Patient Information

(Please print all information – Thank you!)

(Please circle appropriate Title and Marital Status) **Dr. / Mr. /Mrs. / Ms. / Miss** **ALSO: S / M / W / D / Other**

Last Name_____ First Name _____ MI _____

Address _____

City _____ State _____ Zip Code _____

Name you like to be called _____ Birthdate _____ # of Children _____

Your SS# _____ Drivers' license number _____ State _____

Cell Phone _____ Home Phone _____ Height: _____ Weight: _____

Your Email _____

Occupation _____ Employer _____

Address _____ City _____ State _____ Zip _____

Who may we thank for your referral to our office today? _____

Parent name / responsible party (for those under 18 yrs. old) _____

Emergency Contact: Name _____ Cell Phone _____ Relationship _____

Language Preference and or Special Communication Needs: _____

Recent Medical Diagnostic Test/Exams: _____

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: (Check all that apply)

- ☐ Relief of a symptom or problem
- ☐ Relief and Prevention of a symptom or problem
- ☐ Healthier spine and nerve system
- ☐ Optimal health on all levels

PLEASE NOTE: If you have chiropractic insurance coverage, please present your ID card for copying…thank you!

Notice of Privacy Practices

The privacy of your health care information is important to us. We understand that your health care information is personal and we are committed to protecting it. We create a record of the care and services you receive at our chiropractic office. We need this record to provide you with quality care and to comply with certain legal requirements. We may use and disclose your health care information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your health care information. In addition to using and disclosing your health care information for payment and health care operations, we may use and disclose the information as legally required by law.

- **We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between health care provider and patient.**
- **Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager.**
- **I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the health care provider to release any information required to process insurance claims.**
- **I authorize Murrieta Chiropractic to contact me by phone, text and email during the course of my care and in the future for educational purposes.**
- **I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.**

Signature of responsible adult _____ **Date** _____

Murrieta Chiropractic

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CHIROPRACTIC INFORMED CONSENT

The doctor of chiropractic evaluates the patient using chiropractic examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise low force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the chiropractic adjustment, some of which utilize specially designed equipment. Chiropractic adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other recommendations may include nutritional and healthy living suggestions. Referral for further diagnosis or management to another health care provider may be suggested based on history and examination findings.

I hereby request and consent to the performance of chiropractic examination and testing procedures and chiropractic adjustments on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated above.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, I do not expect the chiropractor to be able to anticipate and explain all possible risks and complications, and I wish to rely on the chiropractor to exercise judgment during the course of the procedures which the chiropractor feels at the time, based upon the facts then known, is in my best interest.

I further understand that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and health care options.

This healthcare building and individual offices are equipped with audio-visual surveillance, and this consent form serves as notice that I am aware of this technology at these premises for my protection.

I have read the above consent, had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures and to be contacted by Murrieta Chiropractic by phone, text and email in regards to my care, appointment and for ongoing chiropractic education. I intend this consent to cover the entire course of chiropractic care for my present condition and for any future condition(s) for which I seek chiropractic care from Murrieta Chiropractic.

_____ _____

Patient signature **Date**

(Or Patient guardian/Parent/Legal representative)

_____ _____

Print name **Witness**

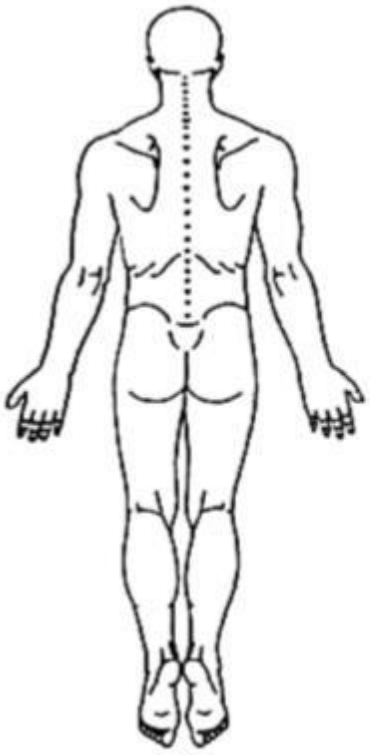
(Provide name & relationship if signing for patient)

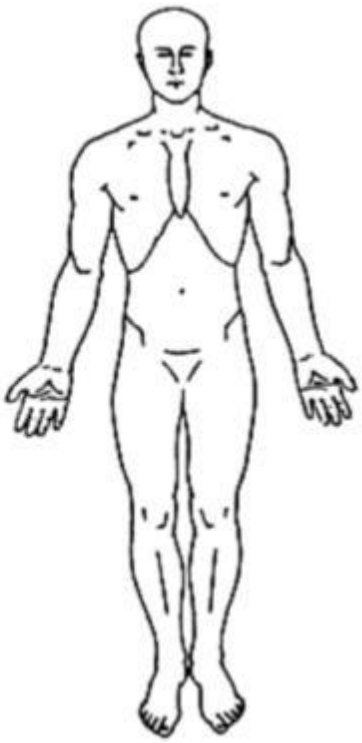
Patient Name _____ **Date**_____

Females only: Are you pregnant? Yes___ **No** ___ **Breast Augmentation? Yes**___ **No** ___ **Date:**_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N = Numbness **B =** Burning **S =** Stabbing **T =** Tingling **A =** Dull Ache





Describe your symptoms in order of severity, with worse symptom being #1:

#1 _____

_____

_____

_____

#2 _____

_____

_____

_____

#3 _____

_____

_____

_____

_____

When did your symptoms begin? Month_____ **Day** _____**Year** _____

Are your symptoms a result of: Motor Vehicle Accident Work related Other_____

How did your symptoms begin? _____

_____

_____

Average pain intensity - last 24 hours**:** (circle number) **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**
Average pain intensity - this past week**:** (circle number) **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

How often do you experience your symptoms?
(1) Constantly (76-100% of the day) **(2)** Frequently (51-75% of the day) **(3)** Occasionally (26-50% of the day) **(4)** Intermittently (0-25% of the day)

How much have your symptoms interfered with your usual daily activities?
(1) No Effect (2) Mild (painful can do) **(3) Mod** (painful limited ability) **(4) Mod/Sev** (limited duty) **(5) Sev** (some limited duty) **(6) Sev** (can't do limited duty)

How are your symptoms changing?
Getting: (1) much worse (2) Worse (3) A little worse (4) No Change (5) A little better (6) Better (7) Much better

In general, would you say your overall health right now is…
(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

_____

_____

_____

_____

_____

Patient Name _____ **Date**_____

Please list all current medications and/or Vitamins being taken _____

_____

_____

_____

Please list all surgeries _____

_____

_____

_____

Review of Systems – (Check box if you have had trouble with any of the following, or NO if none)

Cardiovascular				**Respiratory**				**Allergic/Immunologic**			
	Past	Present	No		Past	Present	No		Past	Present	No
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			
Jaw Pain				**Eyes**					Past	Present	No
Irregular Heartbeat					Past	Present	No	Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary				Blurred Vision				Sore Throat			
	Past	Present	No					Nosebleeds			
Kidney Disease				**Psychiatric**				Bleeding Gums			
Burning Urination					Past	Present	No	Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			
Kidney Stones				Stress					Past	Present	No
Lower Side Pain								Gall Bladder Problems			
				Endocrine				Bowel Problems			
Neurologic					Past	Present	No	Constipation			
	Past	Present	No	Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**							
Pinched Nerves					Past	Present	No	**Musculoskeletal**			
Parkinson's				Hepatitis					Past	Present	No
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional				Bleeding				Muscle Weakness			
	Past	Present	No	Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											