

New Patient Consultation

Date _____

Patient _____ Doctor _____

Accident? Yes No Type: AC PI WC Other _____

Reason for visit: _____

Date symptoms started: _____

Symptoms getting worse? Yes No Same

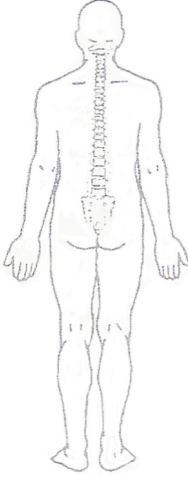
Pain Classification: Constant Intermittent Occasional
 AM PM Before Activity After Activity

Pain Type: Slight Mild Moderate Severe Burning
 Sharp Throbbing Tingling Dull Aching
 Shooting Cramping Stiffness Swelling
 Numbness Stabbing Other _____

Pain Interferes with: Sleep Daily Routine Work Recreation

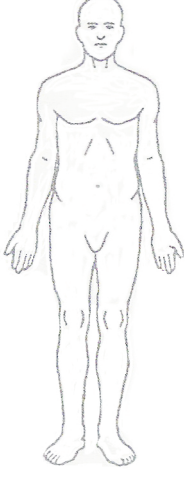
Severity of Pain
List region of pain and circle severity number. (1 = least, 10 = greatest)

Mark Pain Region
Burning • Stabbing • Sharp • Constant
Ex. Neck 1 2 3 4 5 6 7 8 9 10



Mark Pain Area
+++ = Burning
000 = Stabbing
--- = Sharp
||| = Constant
XXX = Other

Mark Area
A = Ache
N = Numbness
P = Pain
S = Soreness
SF = Stiffness
T = Tingling



Neck	1	2	3	4	5	6	7	8	9	10
Mid Back	1	2	3	4	5	6	7	8	9	10
Low Back	1	2	3	4	5	6	7	8	9	10
Hips	1	2	3	4	5	6	7	8	9	10
Arms	1	2	3	4	5	6	7	8	9	10
Legs	1	2	3	4	5	6	7	8	9	10

Please mark area of pain on the drawing using the code listed above.

Helps	Position	Hurts
<input type="checkbox"/>	Bending Backward	<input type="checkbox"/>
<input type="checkbox"/>	Bending Forward	<input type="checkbox"/>
<input type="checkbox"/>	Bending Leg R L B	<input type="checkbox"/>
<input type="checkbox"/>	Driving	<input type="checkbox"/>
<input type="checkbox"/>	Lifting	<input type="checkbox"/>
<input type="checkbox"/>	Lying Face Down	<input type="checkbox"/>
<input type="checkbox"/>	Lying on Back	<input type="checkbox"/>
<input type="checkbox"/>	Lying on Side	<input type="checkbox"/>
<input type="checkbox"/>	Sitting	<input type="checkbox"/>
<input type="checkbox"/>	Standing	<input type="checkbox"/>
<input type="checkbox"/>	Stretching	<input type="checkbox"/>
<input type="checkbox"/>	Stretching Leg R L B	<input type="checkbox"/>
<input type="checkbox"/>	Turning Body	<input type="checkbox"/>
<input type="checkbox"/>	Turning Head R L B	<input type="checkbox"/>
<input type="checkbox"/>	Walking	<input type="checkbox"/>
<input type="checkbox"/>	Other: Describe:	<input type="checkbox"/>

Patient Symptoms _____

Organic or Visceral Symptoms _____

Position of Pain _____

Duration of Condition _____

Hereditary Possibilities _____

Previous Surgery, Falls, Accidents _____

Names of Doctors _____

Previous Diagnosis _____

Past Treatment _____

Medications _____

Length of Treatment _____

Which of the following activities cause you difficulty or pain?

- | | | | |
|---|--|-----------------------------------|--|
| <input type="checkbox"/> Bending backward | <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Pushing | <input type="checkbox"/> Kneeling |
| <input type="checkbox"/> Bending forward | <input type="checkbox"/> Getting in/out of car | <input type="checkbox"/> Pulling | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Turning over in bed | <input type="checkbox"/> Reaching | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Climbing | <input type="checkbox"/> Lying flat on stomach | <input type="checkbox"/> Stooping | <input type="checkbox"/> Standing for periods over one |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Lying on back | <input type="checkbox"/> Gripping | hour |
| <input type="checkbox"/> Dressing self | <input type="checkbox"/> Lying on side with knees bent | <input type="checkbox"/> Sitting | <input type="checkbox"/> Other _____ |

Fill out the next three sections as they apply to you:

Neck Pain

If you have a neck injury, does it affect (circle all that apply) hearing vision balance cause ringing in your ears

Do you hear grating sounds? Yes No Do you feel pressure or pain behind your eyes? Yes No

Do you feel ripping or tearing? Yes No If yes, where? _____

Do you have difficulty turning or lifting your head? Yes No If yes, in which direction? Right Left Up Down

Lower Back Pain

Do you ever experience ripping or tearing sensations in your back? Yes No If yes, where? _____

Does pain radiate to the abdomen? Yes No

Do you ever have impairment of bowel or urinary function? Yes No If yes, explain: _____

Headaches

Do you have a family history of headaches? Yes No Do you get headaches? Yes No If yes, how often? _____

Do you experience any of the following with your headaches: Pain or cracking in your jaw? Yes No

Abnormal blood pressure? Yes No If yes, High Low Nausea, vomiting or visual disturbances? Yes No

When was your last eye exam by a doctor? 1-6 months 6-12 months 1-2 years over 2 years Results: _____

If female, are you pregnant? Yes No Not Sure If yes, when is your due date? _____

List all medications you are taking now, including over-the-counter: _____

Are you allergic to any medications? Yes No Not Sure If yes, please list: _____

Have you ever been hospitalized or had surgery? Yes No If yes, please list: _____

Type of hospitalization/surgery: _____	Date: _____	Type of hospitalization/surgery: _____	Date: _____
_____	_____	_____	_____
_____	_____	_____	_____

Have you been x-rayed in the last 12 months? Yes No If yes, when? _____

Have you ever been seen by a chiropractor before? Yes No If yes, please list below:

Name of Chiropractor: _____	Dates: _____	Name of Chiropractor: _____	Dates: _____
_____	_____	_____	_____

Do you have a family physician? Yes No If yes, doctor's name: _____ Phone: _____

Address: _____ City/State/Zip: _____

Additional Complaints

Please check all additional complaints that you have at this time:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Neck Pain
<input type="checkbox"/> Neck Stiffness
<input type="checkbox"/> Neck Motion Restricted
<input type="checkbox"/> Upper Back Stiffness/Pain
<input type="checkbox"/> Mid-Back Stiffness/Pain
<input type="checkbox"/> Lower Back Stiffness/Pain
<input type="checkbox"/> Shoulder Pain Right/Left
<input type="checkbox"/> Arm Pain Right/Left
<input type="checkbox"/> Leg Pain Right/Left
<input type="checkbox"/> Pins & Needles Arms/Legs
<input type="checkbox"/> Headache
<input type="checkbox"/> Loss of Concentration
<input type="checkbox"/> Heavy Feeling of Head
<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Ringing in Ears
<input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Loss of Smell
<input type="checkbox"/> Loss of Taste
<input type="checkbox"/> Eyes Sensitive to Light
<input type="checkbox"/> Pain Behind Eyes
<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Fainting
<input type="checkbox"/> Palpitation
<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Irritable
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Depression
<input type="checkbox"/> Insomnia
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Flushed Face
<input type="checkbox"/> Excess Perspiration | <input type="checkbox"/> Digestive Trouble
<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Constipation
<input type="checkbox"/> Cold Hands
<input type="checkbox"/> Cold Feet
<input type="checkbox"/> Jaw Pain
<input type="checkbox"/> Cancer
<input type="checkbox"/> Hypertension
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Convulsion
<input type="checkbox"/> Allergies (Please List) _____

_____ | <input type="checkbox"/> Anemia
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Arthritis
<input type="checkbox"/> HIV (Aids)
<input type="checkbox"/> Other (Please List) _____

Please Specify Location:

Numbness _____
Swelling _____
Cuts _____
Bleeding _____
Broken Bones _____
Bruising _____ |
|---|--|--|--|

Do you have, or have you ever had, any diseases or medical problems not listed? Yes No If yes, please list: _____

Is there anything else you would like the doctor to know about before beginning care at Advanced Back and Neck? _____

Personal History

Name: _____	Circle One: Married Single Widowed Divorced Separated
Address: _____	Spouse's Name: _____
City/State/Zip: _____	Spouse's Employer: _____
Home Phone: _____	Spouse's Type of Work: _____
E-Mail: _____	Spouse's Social Security #: _____
Birthday: _____ Age _____ Gender F M	Spouse's Business Phone: _____
Social Security #: _____	Name & Ages of Children: _____
Employer: _____	_____
Business Phone: _____	Referred By: _____
Type of Work: _____	
Emergency Contact Name and Phone #: _____ Relationship: _____	
Who is responsible for your bill? You and Spouse Worker's Comp Auto Insurance Medicare Medicaid	
Health Insurance Company: _____ ID# _____	

With all the resources at our disposal to make dramatic improvements in our patient's health, to make appropriate recommendations based on your health goals, we need to know the following:

On a scale of 1-10 with 10 being the highest, how would you rate your health as a priority in life? _____

What is your commitment level (1-10) to making the necessary changes to reach your health goal? _____

With regard to quality of life, lifestyle, sports, hobbies, activity level, etc., What would you most like to see improve? _____

Informed Consent

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. 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 treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

I hereby authorize physicians and staff at Arizona Back and Neck Care to treat my condition as deemed appropriate. It is understood and agreed the amount paid the doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time. 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 staff member of Arizona Back and Neck Care responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as many 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 advised about the potential risks related to your care to 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 your 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 performed carefully to minimize such risk.

Physical Therapy Burns - Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but if it occurs you should report it to your doctor or a staff member at Arizona Back and Neck Care.

Stroke - Stroke is the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol. 37, No2, June, 1993) estimate that the incidence of this type of stroke is 1 in every 3 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 questions 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.

Patient Signature

Date

Parent/Legal Guardian Signature

Date



INSURANCE INFO & CANCELATION POLICY

Date: _____ / _____ / _____

Patient Name _____

Policy Holder Name _____

Policy Holder Date of Birth ____/____/____

Address (City, State, Zip) _____

Phone#s _____ () _____ / _____ () _____

Secondary Insurance? Yes No

Insurance Carrier: _____

ID# _____ Group# _____

Hour massage appointments are subject to our 24 hour cancelation policy. In the event you fail to cancel within 24 hours, or do not show up for a scheduled appointment, you will be subject to a \$15.00 fee. This fee goes directly to the therapist and may be paid in cash, check, or credit card.

Patient Signature

Date