"/> Kidney Infection	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney Stone	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Sinus Infection
<input type="checkbox"/> Anemia	<input type="checkbox"/> Digestions Problems	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Sleep Problems/Insomnia
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Spinal Curvatures
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Excessive Menstruation	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eye Pain/Difficulties	<input type="checkbox"/> Migraine Headache	<input type="checkbox"/> Swelling in Ankles
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Neck Pain or Stiffness	<input type="checkbox"/> Swollen Joints
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Headache	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Polio	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Chest Pain/Conditions	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Poor Posture	<input type="checkbox"/> _____
<input type="checkbox"/> Cold Extremities	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Prostate Issues	<input type="checkbox"/> _____
<input type="checkbox"/> Constipation	<input type="checkbox"/> Irregular Cycle	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> _____

Is there a family history of? (Include Relationship)

Heart Disease _____

Cancer _____

Stroke _____

Arthritis _____

Diabetes _____

High Blood Pressure _____

Other _____

Women Only

Are you pregnant? Yes No Maybe

Number of Weeks _____

Estimated Due Date _____

The information that I have provided above is accurate to the best of my knowledge and will be used to determine appropriate chiropractic care.

Patient's Signature

Notice of Privacy Practices

Our practice is dedicated to maintain the privacy of your health information according to the guidelines set forth by federal and state laws. These laws also require us to provide you with notice of privacy practices, and to inform you of your rights and our obligations concerning your health information. The undersigned hereby acknowledge that I have received, reviewed, and understand and agree to the notice of Privacy Practices of Redenius Chiropractic, which describes the practice’s policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by Redenius Chiropractic.

Patient’s Initials_____

Patient’s Rights and Responsibilities

Health care involves a partnership between patients, families, and health care providers, each of whom have certain rights and responsibilities. When you are well-informed, participate in treatment decisions, and communicate openly with your doctor and other health professionals, you help make your care as effective as possible. This clinic encourages respect for the personal preferences and values of each individual. The undersigned hereby acknowledges that I have received, reviewed, and understand my rights and responsibilities.

Patient’s Initials_____

Statement of Informed Consent

Chiropractic adjustments are performed in our office by a skilled doctor of chiropractic who has successfully completed advanced educational requirements, national board examinations and state board licensure. As with any healthcare procedure, there are some inherent risks that exist. Whenever possible this risk is minimized to its lowest level. The undersigned hereby consents to evaluation to provide the safest chiropractic care available. The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and that any/ all treatment have risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from the doctor.

Patient’s Initials_____

Assignment of Benefits

Assignment of benefits authorizes Redenius Chiropractic to file charges directly to your insurance company, saving you time and effort of filing claims yourself. The undersigned hereby authorizes Redenius Chiropractic to submit my insurance claims to my insurance company. By having my signature of file, I need not sign each claim submitted by this office. I understand that I may withdraw my signature at any time. I understand that I may ultimately be responsible for all charges for which my insurance does not pay. I also understand that as the patient I am responsible for paying the copay/coinsurance/deductible at each time of service.

Patient’s Initials_____

Patient Signature_____ Date_____



Patient Acknowledgement & Receipt of Notice of Privacy Practices Pursuant to HIPAA & Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of Redenius Chiropractic Notice of Privacy Practices Pursuant to HIPAA & has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law & Federal Law.

By _____ Date _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State Law:

By _____ Date _____
Signature of Parent/ Guardian

Pregnancy Waiver For Films

I hereby acknowledge that Dr. Jeff Redenius of Redenius Chiropractic has informed me prior to having Radiographic Films of the advisability of risk & the probable consequences of receiving such procedures during pregnancy. I have stated on my own volition that I am not pregnant at this time & do hereby release & hold harmless from any legal action or responsibility caused by the use of this procedure.

By _____ Date _____
Signature of Patient or Authorized Representative

If Patient is Under the age of 18

I the parent/guardian allow my child that is a minor under the age of 18 to be seen at Redenius Chiropractic PLC for care. Without my supervision.

By _____ Date _____
Signature of Parent/Guardian

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Redenius Chiropractic PLC

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Sign only after you understand and agree to the above.

Printed name of Patient _____ Date _____

Signature of Patient _____ *Date* _____

Signature of Representative _____ *Date* _____

(If patient is a minor or is handicapped)

Note: The patient needs to sign this form **before** treatment actually begins.