PATIENT INFORMATION

Thank you for choosing our office. In order to serve you properly, we need the following information. PLEASE PRINT. *All information will be confidential.* Account # ____________________

Patient's Name: ____ Date: ___________________________________

Phone: ___________________________SS#:_____________________________ Male: ___________ Female: ___________

Birth Date: _________________________________ Age: ___________

Alternate Phone#: __________________________ Email: ____

Address: ____

City, State, Zip: ____

Check Appropriate Box: ( ) Married ( ) Single ( ) Minor ( ) Widow ( ) Other

Patient or Guardian's Employer: ____

Work Phone: ___________________________ Address: ____

Spouse or Parent / Guardian Name: ____

Person to Contact In Case of Emergency: ____

Whom may we thank for referring you? ____

Were you recently in an automobile accident? **( ) Yes ( ) No If yes, complete the following:**

Date of accident: ______________________________

Are you still under litigation for the auto accident? **( ) Yes ( ) No**

Responsible Party:

Name of person responsible for this account: ____

Relation to patient: ( ) Self ( ) Spouse ( ) Other: _________________________________

Insurance Information:

Name of Insured: ____ Relation to Patient: _________________________

Birth Date: _______________________ SS#: ________________________

Insurance Company: ____ Group #: _________________________

Do you have any additional insurance? ( ) Yes ( ) No If yes, complete the following:

Name of Insured: ____ Relation to Patient: _________________________

Birth Date: _______________________ SS#: ________________________

Insurance Company: ____ Group #: _________________________

I authorize Pham Chiropractic Services to release any information regarding my examination or treatment for the purposes of obtaining insurance compensation, pre-certification, or medical records. I authorize payment of the chiropractic benefits to Pham Chiropractic Services when claim forms are filed upon my behalf for treatment of extensive office procedures. I also give my permission for treatment to patient, if minor. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or updating of this form.

Signed: ____ **Dated:** ________________________________

Confidential Health Record

Name ____ **Date** ____________________

Current Health Condition

Major Complaint: ____
____

Where specifically does this cause you pain or discomfort? _______________________________

When did it begin? ____

Was there a specific mechanism or injury that brought on the pain/condition? ______________

Was the onset of pain: (circle all that apply) Sudden Gradual

Has this pain occurred before? Yes No If yes when? __________________________

How long have you had this current episode of pain? ____________________________________

How present are the complaints/pain? ___ Constant 75-100% ___ Frequent 50-75%
___ Occasional 25-49% ___ Intermittent 25% or less

Have you had prior or current treatment for this condition? ______________________________

What helped and what did not help with your pain? _____________________________________

Rate your pain on a scale of 1 to 10 with 10 being the max: 1 2 3 4 5 6 7 8 9 10

Is the condition/pain getting worse? ____

Is the condition interfering with your: (circle all that apply) Work Sleep Daily routine

What activities are you unable to do now that you previously were able to do? _____________
____

Does this condition wake you at night? Yes No Sometimes

Is the pain localized or does it radiate to other areas? ____________________________________

What aggravates your condition? ____

What relieves your condition? ____

Are you wearing any orthotics or heel lifts? Yes No If yes, how long? ______________

Other doctors seen for this condition: ____

Type of treatment received: ____

List all medications (prescriptions or over the counter) you are taking: ______________________
____

Health History

Have you previously had Chiropractic care? Yes No

If yes, Chiropractor's name: ____

Date of last visit? _________________________________

List any other medical doctors you are seeing: ______________________________________

____

Personal History

Have you ever been in an automobile accident? Yes No

If yes, list dates of injuries: ____

Have you ever broken any bones? Yes No

If yes, list which ones, where and when? ____

____

Have you had any falls, sprains, strains or stitches in the past? Yes No

Details: ____

Have you had x-rays or your neck or spine? Yes No

If yes, when? ____

Can you get a copy of your x-rays for our office? Yes No

Did you use ice or heat on the painful areas? Yes No If yes, which one? ______________

Family History Check any of the following conditions found in your family and the family member beside it. (Example: Mother, Brother, Aunt)

_____ Cancer ________________________ _____ Kidney Disease ________________

_____ Diabetes _______________________ _____ Stroke _______________________

_____ Hypertension ___________________ _____ Thyroid Disease _______________

_____ Heart Attack ____________________ _____ Tuberculosis ___________________

_____ Heart Disease ___________________ _____ Other ________________________

PLEASE CHECK THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Typhoid Fever
- ☐ Malaria
- ☐ Appendicitis
- ☐ Goiter
- ☐ Measles
- ☐ Thyroid
- ☐ Eczema
- ☐ Alcoholism
- ☐ Venereal Disease
- ☐ N/A

CIRCLE CURRENT CONDITIONS – CHECK FORMER CONDITIONS

GENERAL SYMPTOMS

- ☐ Tremors
- ☐ Headache
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Loss of sleep
- ☐ Fatigue
- ☐ Nerviousness
- ☐ Depression
- ☐ Loss of weight
- ☐ Numbness or pain in arms hands, elbows, shoulders, hips, legs, knees or feet
- ☐ Paralysis
- ☐ Forgetfulness
- ☐ Confusion

EYES, EARS, NOSE & THROAT

- ☐ Failing vision
- ☐ Near sightedness
- ☐ Crossed eyes
- ☐ Eye pain
- ☐ Eye strain
- ☐ Eye inflamiation
- ☐ Deafness
- ☐ Earache
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Sore throat
- ☐ Horseness
- ☐ Difficult speech
- ☐ Hay fever
- ☐ Allergies
- ☐ Dental decay
- ☐ Gum troubles
- ☐ Frequent colds
- ☐ Enlarged thyroid
- ☐ Sinus infection
- ☐ Nasal drainage
- ☐ Enlarged glands
- ☐ Tonsillitis

SKIN

- ☐ Skin eruptions itching
- ☐ Itching
- ☐ Bruises easly
- ☐ Dryness
- ☐ Boils
- ☐ Rashes
- ☐ Sensitive skin
- ☐ Hives or allergy
- ☐ Eczema

RESPIRATORY

- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Whooping cough
- ☐ Influenza
- ☐ Pleurisy
- ☐ Asthma

CARDIO-VASCULAR

- ☐ Rapid beating heart
- ☐ Slow beating heart
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over the heart
- ☐ Stroke
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Heart attack
- ☐ Varicose veins

MUSCLE AND JOINT

- ☐ Stiff neck
- ☐ Back ache
- ☐ Swollen joints
- ☐ Painful tail bone
- ☐ Foot trouble
- ☐ Pain between shoulders
- ☐ Hernia
- ☐ Spinal curvature (Scoliosis)
- ☐ Faulty posture

MUSCLE AND JOINT CONT..

- ☐ Arthritis
- ☐ Stiff joints
- ☐ painful joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Sciatica

GENITOURINARY

- ☐ Frequent urination
- ☐ Scanty urine
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection or stones
- ☐ Bed wetting
- ☐ Inability to control urine
- ☐ Prostate trouble
- ☐ Bladder trouble
- ☐ Discolored urine

GASTROINTESTINAL

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Belching or gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting of blood
- ☐ Pain over the stomach
- ☐ Distention of abdomen
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black stool
- ☐ Colon trouble
- ☐ Hemorrhoids (piles)
- ☐ Intestinal worms
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Jaundice
- ☐ Colitis
- ☐ Weight trouble
- ☐ Antibiotic therapy
- ☐ Appendicitis
- ☐ Ulcers
- ☐ Bloody stool

GASTROINTESTINAL CONT..

- ☐ Goiter
- ☐ Gout

OTHER

- ☐ Foot orthotic/ supports
- ☐ Prosthesis
- ☐ Breast implants

FEMALE

- ☐ Painful menstrual
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Cramps or back ache
- ☐ Miscarriage
- ☐ Vaginal discharge
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps in the breast
- ☐ Menopausal symptoms
- ☐ Abnormal bleeding

When was your last period?

____

Are you pregnant?

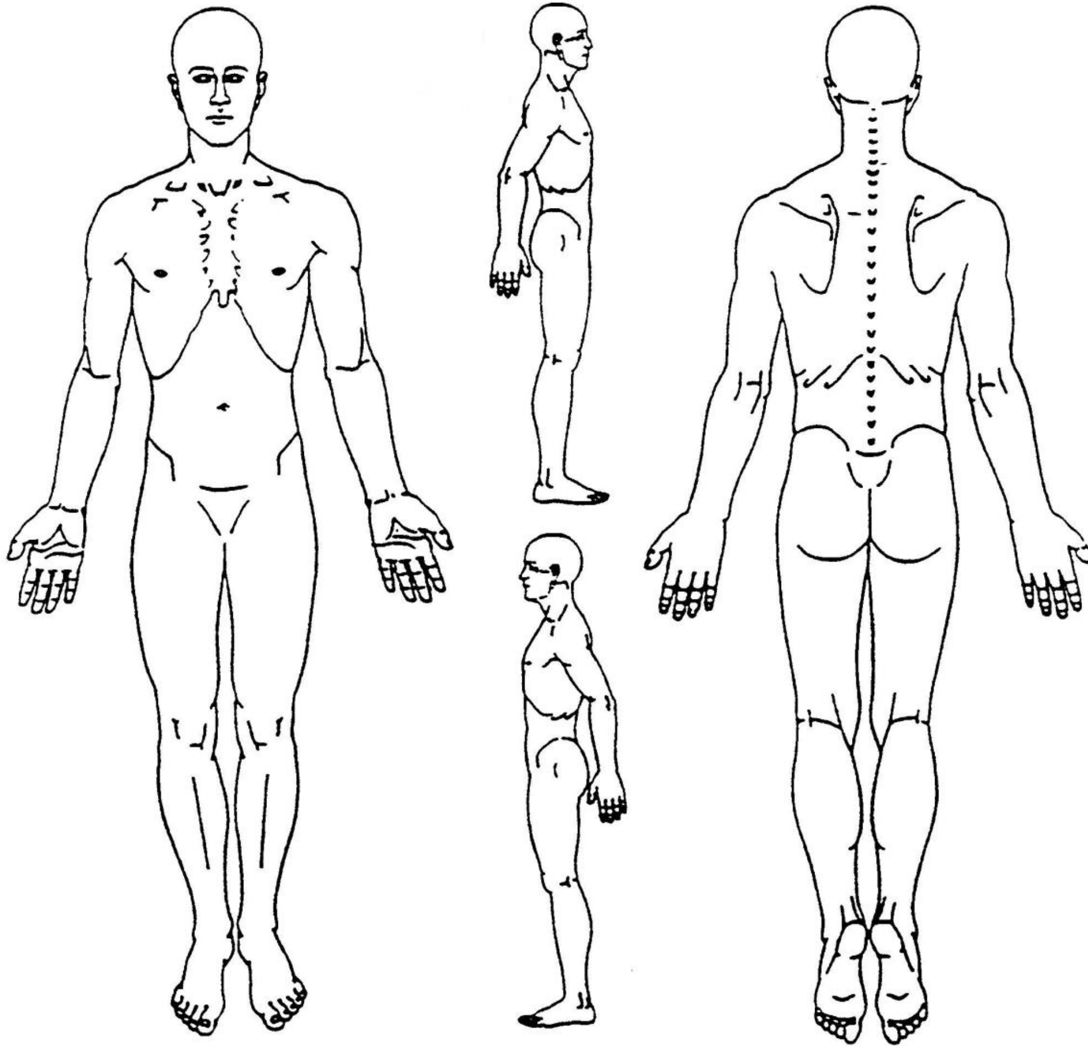
- ☐ Yes
- ☐ No
- ☐ Not sure

Patient Name:_________________________ Phone: _____________________ Date:___________

PAIN DRAWING ASSESSMENT

Draw the location of your pain on the body outlines using the appropriate symbol. Include all affected areas. Mark the severity of your pain at the bottom of the page.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING
ZZZ	BBB	XXX	= = =	////



CIRCLE YOUR PAIN ESTIMATE

NO PAIN 1 2 3 4 5 6 7 8 9 10 INTOLERABLE

I understand and agree that health and accident Insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance carrier and that any amount authorized to be paid to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me 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 me will be immediately due and payable.

Patient's Signature: ________________________________Date: ____________________________

Informed consent to Chiropractic Treatment

<u>The nature of Chiropractic treatment</u>: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop, such as the noise when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

<u>Possible Risks</u>: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligament us sprain dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patient's may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

<u>Possibility of risks occurring</u>: The risk of complications due to chiropractic treatments have been described as "rare" about as often as complications are seen from the taking of a single aspirin tablet. The risks of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare."

<u>Other treatment options which could be considered may include the following</u>:

- **Over-the-counter analgesics. The risk of these medications include: irritation to stomach, liver and kidneys and other side effects in a significant number of cases.**
- **Medical care, typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.**
- **Hospitalization in conjunction with medical care adds the risks of exposure to virulent communicable disease in a significant number of cases.**
- **Surgery in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well an extended convalescent period in a significant number of cases.**

<u>Risk of remaining untreated:</u> Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

<u>Unusual risks:</u> I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

_______________________________ _______________________________ ________________

Printed Name **Signature** **Date**

_______________________________ _______________________________ ________________

Witness Printed Name **Signature** **Date**