Confidential Health Information:
Care Chiropractic 134 Executive Drive #3
Lafayette IN 47905
(765) 448-6489

_____
Patient Number
____/_____/_____
Today's Date

_____ _____ ___/_____/___ _____
Last Name Social Security Number Birthdate Age

_____ _____ Male_____Female
First Name Middle Name (Initial) Gender

_____ Married Single Divorced Widowed
Address Marital Status

_____ _____ _____ _____
City State Zip Code Email

_____ _____ _____
Home Phone Cell Phone Best time and place to reach you

Would you like to receive appointment reminders by **email** or **text** ? Cell Carrier: _____

_____ _____
Employer Occupation

_____ _____
Spouses Name Whom may we thank for referring you ?

_____ _____ ___/___/___
Insurance Carrier Insured's Last Name Birth Date

_____ _____ Self____Spouse___Parent
Member ID Number Group Number Who carries this policy?

If you are covered by additional insurance please indicate : _____

Assignment and Release
I certify that I, and /or my dependent(s) have insurance coverage with _____
And assign directly to Care Chiropractic / Williams Chiropractic Corporation all insurance 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 insurance. I authorize the use of my signature on all insurance submissions. The above named clinic may use my health care information and may disclose such information to the above named insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

_____ _____
Signature of Patient, Parent, Guardian, Representative Relationship to Patient

_____ _____
Printed Name of Patient, Parent, Guardian, Representative Date

30 Day Pain & Function Form #_____

Name: _____ Date: _____

1. Where does it hurt and how bad? (0 no pain, 10 is worst possible pain)

Neck-Shoulder:	Right	Left	0	1	2	3	4	5	6	7	8	9	10
Middle Back:	Right	Left	0	1	2	3	4	5	6	7	8	9	10
Lower Back/Hip:	Right	Left	0	1	2	3	4	5	6	7	8	9	10
_____ other	Right	Left	0	1	2	3	4	5	6	7	8	9	10

2. When did the most recent episode begin and why ?_____

_____

3. What does the pain feel like? Burn Ache Spasm Tight Numb _____ other

4. For each item below, please circle the number which most closely describes your condition right now. Please do not leave any blank. Circle 0 if it does not apply to you.

0= No Pain 1= Mild Pain 2= Moderate Pain 3= Severe Pain 4= Worst Possible Pain

Pain Intensity Overall	0	1	2	3	4
Sleeping (Laying down)	0	1	2	3	4
Personal Care (washing, dressing, etc.)	0	1	2	3	4
Travel (driving, sitting)	0	1	2	3	4
Work (includes house / yard work)	0	1	2	3	4
Recreation	0	1	2	3	4
Lifting	0	1	2	3	4
Walking	0	1	2	3	4
Standing	0	1	2	3	4

5. What percentage of the day are you in pain? None 25% 50% 75% 100%

6. Please Check any other issues you are having:

	Going up and down stairs		Bending over
	Reaching up		Going from sitting to standing
	Rolling over in bed		Looking over a shoulder
	Caring for your family		other: _____

Notes:

Review of Systems (This form helps us understand your overall health status)

Name: _____ # _____ Date _____

Please check if you have had any of the following:

	Acid Reflux /HeartBurn		AIDS/HIV		Alcoholism
	Alzhiemers		Anemia		Angina
	Anxiety		Apnea (Sleep)		Arthritis
	Asthma		Blurred Vision		Breast Lump
	Broken Bones		Cancer		Chemical Dependency
	Chest Pain		Chronic Ear Infection		Concussion
	COPD / Emphysema		Depression		Diabetes
	Dizziness		Epilepsy		Erectile Dysfunction
	Fainting		Fever / Chills		Frequent Infection
	Gout		Headache (Frequent)		Heart Disease
	Hepatitis		Herniated Disc		High/Low Blood Pressure
	High Cholesterol		High Triglycerides		Jaw Pain
	Kidney Disease / Stones		Liver Disease		Loss of Smell
	Loss of Taste		Migraine Headaches		Multiple Sclerosis
	Nausea / Vomiting		Night Sweats / Chills		Numbness
	Osteoporosis		Pacemaker		Parkinson's Disease
	PMS Symptoms		Polio		Poor Circulation
	Poor Posture		Prostate Problems		Psoriasis
	Rash		Rheumatoid Arthritis		Ringing In The Ears
	Scoliosis		Sexual Disease		Shortness of Breath
	Skin Cancer		Stroke / Heart Attack		Suicide Attempt
	Thyroid Problems		Tongue / Lip Tie		Tuberculosis
	Ulcers		Unexplained Bleeding		Unexplained Lumps
	Rapid Weight Change		Weakness		

Use this space to let us know anything else you feel is important to your health history:

_____

Additional Information

1. Please check any that apply:

	I am a smoker		I have had a broken bone
	I exercise three or more times per week		I have been knocked unconscious
	I take pain relievers at least once per week		I have been in a car, work or other accident

2. Please list any surgeries you have had: _____

_____

_____

3. Please list (or provide a list) of any medications you are currently on: _____

_____

_____

_____(Use the back of this page if necessary)

4. Is there anything else you would like to discuss with us today ?

_____

_____

_____

Acknowledgements

Name: _____Date: _____ #_____

Acknowledgements:

- ☐ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
- ☐ I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YY): _____
- ☐ I understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient:_____
Signature: _____ Date: _____

Parent or Guardian: _____
Signature: _____ Date:_____

Witness Name: _____
Signature: _____ Date:_____