PATIENT CASE INFORMATION

Date: _____ **Patient No:** _____

Patient Information

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

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

Cell Phone: _____ **Cell Carrier:** _____ **Home Phone:** _____

Email Address: _____ **Gender:** M / F **Marital Status:** Single / Married / Other

Social Security #: _____ **Date of Birth:** _____

Student Status: Full Student / Part Student / Non-Student **Employed:** Y / N **Where:** _____

Ethnicity: Hispanic or Latina / Not Hispanic or Latino / Decline **Preferred Language:** English / Decline / Other: _____

Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline

Smoker: Everyday / Some Days / Former / Never

** **Referred By:** _____ Family / Friend / Co-Worker / Doctor/ Other Source

Emergency Contact Information

Name: (First MI Last) _____ **Primary Care Physician:** _____

Phone: _____ **Doctor's Phone:** _____

Relationship: Child / Parent / Spouse / Other: _____

Insurance / Financial Information

Who is responsible for payment? Self / Other - Name: _____ **Relationship:** _____

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

Primary Insurance Name: _____ **Secondary Insurance Name:** _____

*** (Please supply insurance cards to office staff so that they can be copied)***

Consent to Treat, Authorization to Release & HIPPA

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation, examination, chiropractic care, diagnostic testing, and/or therapeutic services on the above, in accordance with this state's statutes. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.
ACKNOWLEDGEMENT: By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

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

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

COMPLAINT INFORMATION

Date: _____ **Patient No:** _____

History of Current Condition

Major Complaint: _____

Secondary Complaint: _____

When and How this began? _____

_____

_____

Intensity of Pain/Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

Quality of pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore

How frequent is the complaint? Off & On / Constant

Does the complaint radiate? No / Yes (Describe) _____

Head - Base of Skull / Forehead / Temple L / R / Both Leg - Hip / Thigh-Knee / Calf / Toes L / R / B

Arm - Across Shoulder / Elbow / Hand-Fingers L / R / Both Other Area: _____

What makes it Better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

What makes it Worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected? (*Describe*) _____

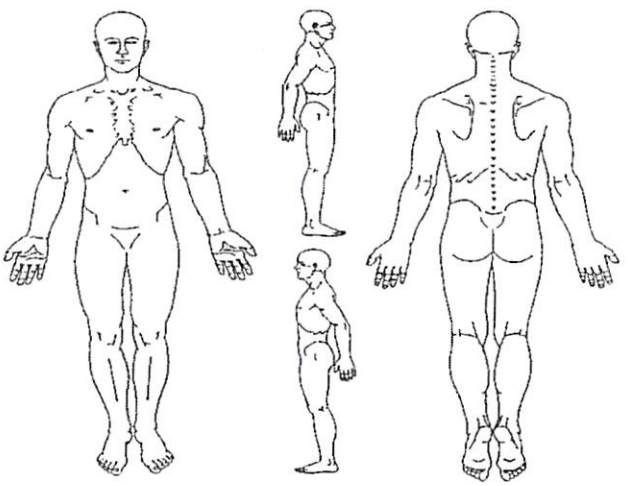
For this condition, have you:

Other Treatment? None / DC / MD / PT / Massage / Other: _____ Where: _____

Other Diagnostic Testing? X-rays / MRI / CT / Other: _____ Where: _____

Pain/Complaint Diagram

SYMPTOM DIAGRAM



P___ Pain T ___ Tender

N ___ Numb H ___ Hypoesthesia

S ___ Spasm

Patient Signature: _____ ***Physician's Initials:*** _____

REVIEW OF SYSTEMS

Patient Name: (First MI Last) _____ **Patient No:** _____

Review of Systems

General:
- ☐ Weight Change
- ☐ Fatigue
- ☐ None

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Stiff Joints
- ☐ Sore Muscles
- ☐ Other: _____
- ☐ None

Neurological:
- ☐ Numbness
- ☐ Loss of Feeling
- ☐ Dizziness
- ☐ Headaches
- ☐ Other: _____
- ☐ None

Mind/Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Loss of Memory
- ☐ Other: _____
- ☐ None

Genitourinary:
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ Bed Wetting
- ☐ Other: _____
- ☐ None

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Change of Bowel
- ☐ Painful Bowel
- ☐ Nausea Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ None

Heart:
- ☐ Rapid Heartbeat
- ☐ Blood Pressure Prob.
- ☐ Swelling hands/ankles
- ☐ Other: _____
- ☐ None

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Asthma
- ☐ Lung Problems
- ☐ Other: _____
- ☐ None

Eyes and Vision:
- ☐ Wear Glasses/Contacts
- ☐ Blurred Vision
- ☐ Glaucoma
- ☐ Other: _____
- ☐ None

Ears, Nose & Throat:
- ☐ Swollen glands in neck
- ☐ Ringing in ears
- ☐ Ear Ache
- ☐ Sinus Problems
- ☐ Hearing Loss
- ☐ Other: _____
- ☐ None

Endocrine & Lymphatic:
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Cold Extremities
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Other: _____
- ☐ None

Women:
- ☐ Infertility
- ☐ Irregular periods
- ☐ None

Health History

Medications and Supplements:

Allergies to Medications: ☐ **NONE**

Name	Reaction

Current Medications & Supplements: ☐ **NONE**

Name	Dosage

Past Health History:

Surgeries: ☐ **NONE**

Date	Describe

Major Injuries / Traumas / Hospitalizations: ☐ **NONE**

Date	Describe

Family Health History: ☐ **NONE**

List major health problems of 1st degree relatives:

Problem	Relation (Parent, Sibling, Child)

Social and Occupational History:

Smoking: ☐ Every Day ☐ Some Days ☐ Former ☐ Never

Habit	Type / Amount / Year Started
Smoking	
Tobacco	
Alcohol	
Caffeine	
Rec. Drugs	

Functional Rating Index

For each item below, please circle the number which most closely describes your current overall health condition right now.

Patient Name _____ Date _____

1. Pain Intensity

0- No Pain	1- Mild Pain	2- Moderate Pain	3- Severe Pain	4- Worst Possible Pain

2. Sleeping

0- Perfect Sleep	1- Mildly Disturbed	2- Moderately Disturbed	3- Greatly Disturbed	4- Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc.)

0- No Pain No Restrictions	1- Mild Pain; No Restrictions	2- Moderate Pain; Go Slowly	3- Moderate Pain; Some Assistance	4- Severe Pain; 100% Assistance

4. Travel (driving, etc.)

0- No Pain on Long Trips	1- Mild Pain on Long Trips	2- Moderate Pain on Long Trips	3- Moderate Pain on Short Trips	4- Severe Pain on Short Trips

5. Work

0- Usual Work + Extra	1- Usual Work, No Extra	2- 50% of Usual Work	3- 25% of Usual Work	4- Cannot Work

6. Recreation

0- All Activities	1- Most Activities	2- Some Activities	3- Few Activities	4- No Activities

7. Frequency of Pain

0- No Pain	1- Occasional (25%)	2- Intermittent (50%)	3- Frequent (75%)	4- Constant (100%)

8. Lifting

0- No Pain with Heavy Weight	1- Increased Pain with Heavy Weight	2- Increased Pain with Moderate Weight	3- Increased Pain with Light Weight	4- Increased Pain with Any Weight

9. Walking

0- No Pain with Any Distance	1- Increased Pain after 1 Mile	2- Increased Pain after ½ Mile	3- Increased Pain after ¼ Mile	4- Increased Pain after Any Distance

10. Standing

0- No Pain with Any Time	1- Increased Pain after Several Hours	2- Increased Pain after 1 Hour	3- Increased Pain after ½ Hour	4- Increased Pain after Any Time

Total _____ (/4, X10) = Functional Rating Score _____%

***Patient or Guardian Signature _____ Date ___/___/___

Treating Doctor Signature _____ Date _____

Stinnette Chiropractic Center, P.C.
Stinnette Chiropractic & Acupuncture, P.C.
Pinnacle C.O.P. Manual-1.0
Revised 04/05/2017

Patient Name: _____ D.O.B.: _____ Date: _____

Consent for Chiropractic Services

Acknowledgement of Treatment Plan: By signing below, I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more to the following services: chiropractic adjustments, examinations and supportive therapies and procedures.

By reading below I have been made aware:

1. The process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually or with a table mechanism to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound.
2. As an addition to the Chiropractic Adjustment "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold.
3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment.
4. That the chiropractor has made no guarantee of a positive outcome from treatment.

Additionally:

1. I have been afforded ample opportunity for questions and answers.

Therefore, by signing below:

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case.

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case.

Patient or Guardian Signature: _____

Witness Signature: _____