

PATIENT INTRODUCTION FORM

Today's Date: _____

Last Name: _____		First Name: _____		Middle Initial: _____	
Mailing Address: _____			City: _____		State: _____
Date of Birth: _____		Age: _____		Social Security Number: _____	
Height: _____		Weight: _____		Who Referred You to Our Office: _____	
Occupation: _____			Marital Status (Circle): Single, Married, Divorced, Widowed		
Employer's Name _____			Primary/ Current Treating Physician: _____		
			Phone number and/or address: _____		

<input type="checkbox"/> YES, <input type="checkbox"/> NO I authorize the following telephone numbers: <input type="checkbox"/> YES, <input type="checkbox"/> NO I authorize the use of my name/address Home: _____ Work _____ Cell: _____ Please star (*) your preferred phone number E-mail Address: _____ I have read and understand my right to privacy, as stated to the right, and agree to have the practitioners and employees of CCPR maintain my records confidentially in accordance with the law. I agree to inform CCPR if I need to have any special arrangements pertaining to this issue. Signature: _____ Date: _____	As a patient of Center for Chiropractic and Pain Rehabilitation (CCPR), you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the ways in which we secure your information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Notes taken during appointments are kept in your chart and secured in our clinic at all times. If patient charts are in public areas, the names are covered. Access to the clinic is limited to practitioners and employees. Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health in the clinic setting to protect your privacy and ensure that important information is kept in your chart. Your healthcare information is private and cannot be copied or shared with anyone else without your written signed consent. In some cases, verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax and are accompanied with a confidential patient information cover sheet is faxed. Our office needs to leave messages, return telephone calls, and send office mail to your mailing address as part of our normal practice. Federal/State HIPAA patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means. Please list telephone numbers to the left that are acceptable for our office to call.
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Emergency Contact: _____ **Phone:** _____

IS THIS VISIT RELATED TO A:		
<input type="checkbox"/> Work Related Injury/Symptoms	<input type="checkbox"/> Motorcycle-Bicycle Injury	<input type="checkbox"/> Non-Injury Pain/Symptoms
<input type="checkbox"/> Sport or Recreational Injury	<input type="checkbox"/> Home Injury Symptoms	<input type="checkbox"/> Check-up Only
<input type="checkbox"/> Motor Vehicle Collision Injury	<input type="checkbox"/> School/Employment Physical	<input type="checkbox"/> Other (Describe): _____

HEALTH INSURANCE INFORMATION

Does your insurance plan cover Chiropractic treatment?	<input type="checkbox"/> Yes, <input type="checkbox"/> No
If yes, we will need to make a copy of your insurance.	Insurance Name: _____
	Address: _____
	Telephone: _____

AS A COURTESY, CCPR WILL BILL YOUR INSURANCE COMPANY. HOWEVER, YOU ARE ULTIMATELY RESPONSIBLE FOR THE BILL. UNTIL BENEFITS ARE CONFIRMED, A 30% CO-PAY WILL BE COLLECTED AT THE TIME OF SERVICE. WE EXPECT PAYMENT AT THE END OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT AND/OR DEDUCTIBLE FOR HEALTH INSURANCE PATIENTS.

MISSED APPOINTMENT POLICY:

A 24-hour notice is required for all cancellations. A \$40 fee will be charged for all missed appointments. This fee will not be covered by your group, auto, or personal insurance. If we are closed, please leave a detailed message.

INFORMED CONSENT FOR CHIROPRACTIC CARE

As a patient at CCPR, I give the doctor of chiropractic (DC) permission and authority to care for me in accordance with the chiropractic tests, diagnosis and analysis s/he performs. The chiropractic adjustments and other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The DC will not provide treatment if s/he is aware of any contraindications. It is the responsibility of you the patient to make it known to the DC if you have any latent pathological defects, illnesses or deformities which would not otherwise be obvious to the DC. I understand that if I am accepted as a patient by a DC at CCPR, I am authorizing them to proceed with any treatment deemed to be necessary. The procedures, alternatives and risks involving the treatment will be explained to me prior to the treatment.

Patient Signature and Date	I am the responsible party. I agree to the above missed appointment and informed consent policies and agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my insurance carrier.
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GENERAL HEALTH HISTORY (Page 1)

LIST ALL SYMPTOM REGIONS AND HOW LONG YOU HAVE HAD THEM

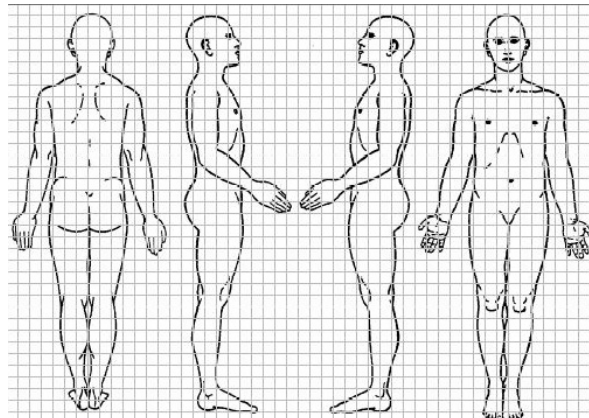
CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
<input type="checkbox"/> Headaches/Migraines		<input type="checkbox"/> Upper Back Pain, Soreness, or Stiffness	
<input type="checkbox"/> Neck Pain, Soreness, or Stiffness		<input type="checkbox"/> Hip Pain	
<input type="checkbox"/> Low Back Pain, Soreness, Stiffness		<input type="checkbox"/> Leg or Foot Pain, Numbness, or Tingling	
<input type="checkbox"/> Arm/Hand Pain, Numbness, or Tingling		<input type="checkbox"/> Knee/Ankle Pain	
<input type="checkbox"/> Shoulder/Elbow/Wrist Pain		<input type="checkbox"/> Dizziness/Vertigo	
<input type="checkbox"/> Jaw Pain		<input type="checkbox"/> Swelling/Stiffness of Joint(s)	
<input type="checkbox"/> Excessive Fatigue		<input type="checkbox"/> Other:	

Did your current symptoms come on? Suddenly, Gradually

How severe is your pain? 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

SYMPTOM/PAIN DESCRIPTION (Please circle any words/areas below that describe your current symptoms.)

Pain	Pinching	Spreading	Stiff or tight	Unbearable
Shooting	Soreness	Pulling	Sickening	Falls asleep
Ache	Tingling	Stabbing	Miserable	Pins and Needles
Tearing	Gnawing	Dull	Pressing	Radiating
Heavy	Nagging	Stinging	Deep pain	Weakness
Irritating	Burning-Hot	Dreadful	Superficial pain	Throbbing
Exhausting	Numbness	Torturing	Sharp	Tender



Please circle or mark with an **X** the areas where you have pain, numbness, tingling or other symptoms.

ARE YOU TAKING ANY MEDICATIONS?

I am not taking any medications currently. Check any of the following that you are taking currently.

<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Blood pressure/Stroke prevention medications	<input type="checkbox"/> Cortisone injections
<input type="checkbox"/> Pain/Anti-inflammatory meds	<input type="checkbox"/> Osteoporosis (bone strengthening) medications	<input type="checkbox"/> Other:

WHEN IS YOUR PAIN WORSE & WHAT ACTIVITIES INCREASE YOUR PAIN?

<input type="checkbox"/> Morning is when pain is worse	<input type="checkbox"/> Bending your back increases pain	<input type="checkbox"/> Walking increases pain
<input type="checkbox"/> Afternoon/evening pain worse	<input type="checkbox"/> Lying down flat increases pain	<input type="checkbox"/> Standing increases pain
<input type="checkbox"/> During sleep hours pain worse	<input type="checkbox"/> Sitting increases pain	<input type="checkbox"/> Exercise/Stretching increases pain
<input type="checkbox"/> Standing up from sitting	<input type="checkbox"/> Poor posture increases pain	<input type="checkbox"/> Other:

WHAT ACTIVITIES LESSEN YOUR PAIN?

<input type="checkbox"/> Walking	<input type="checkbox"/> Being flat on your back	<input type="checkbox"/> Exercise/Stretching
<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Other:

DO YOU EXERCISE?

<input type="checkbox"/> I do no regular exercise	<input type="checkbox"/> I exercise 1-2 times a week	<input type="checkbox"/> I exercise 3-5 times a week
<input type="checkbox"/> I stretch regularly	<input type="checkbox"/> I do weight lifting at gym/home	<input type="checkbox"/> I do cardiovascular work outs
<input type="checkbox"/> I am willing to do exercise	<input type="checkbox"/> I am not willing to do exercises	<input type="checkbox"/> I do regular sports activities

GENERAL HEALTH HISTORY (Page 2)

Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST	PRESENT
<input type="checkbox"/>	Heal slowly or bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Smoke cigarettes or use tobacco products	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of drug or alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes, hypoglycemia, thyroid disorder, kidney or liver disease, or tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Heart attack or have a heart pacemaker or neck or chest shunt?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Currently or recently had any infectious disease such as AIDS, Tuberculosis, etc	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have problems with dizziness, blacking out, balance, fainting, or tripping	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Epilepsy-Seizure-Convulsion history or other neurological disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of multiple sclerosis, lupus, psoriasis, temporary paralysis, or meningitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cancer history or cancer treatment of any type	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have a bulging/herniated disc or disc degeneration in the spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Have you ever been hospitalized? Why:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hypertension or high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have osteoarthritis, rheumatoid arthritis, or gout of your spine or joints	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have any type of chest or breast implants presently (males & females)?	N/A	<input type="checkbox"/>
<input type="checkbox"/>	Women only: Check box to left if there any chance that you are currently pregnant		

No, Yes Do you have any problems laying face down on an examination table? If yes, why: _____

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

<input type="checkbox"/> Excessive fatigue-malaise	<input type="checkbox"/> Bowel or bladder disorders	<input type="checkbox"/> Night pain or night time sweats
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Ovarian pain	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Low grade fever	<input type="checkbox"/> Kidney pain/painful urination	<input type="checkbox"/> Balance problems

PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN

(I have no history of previous painful injury or pain) If you have had prior injuries or pain, please check below:

<input type="checkbox"/> Work Injury	<input type="checkbox"/> Fall	<input type="checkbox"/> Sports Injury	<input type="checkbox"/> Lifting Injury	<input type="checkbox"/> Car Accident
<input type="checkbox"/> Motorcycle Injury	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Pedestrian Injury	<input type="checkbox"/> Military Injury	<input type="checkbox"/> Other Injury
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Shoulder Pain
<input type="checkbox"/> Arm numb-tingling	<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Leg pain-numb-tingling	<input type="checkbox"/> Other Pain:	

FRACTURES/BROKEN BONES HISTORY

(I have never had any broken bones). If you have broken any bones, indicate where and when below:

Region	Year	Region	Year
<input type="checkbox"/> Spinal Vertebra		<input type="checkbox"/> Skull	
<input type="checkbox"/> Collar bone (clavicle)		<input type="checkbox"/> Rib bone	
<input type="checkbox"/> Arm or hand bones		<input type="checkbox"/> Leg or foot bones	
<input type="checkbox"/> Pelvis or hip bones		<input type="checkbox"/> Other: List	

PREVIOUS SURGERIES

(I have never had any surgical procedure). If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
<input type="checkbox"/> Spine Surgery (neck, back, or pelvis)		<input type="checkbox"/> Appendix or stomach	
<input type="checkbox"/> Disc surgery in neck or back		<input type="checkbox"/> Gallbladder/Stomach/Kidney	
<input type="checkbox"/> Heart		<input type="checkbox"/> Cancer (any type)	
<input type="checkbox"/> Head/Brain		<input type="checkbox"/> Hernia (inguinal or hiatal)	
<input type="checkbox"/> Shoulder/Arm/Hip/Leg		<input type="checkbox"/> Other	

Have you ever been to a Chiropractor before for any condition?

No, Yes If yes, Chiropractor's Name : _____ Year: _____

Problem(s) seen by Chiropractor for: _____