Taylor Sport Chiropractic, PLLC

Case History

Patient name ____ Date ________________

Major complaint ____

Other complaints____

When did this begin? ____

Have you had any similar problems like this before? ____________________________

How did it occur? ____

How did it start? (Circle) Gradual Sudden

Describe pain (Circle) sharp dull stabbing burning ache
Constant intermittent

Is the condition getting progressively worse? (Circle) Yes No Not sure

Does it interfere with your (Circle) work sleep daily routine recreation

Activities or movements that are painful to perform (Circle)
walking bending lying down lifting sitting

Other ____

Does anything make it better? (Circle) Rest ice heat analgesics

Explain ____

Do you have any numbness/tingling in your arms/legs? Explain ____________________
____

Have you seen any other doctors for this problem? Explain who, when, and what treatments recommended. ____
____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

________________________	________________________	___________
Printed Name	**Signature**	**Date**

Taylor Sport Chiropractic, PLLC

Patient Information

Name ____ Date ______________

Address ___________________________________ SSN# _____________________

City, State, Zip ____

Home Phone ____________________________ Work Phone ___________________

Cell Phone _____________________________ E-Mail _______________________

Date of Birth _____________________ Age____________ Sex ________________

Marital Status __________________________________ Children_______________

How did you hear about us? ____

Family Physician ____

Employer ______________________________ Occupation _____________________

Address ____

City, State, Zip ____

Insurance Company ____

Address/Phone ____

Group Number __________________________ Policy Number ___________________

Policy Holders Name ______________________ Date of Birth ___________________

I, the undersigned assign directly to Taylor Sport Chiropractic, PLLC all medical 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

______________________________ ______________________________

Signature/ Insured/Guardian Date

Taylor Sport Chiropractic, PLLC

General Health Questionnaire

GENERAL SYMPTOMS (Please circle all that apply)

GENERAL
- Bruise easily
- Chills
- Dental problems
- Depression
- Difficulty sleeping
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headaches
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats
- Tiredness
- Weight gain

GENITO-URINARY
- Blood in urine
- Frequent urination
- Lack bladder control
- Painful urination

GASTROINTESTINAL
- Poor appetite
- Bloating
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting Blood

CARDIOVASCULAR
- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart rate
- swelling of the ankles
- Varicose veins

EAR, EYE, NOSE,THROAT
- Bleeding Gums
- Blurred vision
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision – flashes
- Vision – halos

SKIN
- Bruise easily
- Hives
- Itching
- Changes in moles
- Rash
- Scars
- Sore that won't heal

MEN ONLY
- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis

WOMEN ONLY
- Abnormal Pap smear
- Bleeding between periods
- Brest lump
- Menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge

Date of last menstrual cycle ____________________

Date of last Pap smear ____________________

Have you had a mammogram? ____________________

are you pregnant? ____________________

NECK, BACK, EXTREMITIES (Please circle all that apply)

NECK
- Pain
- Stiffness
- Weakness
- Pinched nerve
- Feels out of place
- Muscle spasms
- Grinding/popping sounds

SHOULDERS
- Pain in joint R L
- Pain across shoulders
- Can't raise arm R L
  - Above shoulder level
  - Over head
- Tension in shoulders
- Pinched nerve in shoulder R L

MID-BACK
- Pain
- Stiffness
- Pain between shoulder blades
- Pain from front to back
- Muscle spasm in mid-back

ARMS & HANDS
- Pain in upper arm R L
- Pain in elbow R L
- Pain in forearm R L
- Pain in hand R L
- Pain in fingers R L
- Pins/needles in arms R L
- Pins/needles in fingers R L
- Numbness in arms R L
- Numbness in fingers R L
- Weakness of arm R L
- Weakness of hand R L
- Cold hands R L

LOW BACK
- Pain
- Stiffness
- Weakness
- Pinched nerve
- Feels out of place
- Muscle spasms

HIPS, LEGS, FEET
- Pain in buttocks R L
- Pain in hip joint R L
- Pain down leg R L
- Pain in knee R L
- Pain in ankle R L
- Pain in foot R L
- Weakness of leg R L
- Weakness of knee R L
- Leg cramps R L

OTHER SYMPTOMS

____

____

____

____

MEDICAL CONDITIONS (Circle the conditions you have or have had in the past)

Aids	Diabetes	Liver disease	Rheumatic fever
Alcoholism	Emphysema	Measles	Scarlet fever
Anemia	Epilepsy	Migraine headaches	Stroke
Anorexia	Fractures	Miscarriage	Suicide attempt
Appendicitis	Glaucoma	Mononucleosis	Thyroid problems
Arthritis	Goiter	Multiple sclerosis	Tonsillitis
Asthma	Gonorrhea	Mumps	Tuberculosis
Bleeding disorder	Gout	Osteoporosis	Tumors, growths
Breast lump	Heart disease	Pacemaker	Typhoid fever
Bronchitis	Hepatitis	Pneumonia	Ulcers
Bulimia	Hernia	Polio	Vaginal infections
Cancer	Herpes	Prostate problem	Venereal disease
Cataracts	High cholesterol	Prosthesis	Whooping cough
Chemical dependency	HIV positive	Psychiatric	Other ______________
Chicken pox	Kidney disease	Rheumatoid Arthritis	___________________

MEDICATIONS - List all medications you are currently taking.

____

____

____

VITAMINS, HERBS, MINERALS - List all you are currently taking.

____

____

____

LIST AUTO ACCIDENTS

____

____

LIST SURGERIES/FRACTURES

____

____

Date of last: Physical exam ________________ Spinal x-rays ____________________

Physicians name ______________ Where taken ____________________

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

____ ______________________

Patient signature Date

____ ______________________

Doctor signature **Date**

Acknowledgement for Consent to Use and Disclosure of
Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by

____ *(Clinic Name)*

or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.
You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

Your may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

____
Name of Patient (print)

____
Signature of Patient **Date**

____
Signature of Patient Representative **Date**

____
Relationship of Patient Representative to Patient

Consent for Chiropractic Treatment Of a Minor Child

I ________________________, the □ Mother □ Father □ Legal Guardian of

_______________________________________ consent to the rendering of care, including

diagnostic procedures, x-rays and treatment given by ***Taylor Sport Chiropractic.***

I acknowledge that I am responsible for all reasonable charges in connection with care and

treatment rendered during this period.

I have read this form and certify that I understand its contents.

Signature: ____ Date: __________
Mother, Father or Legal Guardian