

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:** _____

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: _____

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.

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).

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.

By signing below, I consent to the above for Thrive Chiropractic Group.

Patient/Guardian Name (Print)

Patient/Guardian (Sign)

Date

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 online in a public forum. I give permission for Thrive Chiropractic Group to utilize my picture, video, or text review in their digital and online marketing campaign.

Patient/Guardian Name (Print)

Patient/Guardian (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 (Sign)

Date