Crossroads Chiropractic CLINIC

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CERTIFIED CHIROPRACTIC EXTREMITY PRACTITIONER
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Contact Information

Title First Name M.I. Last Name

Scheduling Name

Address Line 1

Address Line 2

City

State ZIP Code

Home Phone ( ) –

Work Phone# ( ) –

Cell Phone# ( ) –

Fax ( ) –

E-Mail

Preferred Language

Identification

Gender Occupation

SSN – – Birth Date / / Age

Driver's License# State

Preferred Confidential Contact Method

Home Phone
Cell Phone
Work Phone
Email
Text message

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Spouse

First Name M.I. Last Name

Spouse SSN

Spouse Employer Name

Spouse Phone

Occupation

Spouse's Birth Date / /

Emergency Contact

Name

Phone# ( ) –

Relation

Employer

Name

Address 1

Address 2

City

State ZIP Code:

Work Phone# ( ) –

Referral

Referred by

Title First Name Last Name

Address

City

State ZIP Code

Marital Status

Employment Status

Accident or Injury Date   Sim. Illness Date

Onset / /   / /

Injury Description

Place of Injury

Complaint

Acute/Chronic

Unable to work from / / to / /

Hospitalization from / / to / /

Patient's Condition Related To:

- Another Party Resp.
- Employment
- Other Accident
- Auto Accident

Primary Referred physician

Last, First

Dr. Phone# ( ) —

Date Referred / /   State

Supervising referred physician (WORKER's COMP)

Last, First

Dr. Phone# ( ) —

Date Referred / /   State

Attorney Information

Title/First/Last

Company name

Address

City

State/Zip   ZIP

Fax ( ) —

Contact

1. The symptom(s) that have prompted me to seek care today are: ______________________

____

2. Intensity (How extreme painful are your current symptoms ?

0 ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 10

Absent   Uncomfortable   Agonizing

Quality of symptoms (What does it feel like?)

- ○ Numbness
- ○ Tingling
- ○ Stiffness
- ○ Dull
- ○ Aching
- ○ Cramping
- ○ Nagging
- ○ Sharp
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Stabbing
- ○ Other ______________________

3. Duration and Timing (When did the symptoms start and how often do you feel them?

○ Constant   ○ Comes and goes. How Often? ________

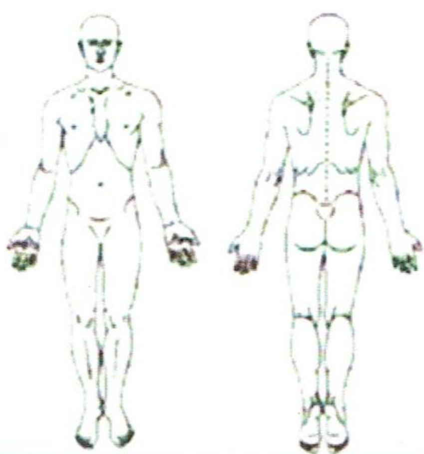
____

4. Have you been treated for this condition before? If so by whom

____

____

Location (Where does it hurt?)
Circle the area(s) on the illustration.
"O" for current condition
"X" for past conditions



ACTIVITIES of DAILY LIVING

How does this condition currently interfere with your ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chairs	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing Stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of cars	○	○	○	○
Driving	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery Shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing yourself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

MEDICATION NAME	Date Started	Strength	Dosage	Frequency taken	Reason
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				

* Do you consent to our office accessing your medication history online? yes or no

VITAMIN NAME	Date Started	Strength	Dosage	Frequency taken	Reason
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				

ALERGIES:

Review of Systems

Musculoskeletal

Had Have ○ ○ Osteoporosis | Had Have ○ ○ Arthritis | Had Have ○ ○ Scoliosis | Had Have ○ ○ Neck Pain | Had Have ○ ○ Back problems | Had Have ○ ○ Hip disorders | none ○

○ ○ Knee injury | ○ ○ Foot/Ankle injury | ○ ○ Shoulder problems | ○ ○ Elbow/Wrist pain | ○ ○ TMJ issues | ○ ○ Poor posture

Please describe ____________________

Neurological

Had Have ○ ○ Anxiety | Had Have ○ ○ Depression | Had Have ○ ○ Headache | Had Have ○ ○ Dizziness | Had Have ○ ○ Pins and Needles | Had Have ○ ○ Numbness | none ○

Please describe ____________________

Cardiovascular

Had Have ○ ○ High blood pressure | Had Have ○ ○ Low blood pressure | Had Have ○ ○ High / low Cholesterol | Had Have ○ ○ Poor Circulation | Had Have ○ ○ Angina | Had Have ○ ○ Bruising | none ○

Please describe ____________________

Respiratory

Had Have ○ ○ Asthma | Had Have ○ ○ Apnea | Had Have ○ ○ Emphysema | Had Have ○ ○ Hay Fever | Had Have ○ ○ Shortness of breath | Had Have ○ ○ Pneumonia | none ○

Please describe ____________________

Digestive

Had Have ○ ○ Anorexia/Bulimia | Had Have ○ ○ Ulcer | Had Have ○ ○ Food sensitivities | Had Have ○ ○ Heartburn | Had Have ○ ○ Constipation | Had Have ○ ○ Diarrhea | none ○

Please describe ____________________

Sensory

Had Have ○ ○ Blurred vision | Had Have ○ ○ Ringing in ears | Had Have ○ ○ Hearing loss | Had Have ○ ○ Chronic ear infections | Had Have ○ ○ Loss of smell | Had Have ○ ○ Loss of taste | none ○

Please describe ____________________

Integumentary (skin)

Had Have ○ ○ Skin cancer | Had Have ○ ○ Psoriasis | Had Have ○ ○ Eczema | Had Have ○ ○ Acne | Had Have ○ ○ Hair loss | Had Have ○ ○ Rash | none ○

Please describe ____________________

Endocrine

Had Have ○ ○ Thyroid issues Hypo Hyper | Had Have ○ ○ Immune Disorders | Had Have ○ ○ Hypoglycemia ○ ○ Diabetes | Had Have ○ ○ Frequent Infection | Had Have ○ ○ Swollen Glands | Had Have ○ ○ Low energy | none ○

Please describe ____________________

Genitourinary

Had Have ○ ○ Kidney Stones | Had Have ○ ○ Infertility | Had Have ○ ○ Bedwetting | Had Have ○ ○ Prostate Issues | Had Have ○ ○ Erectile Dysfunction | Had Have ○ ○ PMS | none ○

Please describe ____________________

Constitutional

Had Have ○ ○ Fainting | Had Have ○ ○ Low Libido | Had Have ○ ○ Poor Appetite | Had Have ○ ○ Fatigue | Had Have ○ ○ Sudden Weight Loss/Gain | Had Have ○ ○ Weakness | none ○

Please describe ____________________

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries illnesses and operations.

PERSONAL

Illnesses

Check the illness you have *Had* in the past or *Have* now

HAD	HAS	
O	O	AIDS
O	O	Alcoholism
O	O	Allergies
O	O	Arteriosclerosis
O	O	Cancer
O	O	Diabetes
O	O	Epilepsy
O	O	Glaucoma
O	O	Goiter
O	O	Gout
O	O	Heart Disease
O	O	Hepatitis
O	O	HIV Positive
O	O	Malaria
O	O	Measles
O	O	Multiple Sclerosis
O	O	Mumps
O	O	Polio
O	O	Rheumatic Fever
O	O	Scarlet Fever
O	O	STD
O	O	Stroke
O	O	Tuberculosis
O	O	Typhoid Fever
O	O	Ulcers

Injuries/Accidents

- ○ Had fracture or broken bones? ______________________
- ○ Have spine or nerve disorder? ______________________
- ○ Been knocked unconscious? ______________________
- ○ Been involved in an auto accident? ______________________
- ○ Have suffered from sprained ankles or knee injuries ______________________

Operations

- ○ Appendectomy
- ○ Gastric bypass
- ○ Gastric banding
- ○ Breast augmentation
- ○ Eye Surgery
- ○ Hysterectomy
- ○ Pacemaker implant
- ○ Tonsilectomy
- ○ Hernia repair
- ○ Joint replacement: ______________________
- ○ Spinal Surgery: Level? ______________________
- ○ Other ______________________

Treatments

Check the ones that you have received in the past or are currently receiving

If so, what were your being treated for? ______________________

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth Control pills
○	○	Blood Transfusions
○	○	Chemotherapy
○	○	Chiropractic Care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone Replacement
○	○	Inhaler
○	○	Massage Therapy
○	○	Physical Therapy
○	○	Nutritional supplements
○	○	Radiation treatments
○	○	Orthotics
○	○	Crutches or other support devices
○	○	Used neck or lumbar braces
○	○	Received tattoo within last 6 months
○	○	Had a body peircing within last 6 months

Family History

Some health issues are hereditary. Tell Dr. Airhart about the health of your immediate family members.

FAMILY

Relative	Age (If living)	Quality of health: Good	Poor	Illnesses	Age at death	Cause of death: Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
		○	○			○	○

Are there any hereditary issue that you know about? ______________________

Social History

Tell Dr. Airhart about your health habits and stress level.

SOCIAL

Alcohol use	O Daily	O Weekly	How much? ____________
Coffee use	O Daily	O Weekly	How Much? ____________
Tobacco use	O Daily	O Weekly	O Never
	O Quit? How long ago? ____________		
Exercising	O Daily	O Weekly	How Much? ____________
Pain Relievers	O Daily	O Weekly	How Much? ____________
Soft Drinks	O Daily	O Weekly	How Much? ____________
Hobbies			

Prayer or Meditation	O YES	O NO
Job pressure/Stress	O YES	O NO
Vaccinated?	O YES	O NO
Mercury Fillings	O YES	O NO
Recreational Drugs?	O YES	O NO

INSURANCE INFORMATION

Primary Responsible

Carrier:			
Policy:			
Relation to Insured:		Group# or Medicaid#:	
Last/First/Middle:		Insured ID #:	
Address:		Insurance Plan Name:	
		Employer/School:	
City/State/Zip:		Policy #:	
Home/Work Phone:			
SSN/Gender:			
Birth Date:			

Secondary Responsible

Carrier:			
Policy:			
Relation to Insured:		Group# or Medicaid#:	
Last/First/Middle:		Insured ID #:	
Address:		Insurance Plan Name:	
		Employer/School:	
City/State/Zip:			
Home/Work Phone:			
SSN/Gender:			
Birth Date:			

MY FINANCIAL RESPONSIBILITY

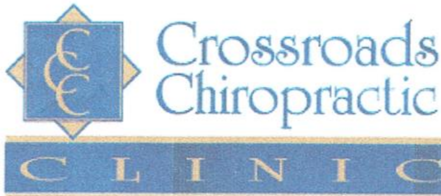
I understand that I am personally **financially responsible** for all services not covered by insurance. Examples: TENS pads ($10), Kristi's services ($40 for ½ hour, $70 for 1 hour). I am also responsible for applicable annual deductibles and/or copayments.

Signature: ______________________________ Date: ____________________

Assignment of Benefits

☐ Initials

I certify that I and/or my dependent(s) have insurance coverage with the aforementioned insurance companies and assign to Dr. Airhart all insurance health benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance companies. I authorize the use of my signature on all insurance submissions. Dr. Airhart may use myhealth care information and disclose any such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable fopr related services.



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C L I N I C

PATIENT FINANCIAL RESPONSIBILITY

This office will provide insurance billing services for you, if you so desire, as a courtesy. **Remember that you are ultimately responsible for any charges incurred in this office. It is your legal responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier at the time of your visit. Your signature on this document indicates that you agree to pay for any outstanding charges incurred in this office.**

We will strive to work out feasible payment options for anyone who is in need of care. Unless other prior written agreements have been made, any outstanding balance more than 60 days old is considered delinquent. A re-billing fee of **1%**, (based on the outstanding balance, per month) will also be added to all accounts that fit this criterion. Office policy dictates that delinquent accounts may be referred to Accounts Receivable Consultants, Inc for collection which may include possible blemishes on your credit record.

In the event that the charges are not paid in full when due and collection activity is instituted, whether by a collection agency or an attorney (or both), I agree to be responsible for and pay in addition to the charges for services and treatment received, all costs reasonably associated with such collection activity including, but not limited to, reasonable collection fees, attorney's fees, skip tracing costs, and court costs.

*I authorize payment of insurance benefits directly to **Crossroads Chiropractic Clinic**. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, collection agencies, and payers to secure the payment of benefits or inform them of concurrent treatment. By signing below I indicate that I have read, understand, and agree with the terms on this page.*

____ ________________
Signature of responsible party (Parent or Legal Guardian) Date

____
Printed name of responsible party (Parent or Legal Guardian)

____ ________________
Signature of Witness Date

INFORMED CONSENT

Patient Name:____ Date:_______________

As a patient in my office, you have the legal right to know of the type of treatment we will use, any complications/side-effects, as well as alternatives to chiropractic care and their complications. This form is intended to inform you of these, and treatment will not be given until you understand these issues and signify your consent by signing this form.

The primary treatment used by doctors of chiropractic is the **spinal adjustment** to reduce spinal subluxations (slight dislocations or misalignments of the spinal joints). I will use that procedure to treat you as well as use other common ancillary treatments such as physical therapies and modalities.

The Nature of the Chiropractic Adjustment: I will use my hands upon your spine or other joints in such a way as to move the joints to restore normal function. This procedure may cause an audible "pop" or "click" similar to what you feel when you pop your knuckles. You may feel or sense movement of the joint, and this usually gives you a very pleasant sense of relief. If a traditional spinal adjustment is inappropriate for your condition, other less forceful and gentler non-traditional types of adjustments that may be used. If, from previous experiences, you prefer non-traditional types of spinal adjustments, please inform me beforehand.

The Material Risks Inherent in a Chiropractic Adjustment: Serious complications to chiropractic treatment are rare; however, these may include fractures, disc injuries, dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some patients will feel some stiffness or soreness following the first few days of treatment, which is considered normal.

The Probability of Those Risks Occurring: Fractures, especially of the ribs, are rare occurrences and generally result from some underlying weakness of the bone such as osteoporosis. If you suffer from osteoporosis, we will take special efforts to adjust your spine carefully. In rare instances, manipulation of the neck has been associated with injuries to the arteries in the neck leading to a stroke. Studies have estimated this occurrence rate to be between 1 in 20,000 and 1 in 1.3 million adjustments. While the actual rate of occurrence is unknown, it is probably somewhere in this range. Mortality from spinal adjustments is extremely rare, but has been known to occur. Chiropractic treatments of disc injuries are frequently successful, yet occasionally they may aggravate the problem and surgery may be necessary to treat the disc.

Ancillary Treatments: In addition to chiropractic adjustments, I intend to use the following treatments if necessary:

Ice or hot packs: We may use both heat and ice packs, and recommend ice for home use. Both may, in rare instances, irritate or bum your skin even if used appropriately.
Electro-therapy: This modality consists of a mild electrical current which sends a message-type action through the muscles and nerves to relax constricted muscles, to block pain impulses, to reduce swelling and to facilitate healing in muscles and ligaments. There are no known side effects.
Ultrasound: an inaudible, acoustic vibration of high frequency that produces a thermal and non-thermal (mechanical) effect to facilitate healing. Although ultrasound is a relatively safe modality, osseous burns may occur.
Acupuncture: the application of needles to effected areas to control pain and improve overall function. In rare instances irritation and soreness may appear at the insertion points. Also, though rarely, infections may also occur at needling sight.
Diathermy: is the application of high frequency electromagnet energy that is primarily used to generate heat in body tissue. In rare instances, irritation or bums may occur even if used appropriately.
Soft Tissue Mobilization: the process in where the doctor applies pressure over areas of irritated muscles. Bruising may occur even when care is taken to prevent it or due to vascular fragility.