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

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). 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 the public use of reviews for Thrive Chiropractic Group.

Patient/Guardian Name (Print)	Patient/Guardian (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 (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

Thrive Chiropractic Group - Health Questionnaire

Name: _____ **Date:** _____

1. Many patients are referred to our office by a family member, friend or co-worker. Who or what made you decide to visit our office?

_____

2. Science tells us your spine, like your teeth, needs to be cared for regularly.
How often do you get adjusted by a chiropractor? ☐ **Frequently** ☐ ____ **times per month** ☐ **Only when I hurt** ☐ **Never**

3. When was your last complete spinal examination including x-rays? _____ ☐ **Never**

4. Do you know if you have: ☐**spinal curvature** ☐ **spinal arthritis** ☐ **Family history of spinal problems**

5. Over time spinal misalignments will cause arthritis and degeneration which results in a loss of nerve health and often grinding or cracking to be heard when you move your neck or back. Do you hear these sounds when you move? ☐**Yes** ☐**No**

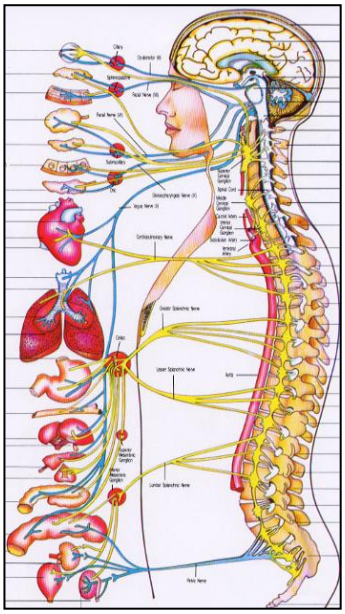
6. If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, or crack your neck or back. Do you often feel the need to crack or pop your neck, mid-back or lower back? ☐**Yes** ☐**No**

7. Poor posture has been shown to lead to poor health and reduced life span.
How would you rate your posture? Poor 1 2 3 4 5 6 7 8 9 10 Excellent :_____

8. Stress causes your spine to misalign and accelerates spinal damage. Rate your stress level over the last 3 months. None 1 2 3 4 5 6 7 8 9 10 Intense :_____

9. Please mark any health issues you are experiencing. Mark L/R if worse on one side

☐ Leg pain/numb ○L ○R	☐ Neck pain ○L ○R	☐ Heart Disease	☐ Thyroid
☐ Mid-back pain ○L ○R	☐ Asthma	☐ Cancer	☐ Allergies
☐ Low-back pain ○L ○R	☐ Headaches/Migraines	☐ Constipation	☐ Other:_____
☐ Arm pain/numb ○L ○R	☐ Diabetes ○I ○II	☐ Menstrual pain	_____



10. Though sometimes necessary, prescription medications can cause various side effects, hide the severity of health problems, and hinder the body's ability to heal. What medications are you currently taking?_____
_____

11. Please list any surgeries (include year) you have had._____
_____

12. Do You Smoke? ☐**Yes** ☐ **No**

13. (Women Only) Spinal health is vitally important to ensure you and your baby are healthy.
Is there a chance you are pregnant? ☐**Yes** ☐**No**

14. Daily trauma, auto accident(s), and work injuries can cause misalignment of vertebrae and serious spinal problems.
When was your most recent injury: At home?_____ **Car accident?** _____
Slip or fall?_____ **Other?** _____

15. Improper sleeping positions can cause spinal misalignment and spinal damage.

Which sleeping positions do you sleep in: ☐**Back** ☐**Stomach** ☐**R Side** ☐**L Side**

16. Exercise level: Never 1 2 3 4 5 6 7 8 9 10 Often:_____

17. When the spine has misalignments, it can often affect our daily activities. How is it negatively affecting your life? (i.e. difficult to get dressed, can't play a sport, hard to drive a car, can't sleep, requires you to take constant breaks, etc)_____
_____

18. Please list vitamins/supplements you take:_____
_____

19. If the doctor identifies your spine to be misaligned, are you committed to follow the recommendations to correct your problem completely? ☐**Yes** ☐**No**

The above information is accurate to the best of my knowledge.

_____ **Date:** _____
Signature (Parent/Guardian if minor)

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_____