MODESTO
PHYSICAL MEDICINE

PATIENT INFORMATION

Name: _____
Last First MI

Email address: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone # (Cell)_____ (Home) _____ (Other) _____

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ____

Occupation: _____

Employer: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

ACCIDENT INFORMATION

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Claim #: _____ Date of Injury: _____

HEALTH OR AUTO INSURANCE INFORMATION

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

Policy Holder Name: _____ D.O.B. :_____

Relationship to patient (if other than self): _____ Phone # _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR DRIVER'S LICENSE AND INSURANCE CARD(S)

ASSIGNMENT AND RELEASE (INSURED PATIENTS)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE: _____ **DATE** _____

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HEALTH HISTORY

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Low Back Pain (L/R)	❑ Elbow Pain (L/R)	❑ Blurred Vision	❑ Sudden Weight Loss
❑ Mid Back Pain (L/R)	❑ Hip Pain (L/R)	❑ Headaches	❑ Pins/Needles in Legs
❑ Neck Pain (L/R)	❑ Leg/Knee Pain (L/R)	❑ Nervousness	❑ Pins/Needles in Arms
❑ Wrist Pain (L/R)	❑ Ankle Pain (L/R)	❑ Tension/Stress	❑ Pins/Needles in Hands
❑ Hand Pain (L/R)	❑ Foot Pain (L/R)	❑ Night Pain	❑ Cold Feet
❑ Arm Pain (L/R)	❑ Fatigue	❑ Allergies	❑ Fever
❑ Shoulder Pain (L/R)	❑ Dizziness	❑ Jaw Problems	❑ Sleeping Difficulties

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cataracts	❑ Gout	❑ Migraines	❑ Stroke
❑ Allergy Shots	❑ Chemical Dependency	❑ Hair Loss	❑ Multiple Sclerosis	❑ Thyroid Problems
❑ Anorexia	❑ Diabetes	❑ Hernia	❑ Osteoporosis	❑ Ulcers
❑ Arthritis	❑ Difficulty Weight Loss	❑ Herniated Disc	❑ Parkinson's Disease	❑ Water Retention
❑ Bleeding Disorders	❑ Food Cravings	❑ High Cholesterol	❑ Polio	❑ Weight Gain
❑ Brittle Nails	❑ Fractures	❑ Hyperactivity	❑ Prosthesis	
❑ Bulimia	❑ Glaucoma	❑ Kidney Disease	❑ Restlessness	
❑ Cancer	❑ Goiter	❑ Liver Disease	❑ Rheumatoid Arthritis	

❑ Other _____

Are you currently under medical care? ❑ Yes ❑ No If yes, explain _____

Please list any medications you are currently taking (**Be sure to include dosage and frequency**)_____

_____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

_____

_____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

Reviewed by SIGNATURE (X) _____ **DATE** _____

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INFORMED CONSENT TO MEDICAL/CHIROPRACTIC TREATMENT

As with any medical or chiropractic procedure there are certain complications which may arise. Medical Doctors, Nurse Practitioners and Chiropractors are required to advise patients that there are risks associated with such treatment. Adverse reactions or potential side effects are listed below:

Chiropractic

1. Some patients may experience some stiffness or soreness following the first few days after a chiropractic treatment.
2. Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
3. We will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.
4. Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

Medical

1. Following an injection (trigger point injections, PRP, Stem Cell therapy, cortisone, HA, Vit.B12, facial or cosmetic procedures, etc.), patients may experience soreness, redness, inflammation, bruising, rash, or an infection.
2. Potential adverse reactions from **IV therapy** include: hypernatremia (high levels of sodium), fluid retention, high blood pressure, heart failure, injection site reactions, kidney damage, electrolyte abnormalities, or infection.
3. Potential adverse reactions for **Hair Restoration Therapy** include: pain at the injection site, edema, facial swelling, discoloration of the skin, rash, or infection.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which we check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with one of the chiropractors and/or nurse practitioner.

I consent to the medical/chiropractic treatments offered or recommended to me by the doctor, including spinal manipulation, any injections, diagnostic testing, etc. I intend this consent to apply to all my present and future medical/chiropractic care.

_____ _____

Patient Signature Date:

_____

Witness Signature

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Patient Quality of Life Survey

Name: _____ Date: _____

Please circle any that apply:

1. How have you taken care of your health in the past?
   a. Medications
   b. ER
   c. Routine medical
   d. Exercise
   e. Nutrition/Diet
   f. Vitamins
   g. Chiropractic
2. How did the previous method(s) work out for you?
   a. Bad results
   b. Some results
   c. Great results
   d. No change
3. How have others been affected by your health condition?
   a. No one is affected
   b. Have not noticed any problem
   c. They tell me to do something
   d. People avoid me
4. What are you afraid this might be (or beginning) to affect (or will affect)?
   a. Job
   b. Kids
   c. Future ability
   d. Marriage
   e. Self-esteem
   f. Sleep
   g. Time
   h. Finances
   i. Freedom
5. Has your health condition affected your job, relationships, finances, family, or other activities? _____
6. What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc)
   _____
7. What are you most concerned with regarding your problem?
   _____
8. Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? _____
9. What would be different/better without this problem?
   _____