

NWA CHIROPRACTIC

PATIENT HISTORY

(Please Print, All information is confidential)

Name: Referred by: Address: Apt: City: State: Zip: Date of Birth: Age: Marital Status: # of Children SS# Home Ph: Other Ph: Work Ph: Cell Ph: E-mail: Occupation: Employer: Driver's License #: Do you have insurance? Yes or No (If yes, please give the front desk your card to copy)

If patient is a minor (under 18yrs old), please fill out this section. If not, please skip:

Parent/Guardian's Name: Date of Birth: Age: Address: City/State: Zip: SS#: Phone#: Work Ph: Occupation: Employer:

Chief complaint or reason for today's visit? How long have you had this condition? Date of Onset? Have you had this condition before? If yes, when? Is the condition related to: Work () Auto () Date of Accident: Have you lost days from work? What doctors have you seen for this conditions? What did they do? When was your last visit to a Chiropractor? Were you helped? What Spinal Correction programs were you given? Did you follow it? If not, why? How did the post X-Rays look? What surgeries have you had? List Drugs you now take (prescription and non-prescription): Are you currently wearing Heal Lifts Arch Supports Back Brace ?

Please mark X for present conditions, O for past conditions

- Fractured Bones, Auto Accidents, 0-1 yrs ago, 1-5 yrs ago, More than 5, Other Accidents/ Falls, Numbness/ Tingling/ Pain, Swollen/ Painful Joints, Convulsions/ Epilepsy, Back Curvature, Cancer, Frequent Colds/ Flu, Depressed, Irritable, Anemia, Tremors, Allergies, Sinus Problems, Headache, Trouble Sleeping, Trouble Concentrating, Learning Disability, Ulcers, Eating Disorders, Pain/ Stiff Neck R L, in buttocks, thighs, legs, feet, toes, Arms/Hands/Fingers R or L, Jaw Pain/TMJ R L, Head/ Shoulders Feel Tired, Difficulty in Excessive (Standing, Walking, Bending, Riding, Twisting, Lifting, Household Duties), Shoulder Pain R L, Dizziness, Ringing in Ears R L, Hearing Loss R L, Fainting, Loss of Balance, Blurred Vision R L, Double Vision R L, Upper Back Pain/ Stiffness, Mid Back Pain/ Stiffness, Low Back Pain/Stiffness, Numbness, Tingling or Pain, Hemorrhoids, Pain with cough, sneeze, Hip Pain R L, Foot Trouble R L, Chest Pain, Asthma, Lung Problems, Difficulty Breathing, Heart Problem, Stroke, High/Low Blood Pressure, Varicose Veins, Liver Trouble, Gall Bladder Trouble, Digestive Problems, Heartburn, Mood Changes, Diarrhea/Constipation, Colon Trouble, Diabetes, Prostate Problems, Impotence, Kidney Trouble, Menstrual Problems, Menopausal Problems, Pregnant (now), Bed Wetting, Ear Infection, Skin Problems, Arthritis, AIDS/HIV

Name: _____ Date of Birth: _____

Symptomatology: (continued from page one)

Problem area #1

The pain is located _____

The pain started _____

The pain is made better by _____

And worse by _____

How would you describe the pain?: _____

There is There is not radiation into _____

There is There is not referred pain into _____

There is There is not parathesia (tingling/numbness) into _____

The pain is (as far as time is concerned: i.e. comes & goes, constant, etc.) _____

On a scale of 1-10 rate your pain: no pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

Problem area #2

The pain is located _____

The pain started _____

The pain is made better by _____

And worse by _____

How would you describe the pain: _____

There is There is not radiation into _____

There is There is not referred pain into _____

There is There is not parathesia (tingling/numbness) into _____

The pain is (as far as time is concerned: i.e. comes & goes, constant, etc.) _____

On a scale of 1-10 rate your pain: no pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

Problem area #3

The pain is located _____

The pain started _____

The pain is made better by _____

And worse by _____

How would you describe the pain: _____

There is There is not radiation into _____

There is There is not referred pain into _____

There is There is not parathesia (tingling/numbness) into _____

The pain is (as far as time is concerned: i.e. comes & goes, constant, etc.) _____

On a scale of 1-10 rate your pain: no pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

NWA Chiropractic, PA

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important for each patient to understand both the objective and the method that will be used to attain it. This will prevent confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustment to the spine.

Health: A state of optimal, physical, mental and social well being, not merely the absence of disease, symptoms or sickness.

Vertebral Subluxations: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of the health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression to the body's innate wisdom. Our only method is the specific adjustment of vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

POLICIES

1. All first visit charges are payable when services are rendered, since it is impossible to determine what insurance covers without a diagnosis of severity.
2. The fee paid for X-Rays is for the analysis of those X-Rays only. The film is the property of this office. Original X-Rays cannot be released; however they can be checked out for 30 days.
3. I have read NWA CHIROPRACTIC's Notice of Patient Privacy Practices.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand NWA CHIROPRACTIC (NWAC) will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to NWAC will be credited to my account upon receipt. However, I clearly understand and agree that all the services rendered to me are charged directly to me, and that I am personally responsible for payment.

_____ I certify that to my knowledge, I am not pregnant.

In case of emergency, notify _____ Phone # _____

I, _____, have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis _____ Date: _____

(Signature)

COMPLETE IF THE PATIENT IS A MINOR CHILD: child's name: _____

I, _____ being the parent or legal guardian of the aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care. _____

(signature)

(date)