McDowell Chiropractic New Patient Questionnaire

Patient Information

PLEASE PRINT

First Name_____Middle_____Last_____
SS#_____
Address_____City_____ State_____Zip_____

❑Male ❑Female ❑Married ❑Single ❑Widowed ❑Divorced ❑Separated
Birthdate_____Age_____ Height_____ Weight_____ Home Phone_____
Cell_____ E-mail Address_____
How do you prefer to be contacted? Cell Email Home Phone Mail
Race: Asian / Black / White / Hispanic / 2 or more races / I choose not to identify

Employer_____ Occupation_____ #years_____
Business Address_____City_____ State_____ Zip_____
Work Phone_____

***Spouse or Parent's Name*_____ Birth Date_____ Phone_____**
Emergency Contact_____ Phone _____ Relation_____

Whom may we thank for referring you to us? _____

Did you see our Road Sign?_____ Yellow Page Ad? _____ Other?_____

Name of local primary Physician_____ May we contact them?____

Insurance Information – If Insured, Please provide copy of insurance card.

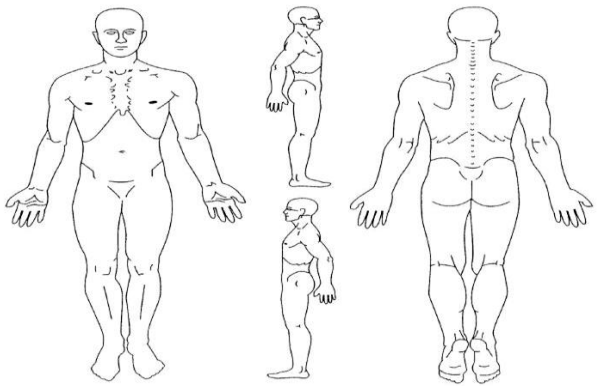
Health History - Please circle all that apply

AIDS/ HIV Allergy Shots Anemia Anorexia Appendicitis Arthritis Asthma Bleeding Breast Lump Bronchitis Bulimia Cancer Cataracts Chicken pox Depression Diabetes Emphysema Epilepsy Fractures Glaucoma Goiter Gonorrhea Gout Heart ds Hepatitis Hernia Herniated disc Herpes High Cholesterol Kidney ds Liver ds Measles Migraines Miscarriage Mono M. S. Mumps Osteoporosis Parkinson's Polio Pacemaker Pneumonia Prostate Prosthesis Implants Rheumatoid Stroke Thyroid Tonsillitis Tuberculosis Tumors Typhoid Ulcers V. D. Whooping Cough Chronic Fatigue High Blood Pressure Fibromyalgia Other_____
_____
Women - How many children?_____Pregnant?_____Date of last Menstrual Cycle_____
Nursing?_____Taking Birth Control Pills?_____
Previous Surgeries and Dates? _____
_____
List ALL Medications you are currently taking (or present a list)_____
_____
What kind of exercise do you do? _____
What supplements do you take?_____
How much do you smoke per day?_____ Drink per week? _____

***All questions on the front and back of this form have been answered accurately, and I understand that giving incorrect information can be dangerous and affect the doctors ability to diagnose and treatment my condition.**
Patient Signature_____ Date_____

Patient Name **Date**

USE THIS FORM IF YOU HAVE ONLY ONE AREA OF COMPLAINT.
If you have more than one complaint area, please ask the front desk for another form.
Mark on the body diagram where you are experiencing symptoms:



1. When did your symptoms begin? **Month_____ Day_____Year _____**

2. Describe Symptoms: (Circle one in each row)

A. Mild Mild/Moderate Moderate Moderate/Severe Severe

B. Constant Occasional Intermittent Frequent

C. Getting worse Getting better No change

3. Circle the number describing your pain level:

***0 1 2 3 4 5 6 7 8 9 10**
mild moderate severe
(0 is no pain 10 is severe pain)

4. Describe your pain: (Circle all that apply)

Ache
Burn
Dull
Numb
Sharp
Tingle
Other_____
_____
_____

5. What makes your pain…..(Circle all that apply)

Better	Worse
Sitting	Sitting
Standing	Standing
Lying	Lying
Lifting	Lifting
Riding	Riding
Hot	Hot
Cold	Cold
Other_____	

6. What caused your symptom? _____.
_____

7. What were you doing when it happened?

Bending Carrying Sitting Cooking Driving
Other_____

8. Have you ever had this symptom before? Y N

Patient Name _____ **Date** _____

Payment/Insurance Information:

Who is responsible for your bill? Self Spouse Parent Other _____

We will be happy to file insurance on your behalf. Please provide the following information and present your card to the front desk.

Personal Health Insurance Carrier: _____
Policy Holder's Name: _____
Policy Holder's Place of Employment _____ Full time / Part time
Policy Holder's Date of Birth _____ / _____ / _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date: _____/_____/_____ Time: _____am / pm

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____
Date_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____
Date_____

Assignment and Release
I, the undersigned, assign directly to Dr. Lynn Burgin, all benefits, if an, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all of my insurance submissions whether manual or electronic. I authorize McDowell Chiropractic, Inc. to endorse any insurance checks made out in my name to be put towards my account on any outstanding balance. I understand that all original documents and original x-rays created will remain the property of McDowell Chiropractic, Inc. McDowell Chiropractic, Inc. and Dr. Lynn Burgin, D.C. will not be held responsible for any undisclosed preexisting condition.

Permission for treating MINORS
As the parent, guardian or parentally authorized agent, I hereby authorize Dr. Lynn Burgin, D.C. and McDowell Chiropractic, Inc., its physicians and agents to administer care to this minor.
Minor's Name_____ Guardian Signature_____

SIGNATURE OF PATIENT _____ **Date:** _____

INFORMED CONSENT FORM PATIENT NAME: _____ DATE: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

spinal manipulative therapy	palpation	vital signs	range of motion testing
orthopedic testing	basic neurological testing	muscle strength testing	postural analysis
ultrasound	hot/cold therapy	electrical stimulation	radiographic studies
mechanical traction	Other (please explain)_____		

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or I have not read [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *(insert doctor's name)* and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____/_____/_____

Patient's Name **Patient's Signature** **Signature of Parent of Guardian (if a minor)**

Lynn Burgin D.C **Dated:** _____

Dr.'s Name **Dr.'s Signature**