Crosby Chiropractic Center

Confidential Patient Health Information

Personal Demographics

Name _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Birthdate: _____ Age: _____

Cell Phone: _____ Social Security #: _____

E-mail: _____

Business Employer: _____ Type of Work: _____

Business Phone: _____ Name of Spouse: _____

Number of Children: _____ Referred to this office by: _____

Current Health Condition

Chief Complaint: _____

Secondary Complaint: _____

Other doctors seen for this condition? ☐ Yes ☐ No

Who? _____ Results: _____

Type of Treatment: _____ Has this condition occurred before? ☐ Yes ☐ No

When did this condition begin? _____

Is condition: ☐ Job related ☐ Auto ☐ Fall ☐ Home Injury ☐ Other: _____

Date of Accident: _____ Time of Accident: _____

Drugs you now take: _____

_____

Do you suffer from any condition other than that for which you are now consulting us? _____

_____

_____

Past Health Condition

Previous Surgery/Operation: _____

_____

Major Accidents or Falls: _____

_____

Hospitalization (other than above): _____

_____

Previous Chiropractic Care: ☐ Yes ☐ No

Dr.'s Name and approximate date of last visit: _____

Below is a list of conditions that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

___ Pneumonia
___ Rheumatic Fever
___ Tuberculosis
___ Anemia
___ Measles
___ Hepatitis
___ Mumps
___ Diabetes
___ Cancer
___ Heart Disease
___ Thyroid
___ Gout
___ Pleurisy
___ Arthritis
___ Epilepsy
___ Mental Disorder
___ Emotional Disorders
___ Eczema

Intake	Amount/Day
___ Coffee/Tea	_____
___ Alcohol	_____
___ Cigarettes	_____
___ Soft Drinks	_____
___ Energy Drinks	_____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST

Musculo-Skeletal
___ Low Back Pain
___ Pain between shoulders
___ Neck Pain
___ Arm Pain
___ Joint Pain/Stiffness
___ Walking Problems
___ Difficulty Chewing/Clicking Jaw
___ General Stiffness

Nervous System
___ Nervous
___ Numbness
___ Paralysis
___ Dizziness
___ Forgetfulness
___ Confusion/Depression
___ Fainting
___ Convulsions
___ Cold/Tingling Extremities
___ Stress

General
___ Fatigue
___ Allergies
___ Loss of Sleep
___ Fever
___ Headaches

Gastrointestinal
___ Poor/Excessive Appetite
___ Excessive Thirst
___ Frequent Nausea
___ Vomiting
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Liver Problems
___ Gall Bladder Problems
___ Weight Trouble
___ Abdominal Cramps
___ Gas/Bloating after Meals
___ Heartburn
___ Black/Bloody stool
___ Colitis

Genito-Urinary
___ Bladder Trouble
___ Painful/Excessive Urination
___ Discolored Urine

C-V-R
___ Chest Pain
___ Short Breath
___ Blood Pressure Problems
___ Irregular Heartbeat
___ Heart Problems
___ Lung Problems/Congestion
___ Varicose Veins
___ Ankle Swelling
___ Stroke

EENT
___ Vision Problems
___ Dental Problems
___ Sore Throat
___ Earaches
___ Hearing Difficulty
___ Stuffed Nose
___ Sinus Problems

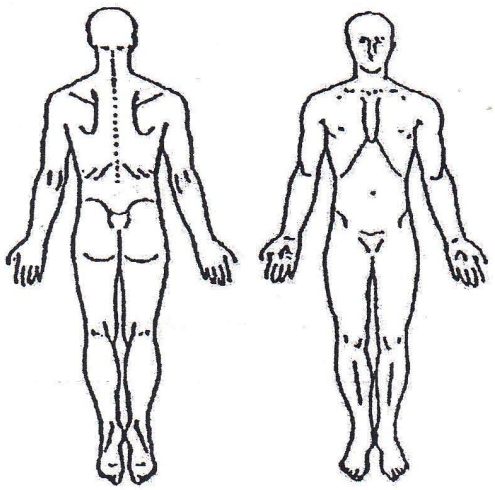
Females Only:

When was your last period?
_____

Are you pregnant?
____ Yes ____ No

Male/Female
___ Menstrual Irregularity
___ Menstrual Cramps
___ Vaginal Pain/Infection
___ Breast Pain/Lumps
___ Prostate Dysfunction
___ Other Problems
___ _____
___ _____
___ _____

Please outline on the diagram the area of your discomfort



Family History of Spinal Problems
___ Mother _____
___ Father _____
___ Brother _____
___ Sister _____
___ Spouse _____
___ Child _____

Thank you for choosing our office. Since 1982 we have helped thousands find better health and enjoy a more active and full life. We look forward to helping you.

Dr. Chad Thornton, D.C.

Patient Signature _____ Date _____

Crosby Chiropractic Center

Dr. Chad Thornton

Informed Consent for Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy modalities on me (or on the patient named below, for whom I am legally responsible) by the doctor(s) and/or anyone working in this office authorized by the doctor(s).

I further understand that such chiropractic services may be performed by the doctor(s) at Crosby Chiropractic Center and /or other licensed Doctors of Chiropractic who may treat me now or in the future at this office. I understand I will have the opportunity at any time in the office or over the phone to discuss with Dr. Chad Thornton and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my care, usually thoroughly covered in the first couple visits, and the doctor and trained staff will answer questions and concerns to the best of their abilities.

I understand that, as in the practice of medicine and all health care, while rare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures; disc injuries, such as herniated/bulging discs; strokes (CVA); dislocations; and sprains/strains. I understand there is also a risk of some increased pain during the healing phase of my care, as my body begins to restore to normal health. I understand that this may be normal and sometimes expected and is therefore part of the overall healing process. I further acknowledge the risks of not following through with my prescribed treatment plan, whether started or not, which can include disc and spine degeneration, loss of mobility, loss of function, loss of muscle tone, muscles spasms, additional increasing pain, and possible interference with my regular activities of daily living. I can always choose to continue or discontinue care at any time and acknowledge and accept the results and/or consequences, accordingly.

I do not expect the doctor(s) to be able to anticipate and explain all risks and complications. Further I wish to rely on the doctor(s) to exercise judgment during the course of the procedures which the doctor(s) feel are in my best interests at the time, based upon the then known facts and in alignment with the professional standards of care. I understand that results are not guaranteed.

I have read, or have had read to me, the above consent and its contents, and by signing below, I agree to the treatment recommended by the doctor(s). I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility in the future.

To be completed by the patient:

_____

Print Patient's Name

_____

Signature of Patient

Date: _____/_____/_____

If the patient is a minor or is physically incapacitated:

_____

Print Name of Representative

_____

Signature of Representative

Date: _____/_____/_____

Crosby Chiropractic Center

GENERAL CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

If applicable, your protected health information will be used by Crosby Chiropractic Center, or disclosed to others, as per our agreement with them, for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of our practice.

You may request a restriction on the use and disclosure of your protected health information. Crosby Chiropractic Center may or may not agree to restrict the use or disclosure of your protected information. If Crosby Chiropractic Center agrees to the request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction may be a violation of the federal privacy standards
.

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 in which you revoke this consent will not be affected.

Crosby Chiropractic Center reserves the right to modify the privacy practices outlined in the notice.

Crosby Chiropractic Center takes every precaution to keep all of my information confidential and that the only times it uses or discloses any of my protected health information, it is done so with the minimal amount necessary to achieve the desired result.

There may be a situation where it may be legally mandated that my information be released to the proper authorities. In this case, I understand that Crosby Chiropractic Center has no choice but to adhere to the legal mandate.

Crosby Chiropractic Center has a policy to advise close family members as to my protected health information. If you do not consent to this check off below asking this office not to do so.

☐ *Do not release my information to any family members*.

I understand that I am entitled to review my information at any time. I consent that if I request copies of my records, that there may be a reasonable charge for them which I am responsible for.

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

I request that payment of authorized benefits be made on my behalf to Crosby Chiropractic Center for services furnished to me by the provider.

_____ _____

Signature **Date**

_____

Relationship to Patient

Crosby Chiropractic Center

Dr. Chad Thornton

Consent for Radiology

I, _____give the doctor(s) and trained staff assistants of Crosby Chiropractic Center my consent to take any and all x-rays needed to better understand my condition. I acknowledge the inherent radiological risks but also appreciate the regulatory safety standards of state compliance for this office.

I also give my consent for x-rays of my child/children for the same reasons, if applicable.

For Ladies only:
To my best knowledge I am not pregnant and know of no contraindications for x-rays at this time.

Patient Signature:_____Date:_____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____