Confidential Patient Information

Name:_____ **Preferred Pronoun:**_____ **Date of Birth**:_____

Gender:_____ Social Security #:_____

Address:_____
Street *City* *State* *Zip Code*

Home Phone #_____ Cell Phone# _____ Email:_____

_____
Your Occupation *Company Name* *City* *Work Phone*

_____
Emergency Contact Name *Relation?* *Cell/Home Phone* *Work Phone*

Current Relationship Status: _____ # of children_____

Health Insurance Co:_____

Name and Gender use for insurance billing: _____

Reason for Visit Today_____

When did it start?_____

How did you find out about our office:_____

PERSONAL HEALTH HISTORY - The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

List ALL Surgical Care or Hospitalizations_____

_____

Current Medications, Herbals or Nutritional Supplements_____

GENERAL CURRENT CONDITIONS

- ❑ Recent accident such as a fall, whip-lash, or blow to the head
- ❑ Spinal/back/neck problems
- ❑ Muscle spasms
- ❑ Restricted movement
- ❑ Tingling or numbness of arms, legs, hands or feet
- ❑ Headaches or migraines more than once per month
- ❑ Sinus problems
- ❑ Depression or Anxiety
- ❑ Difficulty dealing with stress
- ❑ Dizziness or vertigo
- ❑ Vision or Hearing problem
- ❑ Sleeping trouble
- ❑ Breathing trouble or Asthma
- ❑ Digestive trouble or Nausea
- ❑ Heartburn/Acid Reflux
- ❑ Menstrual problems
- ❑ Jaw or mouth problem
- ❑ Arm, shoulder, elbow or hand problem (circle)
- ❑ Leg, hip, knee or foot problem (circle)
- ❑ OTHER:

DIAGNOSED CURRENT CONDTIONS

- ❑ Born with bone or joint disorder
- ❑ Degenerative arthritis
- ❑ Rheumatoid arthritis
- ❑ Compression fracture
- ❑ Heart attack or heart disorder
- ❑ History of stroke or aneurysm
- ❑ Cancer
- ❑ Diabetes
- ❑ Gout
- ❑ Lupus
- ❑ Ankylosing spondylitis
- ❑ Immune suppression treatment or dis-order from chemotherapy, organ transplant, drug, etc.
- ❑ 3 or more months of steroid medica-tions or intravenous drugs (past or present)
- ❑ Tuberculosis, Hepatitis or HIV
- ❑ Multiple sclerosis
- ❑ Thyroid or hormone disorder
- ❑ High blood pressure
- ❑ Convulsions/epilepsy
- ❑ Allergies:_____
- ❑ OTHER:

CURRENT OTHER ISSUES

- ❑ Difficulty swallowing because of neck pain
- ❑ Pain or electric shocks in arms or legs when moving neck
- ❑ Leg pain worse with exercise
- ❑ Numbness of inner thighs
- ❑ Back pain with urinary problems
- ❑ Severe pain that interrupts sleep
- ❑ Constant pain that doesn't improve by changing positions or by lying down

SPECIFIC CURRENT CONDITIONS

- ❑ Poor balance
- ❑ Loss of bowel or bladder control
- ❑ Blurred or double vision, dizziness, nausea or faintness <u>when neck is in certain positions</u>
- ❑ Memory loss after injury
- ❑ Recent, unexplained weight loss
- ❑ Recent progressive muscle weakness or shaking
- ❑ Recent or current fever over 102℉

Last known: Height_____ **Weight**_____ **Are you pregnant?** □Yes □No How is your diet?_____

Do you exercise regularly? □Yes □No How do you de-stress?_____

FAMILY HISTORY (Circle) Spine problems Autoimmune disorders Arthritis Cancer Diabetes Heart disease Kidney disease Mental illness Seizures Other:_____

Personal Medical Physician_____ Phone _____

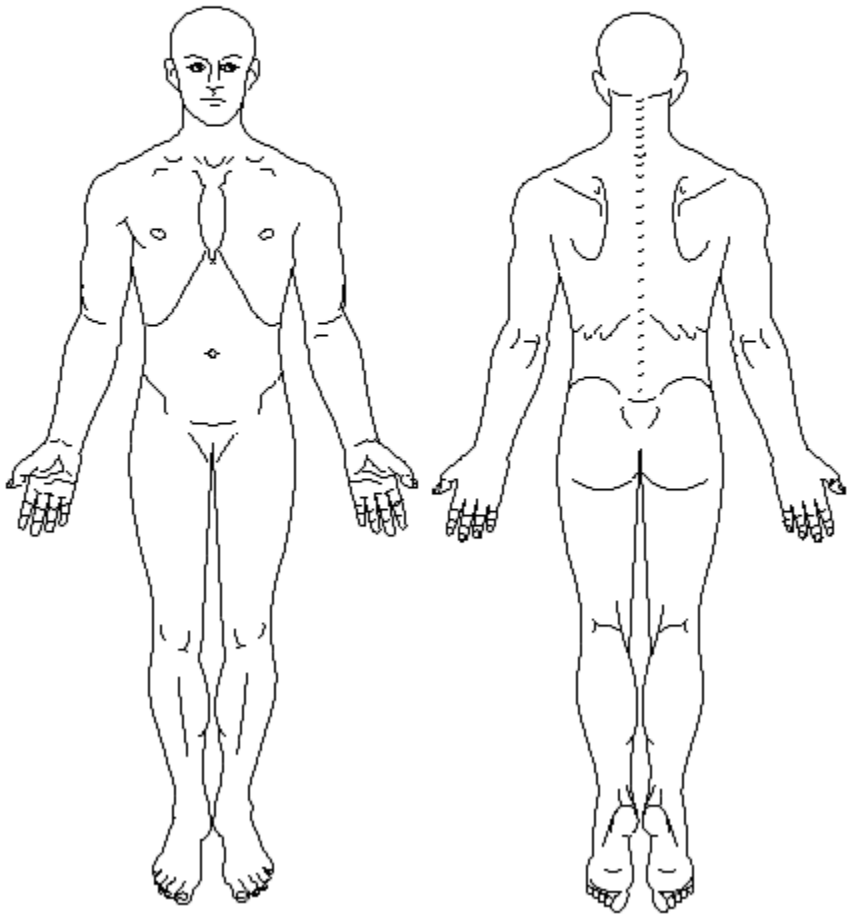
Have you been under Chiropractic care before? □Yes □No When was your last visit?_____

(Confidential Patient Information Continued)

Name:_____ **Date:**_____

PAIN DRAWING

SHADE IN WITH A PEN ALL AREAS YOU HAVE PAIN.
(Don't forget to include the head or areas of lesser pain).
Use small x's to show any areas of numbness or tingling



Please mark on the line, the pain level that most accurately represents your pain for **each** body area:

	0	1	2	3	4	5	6	7	8	9	10
Right now:	No pain										Unbearable
Average pain:	No pain										Unbearable
At best & worst:	No pain										Unbearable

What makes it better?_____ What makes it worse?_____

What percentage of each day does it currently bother you? (Circle one) 0% 25% 50% 75% 100%

(Confidential Patient Information Continued) (S.O.N.O.M.A. FORM)

Name:_____ **Date:**_____

CURRENT DIFFICULTIES WITH ACTIVITIES OF DAILY LIVING

People with spinal pain may find that certain activities are restricted or difficult to do. Circle all activities that you find difficult or painful to do NOW:

- Sleep through the night
- Get out of bed
- Make your bed
- Bathe or shower
- Wash, comb or dry hair
- Bend over a sink for 10 minutes
- Go to the bathroom
- Put on socks, shoes or clothing
- Walk up one flight of stairs
- Crawl on all fours
- Turn a door knob
- Open a heavy door
- Sit in a chair for 30 minutes
- Sit and work at a desk for one hour
- Get up from a low seat
- Cross legs
- Walk one mile
- Stand for 30 minutes
- Travel that takes more than one hour
- Push or pull vacuum cleaner or lawn mower
- Carry laundry basket, groceries, or a small child
- Wash windows or walls
- Bend over to clean a bathtub
- Shovel dirt or snow
- Use pencil, scissors, screwdriver, or pliers
- Lift a heavy suitcase (about 40 pounds)
- Reach in front or overhead to high shelves
- Enjoy hobbies or social activities
- Enjoy sexual activities

Other specific activities (please list):_____

_____

Circle any of the following conditions you are currently experiencing:

- Neck or back weakness
- Restricted movement of neck or back
- Persistent tender areas in muscles around neck or back
- “Catch” or “kink” in the neck or back

Total # of items circled:_____

Patient name_____ Date_____

Consent for Treatment

I, the undersigned, a patient at Rosser Chiropractic, hereby authorize Dr. Andy Rosser to administer chiropractic treatment as needed. I understand that each individual case is unique so there have been no guarantees regarding the results that may be obtained while under care. I understand that Dr. Rosser is treating me solely for the correction of spinal misalignments and posture abnormalities. I understand that while there are many associated health benefits from having a healthy spine, this office and practitioner are not treating me for any specific disease or condition.

Patient signature_____

Authorization for Insurance Payment

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that ultimately, I am responsible for the final settlement of my account.

I understand that as a courtesy to me, this office may file my insurance according to the particulars of my policy. If so, I authorize my insurance carrier(s) to make payment for the expense benefits allowed and otherwise payable to me, directly to Rosser Chiropractic for professional services I have received while under Dr. Rosser's care. I have agreed to pay, in a current manner, any balance of said professional charges.

Patient signature_____

Authorization to Release Medical Records

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information provided to this office is accurate and complete.

Patient signature_____

Authorization to Treat a Minor

I authorize Dr. Andy Rosser to administer treatment as needed to my child, _____.

Patient signature_____

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please know that we have and always will respect the privacy of your health information.

There are a few situations in which we may have to disclose your health care information:

- We may need to disclose it to another healthcare provider or hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your condition.
- We may need to disclose your health or billing details to another party (such as your insurance company or claimant's insurance company in an accident) if they are potentially responsible for the payment of your services.
- We may need to use your information within our practice for quality control or other operational purposes.

You are entitled to review a more detailed description of this notice before signing this consent form. It is available in the reception area of our office. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your Right to Limit Uses or Disclosure

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. Please provide us (in writing) with your specific restrictions for the use or disclosure of your health information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your revocation request. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Acknowledgement of Privacy Practices

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice, if desired.

Printed Name _____ m Parent, Guardian or Patient's Legal Representative

Signature _____ **Date** _____

Optional Authorizations **(Please initial/complete the following as you choose.)**

- You have my permission to leave me a voice mail message if the need arises. __Yes / No___
- You may discuss my health information with the following people (family/friends).

_____ _____ _____ _____