Welcome to Pinnacle Chiropractic Spine and Sports Center

Name: _____ **Social Security Number:** _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Telephone → ***Home:*** _____ ***Work:*** _____ ***Mobile:*** _____

Age: _____ **Date of Birth:** _____ **Height:** _____ **Weight:** _____ **Gender: M / F**

Employer: _____ **Occupation:** _____ **Average Hours Worked Weekly:** _____

Marital Status: _____ **Spouse's Date of Birth:** _____ **Number of Children:** _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: ***Home:*** _____ ***Work:*** _____ ***Mobile:*** _____

Whom can we thank for referring you? _____

Have you received chiropractic or physical therapy treatment within the last year? _____

List your current treating Doctors (Include Name and specialty)

PCP / Family Care: _____ **Specialist:** _____
Specialist: _____ **Specialist:** _____

What is your Primary Reason for seeking care? _____
Secondary Reasons? _____

Please Describe your Primary Complaint: _____

_____

How do you think this condition started? _____ *Not Sure*
Have you ever had a complaint similar to this in the past? *No Yes*
Is your complaint related to any particular accident or injury? *No Yes*
If yes, do you hold an accident policy? *Yes No*

Is your complaint *Constant (100%)* *Frequent (75%)* *Often (50%)* *Intermittent (25% or less)*

Does anything make your complaint better? _____
Does anything make your complaint worse? _____

Is your complaint *Getting Better?* *Getting Worse?* *Staying the Same?*

Have you been treated for this condition in the past? *Medical* *Chiropractic* *Physical Therapy* *Other*

Please List All Medications You Are Currently Taking: _____

Please List All Vitamins and Minerals You Are Currently Taking: _____

Please List Any Known Allergies: _____

Previous Illnesses / Hospitalizations *No Yes*

Previous Injuries, Accidents, Broken Bones, Concussions, Etc. *No Yes*

Previous Surgical Procedures *No Yes*

When Was Your Last	Less than 6 Months	6-18 Months	Over 18 Months	Never
Physical Exam	☐	☐	☐	☐
Blood Test	☐	☐	☐	☐
X-Ray, CT-scan, or MRI	☐	☐	☐	☐

General Health

- O Fever
- O Chills
- O Weight Loss
- O Weight Gain
- O Allergies
- O Stuffiness
- O Sinus Pain
- O Fatigue
- O Trouble Sleeping
- O Weakness
- O Lumps / Swollen Glands
- O Swelling
- O Itching
- O Rash
- O Dry Mouth

Head / Neurological

- O Headache
- O Head Injury
- O Blurry or Double Vision
- O Flashing Lights
- O Sensitivity to Light
- O Earaches
- O Ringing in the Ears
- O Sensitivity to Noise
- O Dizziness
- O Fainting
- O Seizures
- O Tremor
- O Nervousness
- O Depression
- O Memory Loss

Cardio / Respiratory

- O High Blood Pressure
- O Low Blood Pressure
- O Chest Pain
- O Difficulty Breathing
- O Painful Breathing
- O Wheezing
- O Cough (Dry or Wet)
- O Palpitations
- O Bruise or Bleed Easily

Endocrine

- O Excessive Thirst
- O Change in Appetite
- O Hair and Nail Changes
- O Heat or Cold Intolerance

Gastrointestinal / Genitourinary

- O Heartburn
- O Difficulty Swallowing
- O Nausea
- O Vomiting
- O Stomach Pain
- O Change in Bowel Habits
- O Constipation
- O Diarrhea
- O Sweating / Night Sweats
- O Yellow Skin or Eyes
- O Burning with Urination
- O Urgency
- O Incontinence
- O Change in Urinary Patterns / Strength

Please Check All That Apply, Presently Or In The Past:

Musculoskeletal System

- O Neck Pain (R or L)
- O Stiff Neck (R or L)
- O Noises in Neck
- O Head Feels Heavy
- O Pain / Tight Between Shoulder Blades
- O Pain / Numbness in Arms (R or L)
- O Pain / Numbness in Hands (R or L)
- O Pain in Shoulders (R or L)
- O Pain in Elbows (R or L)
- O Pain in Wrists (R or L)
- O Swelling of Joints
- O Pins / Needles in Arms (R or L)
- O Pins / Needles in Hands (R or L)
- O Cannot Raise Arm (R or L)
- O Back Pain (R or L)
- O Stiff Back (R or L)
- O Leg Cramps (R or L)
- O Redness of Joints
- O Pain / Numbness in Legs (R or L)
- O Pain / Numbness in Feet (R or L)
- O Cannot Lift Leg (R or L)
- O Pain in Hips (R or L)
- O Pain in Knees (R or L)
- O Pain in Ankles (R or L)
- O Pain in Feet (R or L)
- O Pins / Needles in Legs (R or L)
- O Pins / Needles in Feet (R or L)
- O Cold Hands / Feet (R or L)

Family History: ***Please Check All of the Following that Apply to Your Direct Relatives***

- O Diabetes
- O High Blood Pressure
- O Heart Disease
- O Pulmonary Disease
- O Stroke
- O Thyroid Disorders
- O Cancer
- O Tumors
- O Muscular Disorders
- O Arthritic Diseases
- O Neurological Diseases
- O Psychological Disorders
- O Autoimmune Disease
- O Connective Tissue Disease
- O Vascular Diseases
- O Other

Habits

Tobacco ☐ **None** ☐ **Yes** Packs Per Day _____ For How Long _____

Alcohol ☐ **None** ☐ **Yes** Drinks Per Week _____

Exercise ☐ **None** ☐ **Yes** Days Per Week _____ Type _____

Water Intake ☐ **None** ☐ **Yes** Glasses Per Day _____

Coffee ☐ **None** ☐ **Yes** Cups Per Day _____

Soft Drinks ☐ **None** ☐ **Yes** Amount Per Day _____ ☐ **Regular** ☐ **Diet**

Sleep Do you sleep soundly all night? ☐ **No** ☐ **Yes** Average Hours per night _____

Do you have difficulty falling asleep or staying asleep? ☐ **No** ☐ **Yes**

Appetite ☐ **Poor** ☐ **Normal** ☐ **Always Hungry** Meals Per Day _____

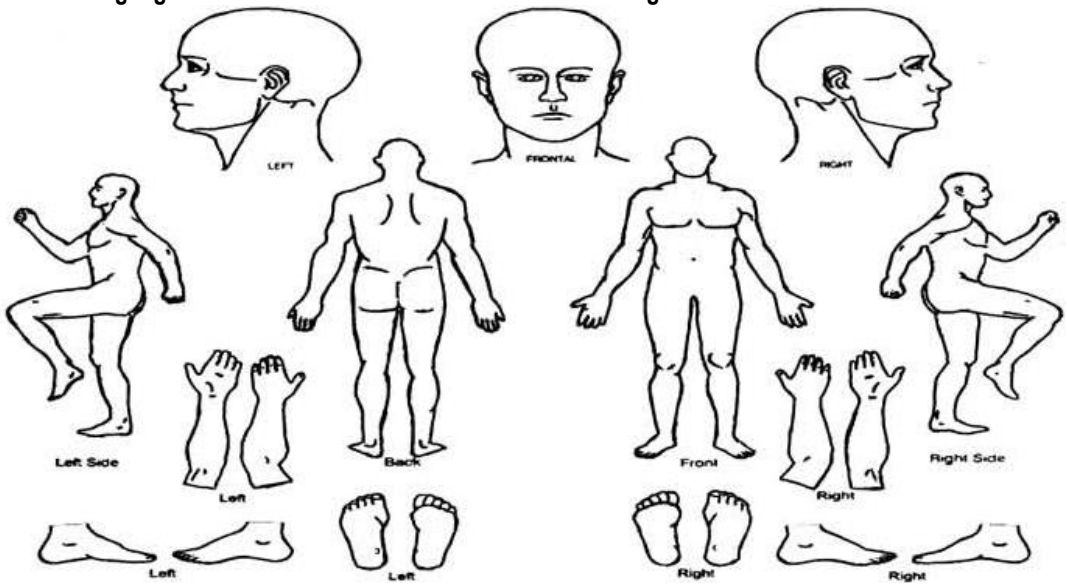
Stress Levels At Work ☐ **Low** ☐ **Med** ☐ **High** **At Home** ☐ **Low** ☐ **Med** ☐ **High**

I certify that the above information is correct to the best of my knowledge. I will not hold the doctors or any members of the staff of Pinnacle Chiropractic responsible for any errors or omissions I may have made in completion of this information.

Patient Signature: _____ Date: _____

Please mark the appropriate diagrams where you are experiencing your complaints.

P = Pain **T = Tingling** **N = Numbness** **B = Burning** **S = Stiffness** **A = Ache**



What is your pain RIGHT NOW?										
O	O	O	O	O	O	O	O	O	O	O
0	1	2	3	4	5	6	7	8	9	10
No Pain										Unbearable Pain

What is your TYPICAL or AVERAGE pain?										
O	O	O	O	O	O	O	O	O	O	O
0	1	2	3	4	5	6	7	8	9	10
No Pain										Unbearable Pain

What is your pain AT ITS BEST?										
O	O	O	O	O	O	O	O	O	O	O
0	1	2	3	4	5	6	7	8	9	10
No Pain										Unbearable Pain

What is your pain AT ITS WORST?										
O	O	O	O	O	O	O	O	O	O	O
0	1	2	3	4	5	6	7	8	9	10
No Pain										Unbearable Pain

Patient-Specific Functional Scale

Initial assessment: Please identify at least three important activities that you are unable to do or are having difficulty with doing as a result of your problem. (Activities affected may be as simple as getting out of bed, carrying groceries, child care, or personal hygiene, or even as complex as duties associated with your occupation.)

Please Use the scale below to grade the amount of difficulty you are having with each activity.

Patient-specific activity scoring scheme (Select one number per activity):

0	1	2	3	4	5	6	7	8	9	10
Unable to Perform Activity										Able to Perform at the same level as before injury or problem

Please List the Activities You are Having Difficulty With:	Score
1.	
2.	
3.	
4.	
5.	
Additional:	
Additional:	

Signature: _____ **Date:** _____

INFORMED CONSENT

After reviewing your health history, the Doctor will examine you and may require other diagnostic tests, such as X-rays, MRI or Lab tests, to make an accurate diagnosis and treatment plan. The Doctor will select a treatment plan which best suits your needs. You will be informed of all alternative treatments available to you. Occasionally the plan may have to be altered during treatment, due to unexpected changes. We encourage you to ask the Doctor any questions you may have so you fully understand your condition.

At this time, we would like to inform you of the risks that may occur from Chiropractic treatment. They are as follows: muscle soreness and irritation, headache, pain, muscle spasm and stiffness. In rare instances, dizziness and/or nausea may occur.

If there is anything you do not understand, please discuss it with the Doctor before signing the statement below.

I certify the information I provided for the health history is true and factual to the best of my knowledge. I understand the office policy and the risks of chiropractic treatment, which were supplied in the statement above. Any additional information which may occur will be supplied to you. I hereby consent to chiropractic treatment.

_____ _____

(Patient Signature) (Date)

The patient is unable to consent because _____

(i.e. underage, etc.) I, therefore consent for the patient.

_____ _____

(Signature) (Date)

Relationship to patient: _____

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at anytime; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, 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 consent any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§ 164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received service from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient name (Printed) Date

_____ _____

Patient Signature Authorized Provider Representative

_____ _____

Personal Representative Printed Personal Representative Signature

_____

Description of personal representative's authority to act for the patient.

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

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

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control to other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§164.520). 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 disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. 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 your 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 request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to you health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms.

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature Date

_____

Date

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Pinnacle Chiropractic Spine and Sports Center as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance and deductibles.
- Patients are responsible for all charges not covered or paid by insurance.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include charges for returned checks.
- If you are unable to pay the charges in full, you may call our office to set up a payment plan.
- If you are unable to keep your appointment and need to cancel, please call at least 24 hours in advance. If you miss an appointment without notifying us, we reserve the right to charge you a $25.00 missed appointment fee.
- By my signature below, I hereby authorize assignment of financial benefits directly to Pinnacle Chiropractic Spine and Sports Center. I authorize the use of my signature on all insurance submissions.

About Medicare:

We accept assignment from Medicare. Medicare has very limited chiropractic coverage. It covers 80% of chiropractic adjustments after the Part B deductible is satisfied. Medicare does not cover the cost of the initial examination, x-rays, or other services. These non-covered charges, as well as 20% of the chiropractic adjustment are patient responsibility if not covered by a secondary insurance.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_____

Printed Name of Patient or Guardian Relationship to Patient

_____

Signature of Patient or Guardian Date