Welcome to Nelson Chiropractic

First Name: _____ MI____ Last Name: _____ Birth Date____/____/_____ Age_____

Address_____City_____State_____Zip_____

Cell #: ( )_____ Home #: ( )_____

Email: _____

_____Male _____Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Women: Are you pregnant? ☐ Y ☐ N Number of children: _____

Place of Employment: _____ Occupation: _____

Primary Care Physician: _____

Please list all prescription / over the counter medications: _____

_____

How did you learn about our office: Referred to the clinic by: _____

Community Screening Website Facebook Other: _____

Have you ever seen a Chiropractor in the past? ☐ Y ☐ N If yes, when was your last adjustment: _____

Health Profile

Chief Complaint: _____

_____ _____

When did this condition begin? _____

Has it ever occurred before? ☐ Y ☐ N

Was this due to a trauma or accident? ☐ Y ☐ N

If yes, explain (fall, auto accident, sports…):_____

How often and how long do your symptoms/ pain occur? _____

Severity: Mild / Moderate / Severe

Quality (mark all that apply):

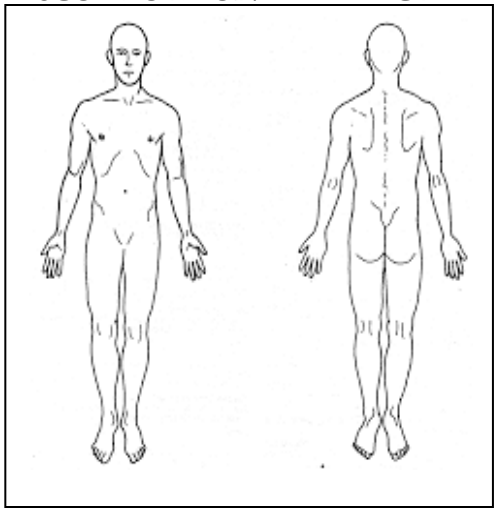
☐ Burning ☐ Diffuse ☐ Dull/ Aching ☐ Localized

☐ Sharp ☐ Shooting ☐ Stabbing ☐ Tingling

☐ Radiating ☐ Other: _____

Is there anything that makes it worse? _____

PLEASE MARK AREAS OF DISCOMFORT ON THE DIAGRAM



☐ Occasional (0-25%) ☐ Intermittent (25-50%) ☐ Frequent (50-75%) ☐ Constant (75-100%)

What other treatments have you attempted to resolve this condition?

_____

Please Check All Past or Current Conditions:

____Numbness/Tingling/Pain in Arms/Hands/Fingers
Right Left Both

____ Headaches/Migraines
____ Hip Pain R/L
____Frequent Colds/Flu
____ Convulsions/Epilepsy
____ Pain with cough/sneeze
____ Heart/ Cardiac Issues
____Loss of Smell / Taste
____ Depression
____Bed Wetting
____ Arthritis
____ Neck Stiffness/Pain
____ Diabetes
____Tremors
____ Chest Pain
____ High Blood Pressure
____ Cold Hands / Feet
____ Tension/Stress
____ Ear Infections

____Numbness/Tingling/Pain in Buttocks/Leg/Feet/Toes
Right Left Both

____ Swollen / Painful Joints
____ Back Stiffness/Pain
____ Cancer
____ Blurred Vision (R/L)
____ Lung Problems
____ Digestive Issues
____ Loss of Balance
____ Nervousness / Anxiety
____ Colic
____ Sinus Problems / Allergies
____ Jaw / TMJ Pain
____ Stroke
____ Double Vision (R/L)
____ Heartburn / Reflux
____ Sleeping Issues / Fatigue
____ Dizziness/Vertigo / Fainting

____Other:_____

Daily Activities: Effects of Current Condition on Performance

Sit to Stand	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Walking	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Climbing Stairs	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Exercising	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Driving	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Carrying Groceries	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Household Chores	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Yard Work	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Lifting	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Bathing	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Dressing	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Sexual Activities	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Sleep	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Reading/ Concentration	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Extended Sitting	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform
Extended Standing	___ No Effect	___ Painful (can do)	___Painful (limits)	___Unable to perform

Please list any other effects this may have on any recreational activities:

_____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation. I understand that I am responsible for payment of all services rendered.

_____ _____

Signature of Patient / Legal Guardian **Date**

Lifestyle Questionnaire

Name: _____ Date: _____

SLEEPING HABITS

1. What position do you sleep? BACK SIDE STOMACH
2. How many hours per night do you sleep? _____
3. How many pillows do you use? _____

EATING HABITS

4. How many meals do you eat per day? _____
5. How many servings of fruits and vegetables do you eat daily?
   _____
6. Do you drink water on a daily basis? YES NO If yes, how many 8-ounce glasses? _____
7. What other beverages do you drink?
   _____
8. Do you take nutritional supplements or vitamins? YES NO
   If yes, please list: _____
9. Do you use artificial sweeteners? YES NO

EXERCISE HABITS

10. How many hours per day do you spend sitting? _____standing? _____
11. Do you do any structured exercise? YES NO
    If yes, how many hours/days per week?
    _____

LIFESTYLE HABITS

12. Do you smoke / vape? YES NO
    If yes, how often do you smoke: _____
13. Please rate your overall level of stress (0=low, 10=high):
    _____
14. Do you regularly practice meditation, yoga or deep breathing exercises?
    _____
15. What would you like to be able to do that you are currently unable to do because of your pain or symptoms?
    _____
    _____

Please rank from 1-5 with 1 being most important, the order of importance in your life for the following items:

_____ Nutrition _____ Exercise _____ Pain relief _____ Weight _____ Stress Management

Informed Consent for Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities on myself (or on the patient named below for whom I am legally responsible) by the licensed doctors of chiropractic of Nelson Chiropractic or any contracted doctor affiliated with Nelson Chiropractic currently or in the future.

I understand that spinal manipulation involves the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

I authorize payment of insurance benefits directly to Nelson Chiropractic. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations, and coordination of care and authorize Nelson Chiropractic to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

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

I have also read, or have had read to me the above informed consent, authorization and release. I have had an opportunity to ask any and all questions about its content. By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment in this office.

I, _____ have read and fully understand the above statements.
(Print Patient Name)

I understand and accept the risks associated with chiropractic care and give my consent to the evaluations and chiropractic care, including spinal adjustments that I may receive in this office. I therefore give informed consent to begin my chiropractic evaluation and any further care on this basis.

_____ _____
Signature of Patient or Legal Guardian **Date**

I authorize the doctors and staff of Nelson Chiropractic to take x-rays. I do not suspect nor know positively that I am or may be pregnant at this time. I release Nelson Chiropractic and all doctors and employees in this office from any and all liability from complications from the diagnostic or treatment procedures utilized in the office.

_____ _____
Signature of Patient or Legal Guardian **Date**

_____ _____
Witness Signature (Office Staff) **Date**

Privacy Policy Information

This document describes how your personal and health related information may be used and disclosed, and how you can get access to this information. Please read it carefully.

In the course of your care as a patient at Nelson Chiropractic, we may use and disclose personal and health related information about you in the following ways:
-personal health information including your clinical records may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnostic assessment or treatment
-health and billing records may be disclosed to another party such as an insurance carrier or your employer if they are responsible for payment of your services
-personal information, health records and billing records may be disclosed to an outside collection agency if needed in an effort to collect payment on overdue unpaid accounts with an outstanding balance

Your name, address, phone number, email, and your health care records may be used to contact you regarding appointment reminders or other health related information that may be of interest to you. If you are not home to receive an appointment reminder, a message may be left on your answering machine. Additionally, text or email appointment reminders or correspondence may be utilized as a patient. You have the right to inspect or obtain a copy of the information that we will use for these purposes. You have the right to refuse to provide us with authorization to contact you regarding these matters. Refusal to provide authorization will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:
-if we are providing health care services based on orders from another health care provider
-if we provide health care services in an emergency
-if there are substantial barriers to communicating with you, but it is in our professional judgment that we believe you intend for us to provide care
-if we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than outlined above will only be made upon your written authorization. If you would like additional information regarding our privacy practices, would like to make a complaint regarding our privacy practices or have additional questions, please contact Dr. Rodney Nelson at Nelson Chiropractic. You have the right to inspect and/or have a copy of your health information for seven years from the date that the record was created or as long as the information remains in our files. Requests must be provided to our office in writing.

I, _____, have received, reviewed, and understand the privacy policies of Nelson Chiropractic.
(Print Patient Name)

_____ _____
Signature of Patient or Legal Guardian **Date**

Office use only: We attempted to obtain written acknowledgement of receipt of our Privacy Policy Information, but acknowledgement could not be obtained because:

☐ Individual refused to sign ☐ Communication barriers ☐ Emergency situation ☐ Other: _____