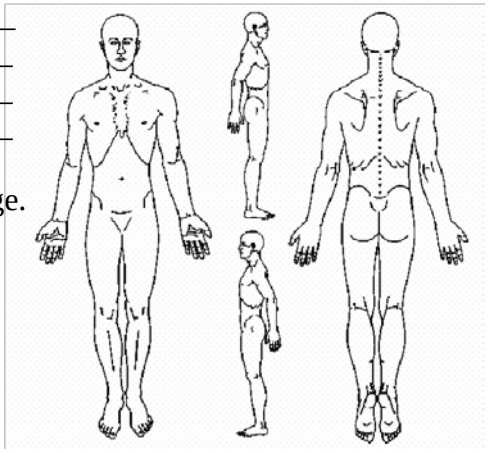
Total Health Chiropractic

Patient Name: _____ Date: _____
Age: _____ Occupation: _____ Height: _____ Weight: _____

*** Present Complaints**: _____
_____
***** When did your symptoms start? _____
***** How did they start? ____Gradually developed ___ Auto Accident ___Other:
____Repetitive incidents ____Work injury **Draw Your Pain:**
***** Describe in detail:_____
_____
_____
_____



***** Have you experienced this before? **Yes / No**
***** Has your pain been… □ Increasing □ Decreasing □ No Change.
***** The pain is…Check all that apply.

____Dull	____Sharp	____Numbness
____Achy	____Shooting	____Burning
____Sore	____Gripping	____Weakness
____Throbbing	____Stabbing	____Tingling

***** The severity of my pain is: **(mild)** **(extreme)**
1 2 3 4 5 6 7 8 9 10
***** I feel it… □ Constantly (76-100%) □Frequent (51-75%) □ Intermittent (26-50%) □ Rare (0-25%)

***** My symptoms are worse: □ Morning □ Afternoon □ Evening □ Wakes me at Night
***** Does your condition interfere with your sleep? **Yes / No** **If yes**, how many times do you wake up in pain each night?_____
***** Does your pain radiate or travel? **Yes / No** (where)_____.
***** Does it hurt to cough, grunt or sneeze? **Yes / No**
***** What makes your condition **Worse**? _____
Better? _____
***** What do you do at home to help relieve your symptoms? _____
***** Does it help? **Yes / No / Somewhat**
***** How does heat (hot bath) affect it? **Better / Worse / Better at first, then it gets worse**
(Cold pack)? **Better/worse**
***** How has your condition changed your life? Please describe in detail. _____
_____
_____
_____
***** Have you seen anyone else for this condition? **Yes / No** Who?_____
***** When were you last seen? _____ What was done/diagnosis?_____
Results of treatment? _____
***** Are you currently on medication for this condition? **Yes / No** What meds? _____

Circle those activities which cause pain when you do them.

Lying on back	Getting in/out of a car	Pulling	Sitting	Standing
Lying on side	Dressing Self	Reaching	Bending forward	Sneezing
Turning over in bed	Sexual Activity	Kneeling	Bending backward	Coughing
Lying on stomach	Pushing	Stooping	Walking	Other:_____

***** If you are FEMALE, are you pregnant? **Yes / No** if so, how far along are you? _____weeks/months

DOCTOR/HOSPITAL INFORMATION:

***** Who is you Family Physician? _____City _____

***** Have you ever been HOSPITALIZED? **Yes / No** When and for what condition? _____

_____

_____

***** Have you been to a Chiropractor before **Yes / No** Who? _____ When? _____

DAILY HABITS:

***** List any **Allergies** to Food, Environment, or Medications. _____

***** List your **Medications**, including "the Pill," Birth Control shots and all "**over the counter medications**".

_____

_____

_____

***** What **Vitamin, Mineral, Herbal or Homeopathic** supplements are you taking? _____

_____

_____

***** Do you… □ Smoke? (_____ packs per day)

□ Alcohol (____drinks per week)

□ Caffeine (type: _____. Cups or cans/day _____)

□ Recreational drugs (type: _____)

***** How much do you **exercise**? Hours per week _____ Type of exercise _____

***** Number of hours you sleep per night. _____hours

***** Do you sleep on your □Back □Side □Stomach

***** Number of meals per day. _____ How is your daily diet? _____

***** How often do you have bowel movements? _____(2X/ day, 1X/ week etc…)

***** Do you wear a heel lift? **Yes / No**

***** What do you do at work, what are your job duties? _____

_____

ADDITIONAL COMPLAINTS…Circle all additional complaints that you have at this time:

General

Bruise easily	Chills	Dental problems	Depression	Difficulty sleeping	Dizziness
Fainting	Fever	Forgetfulness	Mental dullness	Headache	Loss of sleep/insomnia
Weight gain	Weight loss	Nervousness/anxiety	Sweats	Fatigue	Irritablility
Skin rash			Hives	Itching	Change in mole(s)

Neck related conditions:

Neck pain	Neck stiffness	Neck weakness	Pinched nerve Neck
feels out	Muscle spasms	Grinding and popping	Upper arm pain
Elbow pain	Forearm pain	Hand pain	Pins/Needles in Arm/Hand/Fingers
Numbness in Arm/Hand(s)	Arm(s) Weakness	Hand(s) cold	Vision problems
Difficulty swallowing	Bleeding gums	Double vision	Earache
Ear discharge	Hay fever	Hoarseness	Loss of hearing/taste/smell
Nosebleeds	Persistent cough	Ringing in ears	Sinus problems
Vision flashes/halos	Dizziness	Balance problems	Headaches…describe_____
Pain/cracking in jaw			_____

Mid-back related conditions:

Mid-back pain	Mid-back stiffness	Pain from front to back	Pain between shoulders
Muscle spasms	Hurts to breath deep	Pain in shoulder joint R L	Pain across shoulders
Tension in shoulders	Can't raise arm(s)	Chest pain	Shortness of breath
High Blood Pressure	Irregular heartbeat	Low blood pressure	Poor circulation
Rapid heart beat	Swelling of ankles	Varicose veins	Painful urination
Frequent urination	Blood in urine	Nausea/vomiting	

Low Back related conditions:

Low back pain	Low back stiffness	Low back weakness	Pinched nerve
Low back feels out of place	Muscle spasms	Pins/needles in legs/feet	Poor appetite
Bloating	Bowel changes	Constipation	Diarrhea
Rectal bleeding	Excessive hunger	Excessive thirst	Gas
Hemorrhoids	Indigestion	Stomach pain	Nausea
Vomiting	Vomiting blood	Pain in buttocks	Pain in hip joint
Pain down leg(s)	Pain in ankle(s)	Pain in foot	Weak leg(s)
Weak knee(s)	Leg cramps	Feet are cold	

Men only

Breast lump
Erection difficulties
Lump in testicles
Penile discharge
Sore on penis

Women only

Breast lump
Abnormal Pap
Bleeding between periods
Extreme menstrual pain
Hot flashes
Nipple discharge
Vaginal discharge
Date of last period _____
Date of last pap _____

Have you ever had….(please circle)

AIDS	Chronic Fatigue	HIV positive	Psychiatric Care	Other_____
Alcoholism	Diabetes	Hypertension	Rheumatic Fever	_____
Anemia	Epilelpsy	Kidney Disease	Rheumatoid Arthritis	_____
Anorexia	Emphysema	Liver Disease	Scarlet Fever	_____
Appendicitis	Ear infections	Measles	Stroke	
Arthritis	Fractures	Migraine headaches	Suicide attempt	Dr. Notes: _____
Asthma	Glaucoma	Miscarriage	Tonsillitis	_____
Bleeding Disorders	Goiter	Mononucleosis	Thyroid problems	_____
Breast Lump	Gonorrhea	Multiple Sclerosis	Tuberculosis	_____
Bronchitis	Gout	Mumps	Tumors/Growths	_____
Bulemia	Heart Disease	Osteoporosis	Typhoid Fever	_____
Cancer	Hepatitis	Pacemaker	Ulcers	_____
Cateracts	Hernia	Pneumonia	Venereal Disease	_____
Chemical Dependency	Herpes	Polio	Whooping Cough	_____
Chicken Pox	High Cholesterol	Prosthesis		

FAMILY HISTORY AND PERSONAL PAST HISTORY….

Who in your family has had:

Arthritis … _____
Diabetes … _____
Cancer … _____
Heart Disease … _____
High Blood pressure … _____
Stroke? … _____

List all of your injuries, car accidents,work inj's. traumas.

_____
_____

Is there anything else Dr. Nyblom needs to be aware of?

_____
_____
_____
_____

Do you have any concerns about getting Chiropractic care? _____

_____

We are here to help you and are very open to questions and inquiries. Do not hesitate to mention concerns to the doctors or staff.

Personal Information

Name: _____ Date: _____
Address: _____
City/State/Zip: _____
Home Phone: ( )_____Work Phone: ( )_____
Mobile Phone: ( )_____ Email: _____
Social Security #: _____ Birth Date: _____ Age: _____Sex: M/F
Occupation: _____Employer Name: _____
Work Address: _____
City/State/Zip: _____
Marital Status: Single Married Divorced Widow/er Spouse's Name: _____
Number of children: _____ Names/Ages of children: _____
_____
How were you referred to our office? _____
In case of an emergency, who may we call? _____Relation: _____
Home Phone #: ( ) _____ Work Phone: ( ) _____
Cell Phone #: ( ) _____

In case of a minor, Parent/Guardian's Name: _____
Parent/Guardian's Address:_____Zip_____
Parent/Guardian's Social Security Number: _____Date of Birth: _____
I hereby authorize this office to examine, x-ray and treat my child as deemed necessary.
Parent/Guardian Signature: _____

PATIENT INSURANCE/FINANCIAL POLICY:

___Cash/Check/Credit Card ___Car/Truck Insurance
___Health Insurance ___Workers Compensation

Insurance Company Name:_____
Who is the primary policy holder? _____SS#:_____
Relationship to Insured: ___Self ___Spouse ___Child ___Other
Birthdate of the primary policy holder? _____Employer:_____
Address of the Primary policy holder? _____
Please bring ALL of your insurance cards and photo ID to the front desk for photocopying.

I am interested in:
___Getting out of pain and focusing on wellness
___Getting out of pain and I later may consider wellness
___Strictly pain relief

Authorization and Assignment, Informed consent

I understand that health information may be released to insurance carriers or other professionals as deemed necessary. I hereby authorize Total Health Chiropractic to release any information you deem appropriate concerning me and my course of care to such professionals (insurance carriers, attorneys, adjusters ect…) in order to process any claim for reimbursement of charges incurred by me, and hereby releases Total Health Chiropractic, it's Doctors and Employees of any consequence thereof.

Signature Needed on the next page…

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned, do hereby appoint Total Health Chiropractic the authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned or a co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that while the doctor's office may process any necessary reports and forms to assist in collecting from the insurance company, and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt, 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 and treatments, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

I hereby authorize physicians and staff at Total Health Chiropractic to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Total Health Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care and allow you to be fully informed before consenting to treatment. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific risk possibilities associated with Chiropractic Care:

Soreness- Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise you doctor if you experience soreness or discomfort.

Soft tissue injury- Occasionally Chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft tissue injury.

Rib injury- Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is preformed carefully to minimize such risk.

Physical Therapy Burns- Heat generated by physical therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or staff member.

Stroke- Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other problems- There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any question concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Date _____ Patient/Parent/Guardian's Signature _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) will be used in this office, and your rights concerning those records. Before any health care operations begin, you must read and sign this consent form, stating that you understand and agree to how your records will be used.

If you would like a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As example, the patient agrees to allow this office to submit requested PHI to his/her health insurance company (or companies) for the purpose of payment. Be assured that this office will limit the release of PHI to the minimum required by insurance companies for payment.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time, or request corrections. The patient may ask which disclosures have been made, and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained once for all subsequent care given in this office.
4. The patient may provide a written request to revoke consent at any time during care. This will not effect the use of those records for prior care, but will apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff in this office have been trained in the area of patient record privacy, and a privacy official has been designated to enforce these procedures. We have taken all possible precautions to assure that your records are not readily available to those who should not have access to them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician has the right to refuse care.

I have read and understand how my Patient Health Information will be used, and I agree to these policies and procedures.

_____

Name of Patient Date