Stinnett Chiropractic

"we correct pinched nerves"

Date:_____

First Name:_____**Last Name:**_____

Address:_____

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

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

Gender: Male Female

Birth Date:_____ **Marital Status: Single Married Divorced Widowed**

Email Address:_____

Spouse Name:_____

Number of Children:_____**Names:**_____

Employer:_____**Occupation:**_____

Employer Phone Number:_____

Emergency Contact Information:_____

Phone Number:_____**Relationship:**_____

Who may we thank for referring you?_____

What brings you in today? _____

When did the problem first start?_____

What is the condition related to? (Check one)

- ❑ Home injury
- ❑ Sports injury
- ❑ Work injury
- ❑ Auto accident: Date_____
- ❑ Other _____

Have you seen other doctor(s) for this condition? YES NO
If yes when?_____

Have you had this condition before? YES NO
If yes, when?_____

Does anyone from your family suffer the same condition? YES NO
If yes, who?_____

Pain duration?

- ❑ Constant
- ❑ Frequent
- ❑ Intermittent
- ❑ Occasional

What makes the condition worse? (Check all that apply)

- ❑ Bending
- ❑ Standing
- ❑ Sitting
- ❑ Lifting
- ❑ Stairs
- ❑ Walking
- ❑ Coughing
- ❑ Sneezing
- ❑ Other: _____

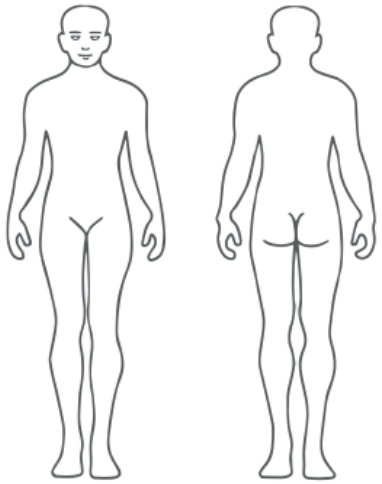
What makes the condition better? (Check all that apply)

- ❑ Rest
- ❑ Heat
- ❑ Ice
- ❑ Massage
- ❑ Medication
- ❑ Other: _____

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10

Please circle the areas where you have pain on the diagram.



Please describe your symptoms by checking all that apply.

- ❑ Numbness
- ❑ Tingling
- ❑ Stiffness
- ❑ Dull
- ❑ Aching
- ❑ Cramping
- ❑ Nagging
- ❑ Sharp
- ❑ Shooting
- ❑ Burning
- ❑ Throbbing
- ❑ Stabbing
- ❑ Swelling
- ❑ Other _____

How is this symptom / condition interfering with your life? (Check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	❑	❑	❑	❑	Energy	❑	❑	❑	❑
Exercise	❑	❑	❑	❑	Attitude	❑	❑	❑	❑
Recreation	❑	❑	❑	❑	Patience	❑	❑	❑	❑
Relationships	❑	❑	❑	❑	Productivity	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	Creativity	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑	Other_____	❑	❑	❑	❑

How committed are you to correcting this issue? 0 1 2 3 4 5 6 7 8 9 10

If you did not have this issue, what would you do more of?_____

If you did nothing about it, what do you think would happen?_____

What else should we know about your condition?_____

Have you had an x-ray in the last six months? ❑ Yes ❑ No

Are you currently pregnant? ❑ No ❑ Yes, I am due_____

I certify to the best of my knowledge I am not pregnant. _____ (initial please)

Prior Interventions (check all that apply)

- ❑ Acupuncture
- ❑ Chiropractic
- ❑ Heat/Ice
- ❑ Homeopathic
- ❑ Massage
- ❑ Physiotherapy
- ❑ Prescription Medication
- ❑ OTC Medications
- ❑ Surgery
- ❑ Other _____

Health History: (Please check the box next to any condition you have or have had.)

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma/Allergies
- ❑ Back Pain
- ❑ Cardiovascular Issues
- ❑ Cancer
- ❑ Circulation Issues
- ❑ Depression
- ❑ Diabetes
- ❑ Digestive Issues
- ❑ Elbow/Wrist/Hand Issues
- ❑ Endocrine Issues (Thyroid)
- ❑ Foot/Ankle Issues
- ❑ Headaches/Migraines
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hip Issues
- ❑ Multiple Sclerosis
- ❑ Neck Pain
- ❑ Reproductive Issues
- ❑ Ringing In Ears
- ❑ Scoliosis
- ❑ Shoulder Issues
- ❑ Stroke
- ❑ TMJ Issues
- ❑ Urinary Issues
- ❑ Osteoporosis
- ❑ Other _____

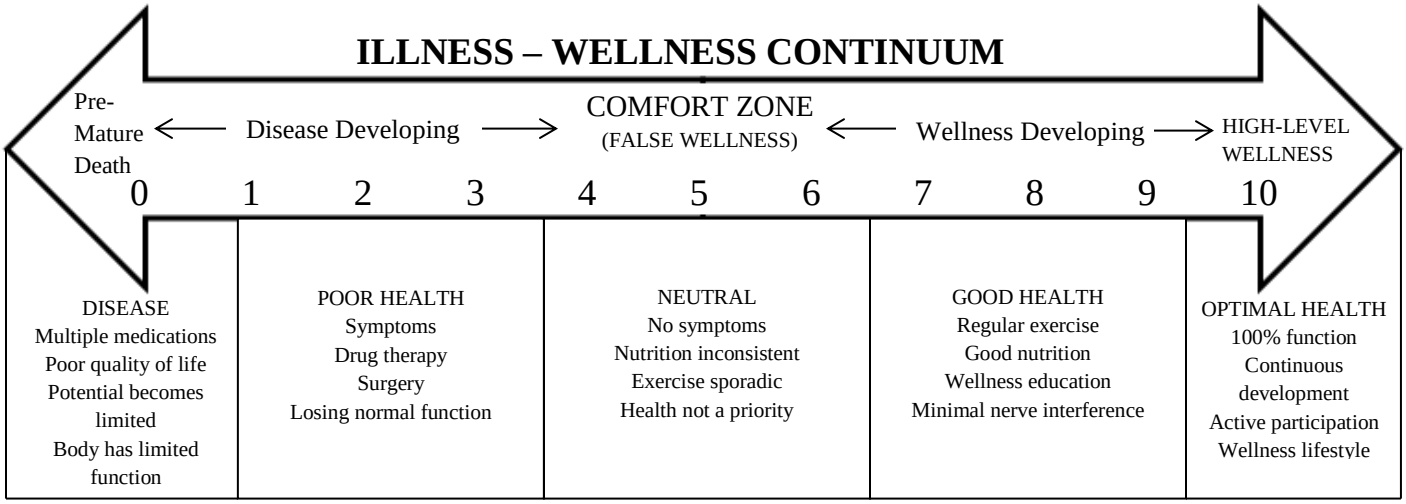
Current Medications (circle all that apply)

Blood Pressure Insulin Muscle Relaxer Nerve Pills Pain Meds

Other:_____

Surgical History (circle all that apply) Cancer Back Surg. Bypass Hernia Other:_____

Fractures	Yes	No	If yes when? _____
Auto Accident	Yes	No	If yes when? _____
Spinal Surgery	Yes	No	If yes when? _____
Hospitalization	Yes	No	If yes why? _____



On the diagram above:

A. What number do you think represents your health today?_____
B. In what direction is your health currently headed? _____

What are your health goals?

Intermediate _____
Short Term _____
Long Term _____

Please read the following carefully before signing.

It is important that we have the same health objectives concerning chiropractic care as our patients. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate the major interference to the expression of the body's internal wisdom and power. Our only method is a specific chiropractic adjustment to correct vertebral subluxations; which interfere with the body's wisdom and power. We believe that the greatest Doctor is the one already inside each of our patients and we only help to maximize that innate healing power, without using drugs or surgery. Your signature verifies that the
Information given in this form is complete and correct and that you accept, if eligible, chiropractic care on this basis.

Signature_____Date_____

Patient Health Information Consent Form

We want you to know your patient health information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you read and sign this consent form stating that you understand and agree with how your records will be used if you would like to have more detailed account of our policies and procedures concerning the privacy of your personal health information we encourage you to read the HIPPA procedures that are in our front waiting area.

1. The patient understands and agrees to allow this chiropractic office to use their patient health information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As the example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) proved to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient agrees to allow this chiropractic office to use their image, likeness, and/or sound of their voice as recorded on audio or video tape, without payment or any other compensation from Stinnett Chiropractic, for educational, marketing, or social media publishing.
3. The patient has the right to examine and obtain a copy of his/her records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
4. A patient's written consent need only be obtained one time for the subsequent care given to the patient by this office.
5. The patient may provide a written request to revoke consent. This request would not apply to care given prior to when the written request was presented.
6. For your security and right to privacy, all the staff has been trained in the area of patient records privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these procedures and policies.
8. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Full Name_____ Signature_____ Date_____

Witness Name_____ Signature_____ Date_____

Do you have health insurance? Yes _____ No_____

For Insurance Recipients Only

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand Stinnett Chiropractic will file claims to my insurance carrier as a courtesy and will prepare any necessary reports and forms to assist in making collections from the insurance carrier. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Full Name_____ Signature_____ Date_____