RECOVERY
CHIROMED

New Patient Medical History Registration

Full Name: _____ Birthdate: _____ Sex: ___ M ___ F
Address: _____
City: _____ State: _____ Zip: _____
Height: _____ Weight: _____ Social Security #: _____
Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed
Home Phone: _____ Employer: _____
Cell Phone: _____ Occupation: _____
Work Phone: _____ Email Address: _____
Emergency Contact Name: _____ Contact Phone #: _____
How were you referred to this office? _____

Chief Complaints: (please circle all that you have experienced since the accident)

Headaches Neck Pain Lower Back Pain Middle Back Pain Hip Pain: L R
Dizziness Weakness Shoulder Pain: L R Arm/Hand Pain: L R Leg/Pain: L R
Other: _____

Is the pain/discomfort constant? ____ Yes ____ No **Is pain on and off (intermittent)** ___ Yes ___ No

How would you describe the pain/discomfort? (please circle all that apply)

Sharp/Stabbing Dull Achy Cramping Soreness
Other: _____

How would you rate the pain? 10 being the worst possible pain and 0 being no pain. (please circle)

0 1 2 3 4 5 6 7 8 9 10

What makes your pain/discomfort worse? (please circle all that apply)

Sitting Standing Sneezing Coughing Moving arms or legs Lifting
Twisting Bathing Dressing Moving head Bending forward Rising from a chair
Driving Moving head Other: _____

Do you have any of the following? (please circle all that apply)

Right arm/hand: numbness pain tingling **Right leg/foot:** numbness pain tingling
Left arm/hand: numbness pain tingling **Left leg/foot:** numbness pain tingling

What have you been doing to decrease your pain/discomfort? (please circle all that apply)

Heating Pad Moving around Resting Sitting Ice
Standing Leaning forward Leaning to Side Laying on back Hot bath/shower
Other: _____

Approximately when did the pain/discomfort begin? (please circle)

Within past 72 hours 4-7 days ago 1-3 weeks ago Months ago: 1-3, 4-6, 6-9 Other: _____

Have you ever experienced this pain/discomfort before? __ Yes __ No If so, how long ago? _____

What were you doing when you first noticed this pain? (please describe in detail): _____

_____

_____

_____

_____

Have you lost any time at work due to your work related injury? ____ Yes ____ No

If yes, how many days have you taken off of work? _____

Have you received any medical treatment for this pain/discomfort? ____ Yes ____ No

If yes, who did you see/ Doctor's name? _____

What is this Doctor's specialty? (please circle)

Orthopedist Chiropractor Neurologist Family/General

Other: _____

Were any diagnostic tests performed? (please circle)

X-Ray MRI CT Scan Myelogram Other: _____

If so, where were they performed? _____

What type of treatment was rendered?

Prescriptions/Injections – please list _____

Chiropractic – Approximately how many treatments? _____

Physical Therapy – Approximately how many treatments? _____

Surgery (please list) _____

What percent better do you feel since beginning these treatments? (please circle)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What medications/vitamins/supplements do you currently take? (please circle and write dosage)

Blood Pressure: _____ Cholesterol: _____ Diabetic: _____

Multi-Vitamins: _____ Supplements: _____

Over the counter meds: _____

Other Medication: _____

Have you ever had a broken/fractured bone? _____ Yes _____ No

If so, please specify what was fractured and how long ago _____

Please list all past surgeries/hospitalizations and include approximate date(s):

_____

_____

Do you suffer from or have you been diagnosed with any of the following conditions? (please check)

___ AIDS
___ Alcoholism
___ Anorexia
___ Arthritis
___ Asthma
___ Bed Wetting
___ Bladder Trouble
___ Bleeding Disorders
___ Breast Disease
___ Cancer
___ Cataracts
___ Diabetes
___ Discolored Urine
___ Dizziness
___ Emphysema
___ Epilepsy
___ Glaucoma
___ Gout
___ Heart Problems
___ Hepatitis
___ Herniated Disc
___ High Blood Pressure
___ High Cholesterol
___ Irritability
___ Kidney Problems
___ Liver Problems
___ Menstrual Cramping
___ Menstrual Irregularity
___ Mononucleosis
___ Multiple Sclerosis
___ Nervousness
___ Pacemaker
___ Prostate Problems
___ Psychiatric Care
___ Rheumatoid Arthritis
___ Sexual Dysfunction
___ Stroke
___ Stress
___ Thyroid Problems
___ Tumors

Other: _____

Do you exercise? ____ Yes ____ No **Approximately how much per week?** _____
Do you smoke cigarettes/cigars? ____ Yes ____ No **Approximately how many per day?** _____
Do you drink alcohol? ____ Yes ____ No **Approximately how many per week?** _____

FEMALES ONLY: When was your last menstrual cycle? _____ Are you pregnant? ____ Yes ____ No

Do the following relatives suffer from any of the following? (please check the condition)

	Mother	Father	Sibling 1	Sibling 2	Sibling 3	Sibling 4
Diabetes						
Heart Disease						
High Blood Press						
Stroke						
Cancer						
Living						
Deceased						

I certify that this information is true to the best of my knowledge.

_____ _____
Patient/Guardian Signature Date

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Informed Consent

Patient Name: _____ **Patient #:** _____

Every type of health care is associated with some risk of potential problem. Health care providers, including chiropractors, are required by law to tell you the nature of your condition, the general nature of the treatment, and the risk involved. In keeping with the Louisiana law of informed consent, you are being asked to sign and date this form which confirms our discussion of these matters.

We want to give each patient the best possible care with the least possible risk of complications. To accomplish this, we format treatment plans to suit the distinctive needs of each patient. The following paragraphs describe the most severe risks associated with chiropractic care which are extremely rare in occurrence.

1. Stroke: Stroke is the most serious problem associated with spinal manipulation. The consequences can be temporary or permanent dysfunction of the brain with a very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise from the vertebral artery, which runs on each side of your neck. This problem occurs so rarely that there is no conclusive data to quantify the probability.
2. Disc Herniation Aggravation: Disc herniations that create pressure on the spinal nerve and/or spinal cord are successfully treated by chiropractors on a daily basis. Chiropractic manipulation can aggravate an existing disc herniation resulting in an increase of symptoms, which may last for a few days but seldom for longer periods of time.
3. Soft Tissue Injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit bone movement. Rarely, chiropractic manipulation can result in minor damage to a particular soft tissue. This may cause a temporary increase in pain and necessary treatments for resolution, but there are no long term effects on the patient.
4. Rib Fractures: The rib cage is found in the thoracic spine or middle back area. Rarely, chiropractic manipulation can cause a fracture to occur. Patients who have weakened bones (osteoporosis or osteopenia) have a higher risk of rib fractures because their bones are weaker than normal. We adjust all patients carefully, especially those who have indications of osteoporosis on their x-rays.
5. Other Possible Complications: There are many other side effects and/or complications that may also rarely occur due to spinal manipulations. These possible complications include, but are not limited to, the following: headaches, skin burns, dizziness, radiating pains into arms and/or legs, exacerbation of pain/problem, soreness, etc

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I hereby authorize Recovery ChiroMed, together with assistance of their choice, to provide chiropractic treatment including examination/diagnostics, spinal manipulations/adjustments, and various modes of physical therapy that may be deemed necessary or reasonable. I have read and understand all information set forth in this document, including any attachments. I acknowledge that I had the opportunity to ask any questions about the contemplated procedure and that my questions have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

_____ _____

Patient or Responsible Party Signature **Date**

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Office Policies

Patient Name: _____ **Patient #:** _____

Thank you for choosing us as your health care provider. Please understand that payment of your bill is considered part of your treatment. The following statements refer to our office policies which we require that you read, accept, sign, and date before any treatment can begin.

1. Every new patient is required to fill out our forms concerning his/her history and general information prior to being examined.

2. Each insurance company or group has specific guidelines that we must follow to warrant payments for our services. As a courtesy to you, we file all claims to your insurance company or group. Please remember that YOU have the contract with the insurance company or group and YOU are ultimately responsible for payment. We cannot accept responsibility for collecting from your insurance company or group nor negotiating a settlement on a disputed claim. If you do need assistance with your insurance, please see our office manager; who will readily assist you.

3. Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. Please understand that you are responsible for payment in full regardless of an insurance company's arbitrary determination of usual and customary rates.

4. Open accounts with no acceptable payment activity for 60 days will be considered past due. A billing charge may be accessed to the account balance along with a finance charge of 1.5% per month. You will be responsible for the original past due balance along with these additional charges. Acceptable payment activity will be determined on an individual basis. Please speak with our office manager to avoid any misunderstandings.

5. Open accounts with no acceptable payment activity for 120 days will automatically be placed with our collection agency. You will be responsible for payment of the original balance plus any billing charges, finance charges, collection fees, and attorney fees assessed to your account.

6. The adult accompanying the minor is responsible for full payment. The adult (i.e. parent, legal guardian) must be present with a minor and sign the Treatment Consent Form before any services can be administered.

_____ _____

Patient or Responsible Party's Signature **Date**

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CONSENT TO THE USE & DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Patient's Name: _____ Id #: _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A mean of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of any healthcare information:

_____

_____

_____

_____

Patient's Signature: _____

Date: _____ Witness Signature: _____

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Pregnancy Warning and Consent to X-Ray

Patient Name: _____ **Patient #:** _____

I understand that if I am pregnant and have X-rays taken, which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the 10 days following onset of a menstrual period are generally considered to be safe for X-ray exams.

With those factors in mind, I am advising my doctor that:

	Yes	No	Don't Know
I am pregnant	___	___	___
I could be pregnant	___	___	___
I am late with my menstrual period	___	___	___
I am taking oral contraceptives	___	___	___
I have an IUD	___	___	___
I have had a tubal ligation	___	___	___
I have had a hysterectomy	___	___	___
I have irregular menstrual periods	___	___	___

My last menstrual period began on: _____

With full understanding of the above, and believing that I am not currently at risk, I wish to have an X-ray examination performed now.

_____ _____

Signature Date

Kevin M. Brien, D.C.
C. Brett Venable, D.C.

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Shane Chaisson, D.C.
Jason Neatherlin, D.C.

I, _____, hereby authorize Kevin Brien, D.C., Brett Venable, D.C., Shane Chaisson, D.C., and/or Jason Neatherlin, D.C. and whomever they/he may designate as their assistant to administer chiropractic care as they deem necessary to my child.

Date: _____

Name of Minor: _____

Parent/Guardian: _____
(Printed Name)

_____
(Signature)

Witness: _____