INTRODUCTION - PATIENT INFORMATION

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First MI)_____ **Preferred Name**: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home: _____ **Mobile:** _____ **Mobile Carrier:** ☐ AT&T ☐ Verizon ☐ Sprint ☐ T-Mobile ☐ Other_____

Work:_____ **Email:** _____ **Date of Birth:**_____

Social Security #:_____ **Gender:** ☐ M ☐ F **Marital Status**: ☐ Married ☐ Single ☐ Other

Student Status: ☐ Full Time ☐ Part Time ☐ Non-Student **Spouse Name:**_____ **# of Kids:** _____

Employer: _____ **Are you:** ☐ Police ☐ Fire ☐ EMS ☐ Military/Vet ☐ Full time clergy

How did you hear about our office? _____

EMERGENCY CONTACT INFORMATION

Full Name: _____ **Primary Care Physician:** _____

Home Phone: _____ **Mobile:** _____ **Doctor's Phone:** _____

Relationship: ☐ Child ☐ Parent ☐ Spouse ☐ Other: _____

FINANCIAL INFORMATION

☐ Insurance ☐ Worker's Comp ☐ Self-Pay (Cash) ☐ Personal Injury/Auto ☐ Other (please explain):_____

PRIMARY HEALTH INSURANCE

Insurance Name: _____

Relation to Insured: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other

If Other than Self:
Insured's Name: _____ **Gender:** ☐ M ☐ F

Phone: _____ **Date of Birth:** _____

SECONDARY HEALTH INSURANCE

Insurance Name: _____

Relation to Insured: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other

If Other than Self:
Insured's Name: _____ **Gender:** ☐ M ☐ F

Phone: _____ **Date of Birth:** _____

Who is responsible for payment? Self / Other - *(Relationship)* _____

If Other than Self:
Full Name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

For the CURRENT condition, have you:

- **Received any other treatment?** ☐ None ☐ DC ☐ MD ☐ PT ☐ Massage ☐ ER ☐ Other: _____
  - **If yes - Where?**_____
- **Had any previous Surgery or Interventions in this area?** *(Describe)*_____
- **Taken any Medications?** _____
- **Had any diagnostic testing?** ☐ X-rays ☐ MRI ☐ CT ☐ Other: _____
  - **If yes - When and Where?** _____
- **Describe any Other Complaints:**_____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

PEDIATRIC CONSULTATION

Child's Name _____ **Date**_____

The majority of children have experienced hundreds of impacts that could cause vertebrae to become misaligned or subluxated. What we need to do now is discover several of the traumas your child has suffered.

What was your child's birth like? ☐**Easy** ☐**Stressful** ☐**Complicated** ☐**Surgical**

How long was the entire labor? _____**How long did you actually push for?** _____
Were you induced? ☐**Yes** ☐**No** **Nerve block?** ☐**Yes** ☐**No** **C- Section?** ☐**Yes** ☐**No**
Was there any pulling on the head? ☐**Yes** ☐**No** ☐**Mid-wife** ☐**OBGYN** ☐**Forceps or vacuum extraction**

Science has shown that 47% of all children fall on their heads by the age of one and have at least 200 major falls by the age of 5 years old.

When was your child's most recent fall? _____
Was any care given? ☐**Yes** ☐**No** **Was he/she checked by a chiropractor?** ☐**Yes** ☐**No**

Major falls before that? _____
Any care given? Yes No Chiropractic adjustment given? ☐**Yes** ☐**No**

What sports or recreational activities does your child do? _____

When was your child's most recent stress, strain, or injury while doing these activities? _____

Has your child ever been involved in a motor vehicle accident as a passenger? ☐**Yes** ☐**No**

Briefly describe When / Details _____
_____
Child seat? ☐**Yes** ☐**No** **Seat belt?** ☐**Yes** ☐**No** **Where in the car were they sitting?**_____
Was care given? ☐**Yes** ☐**No** **Chiropractic adjustment?** ☐**Yes** ☐**No**

This information is important. Thank you for explaining your child's history of accidents and traumas. This will help the doctor better understand where the spine is damaged or subluxated. What we need to do now is ask you a few questions regarding your child's current health concerns.

Does your child have any health concerns? ☐ **Yes** ☐ **No** **If yes, What are they?** _____
_____
If yes, how long have they been present for?_____

Subluxated vertebra can cause irritation to nerve fibers affecting organs and tissue leading to sickness and illness.

Depending on where and the degree of the subluxated vertebra, nerve pressure can be constant or occasional.
How often does your child have this condition(s)? _____
Does your child take multi-vitamins regularly? ☐**Yes** ☐**No**
What other supplements does your child take? _____

Please list all medications your child takes: _____

Signature Parent or Guardian:_____ **Date:**_____

Thrive Chiropractic Group
Our mission is to improve the health of families

Are you *currently* experiencing any of these symptoms? *(Check all the apply)*
Many of the following conditions respond to Chiropractic adjustments.

General: *(constitutional)*
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems _____
- ☐ Leg Problems _____
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones_____
- ☐ Other: _____
- ☐ *None in this Category*

Neurological:
- ☐ Numbness or tingling sensations
- ☐ Loss of Feeling
- ☐ Dizziness or light headed
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Have you ever had a head injury?
- ☐ Ever been in an auto accident?
- ☐ Other: _____
- ☐ *None in this Category*

Mind/Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____
- ☐ *None in this Category*

Genitourinary:
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/strain w Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: _____
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains
- ☐ Rapid or Heartbeat changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ Other: _____
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other: _____
- ☐ *None in this Category*

Eyes and Vision:
- ☐ Wear contacts/glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other: _____
- ☐ *None in this Category*

Ears, Nose and Throat:
- ☐ Bleeding gums / mouth sores
- ☐ Bad Breath or bad taste
- ☐ Dental Problems
- ☐ Swollen throat or voice change
- ☐ Swollen glands in neck
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Sinus / Allergy problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other: _____
- ☐ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive Thirst or urination
- ☐ Cold Extremities
- ☐ Heat or Cold intolerance
- ☐ Change in hat or glove size
- ☐ Dry skin
- ☐ Glandular or hormone problem
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other: _____
- ☐ *None in this Category*

Skin and Breasts:
- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change of appearance of a mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other: _____
- ☐ *None in this Category*

Women Only:

Are you pregnant?
- ☐ **Yes -** ***Due Date*** ___/____/____
- ☐ **No -** ***Last Menstrual*** ___/____/____
- ☐ Infertility
- ☐ Painful or Irregular periods
- ☐ Vaginal Discharge
- ☐ Other: _____
- ☐ *None in this Category*

Pregnancies with Outcome | Date:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Comments: _____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date_____

Treating Doctor Signature _____ Date_____

Consents

Consent to Bill/Collect Insurance: I consent, if I am using a third party for payment of my services (health insurance, auto accident insurance, worker's compensation insurance, Parent/Guardian, etc), to allow Thrive Chiropractic Group to submit all necessary information needed to receive payment for the services I received to these third parties. I further consent to accept assignment of payments from my insurance company to be paid directly to the clinic or doctor. I also consent to allow Thrive Chiropractic Group to retrieve my insurance benefits. If my case is an auto accident, this would include coverage amounts for the accident as well as medpay/UIM coverage and/or canceled checks proving payment was provided. I understand that I am fully responsible for any balance for services rendered. I also understand that if payment is denied by the above-mentioned parties, I will be personally responsible for the full amount charged for all services rendered.

Consent to Examination and Treatment: I give the doctors and staff of Thrive Chiropractic Group permission to perform all examinations, x-rays, and treatment deemed necessary by the doctor. I understand that some of these procedures may be performed by either the staff or the doctor.

Consent to Retrieve Medical Records: I give the doctors and staff of Thrive Chiropractic Group permission to obtain any and all medical records from other providers, offices or hospitals which may assist with my care.

HIPAA: A copy of the full Health Information Privacy Policy for our clinic can be requested at our front desk. In brief, it states that we will not give any information about you except as consented to above. The only people we give information to are parents/guardians (if you are a minor) or whomever is responsible for your bill (i.e. insurance company, third party, or attorney if you have one). Please list anyone else you'd like to have access to your records:_____

Clinical Summary Report (CCR): I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Thrive Chiropractic Group to save these electronically for me and not print them out after each visit. I understand that, upon written request, these reports are available to be printed or emailed to me for review within 72 hours.

Public Display of Reviews: I understand that, if I leave a text or video review for Thrive Chiropractic Group, that they may display this review on-line in a public forum. I give permission for Thrive Chiropractic Group to utilize my video or text review in their digital and on-line marketing campaign. By signing below, I consent to the public use of reviews for Thrive Chiropractic.

Patient/Guardian Name (Print)	Patient/Guardian Name (Sign)	Date

Informed Consent: As part of your initial evaluation, we will be taking a history, performing an examination, and may need to take x-rays to have a full understanding of your condition. The chiropractic care offered at our office involves a chiropractic adjustment (generally performed by hand or by instrument). There may be supportive procedures or recommendations such as mechanical traction, stretching, bracing, orthotics or any others that the doctor believes would benefit your condition. You understand, as with all health care approaches, results are not guaranteed. There are some risks to care including discomfort, spasms, or even potential worsening of the condition. Severe, but rare risks include fracture, arterial dissection or stroke. The odds of a stroke occurring during an adjustment are rated at approximately 1 in 4,000,000. There are also other treatment options available such as pain medication, muscle relaxers, physical therapy, bracing, injections or surgery. You always have the right to a second opinion for your health. By signing below, I have read and understand the informed consent and am requesting care from this office.

Patient/Guardian Name (Print)	Patient/Guardian Name (Sign)	Date

Pregnancy Waiver (Women Only): By my signature below, I am stating that to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this time.

Patient/Guardian Name (Print)	Patient/Guardian Name (Sign)	Date