# FANWOOD
# BACK RELIEF CENTER

*Name_____ Date_____

*Phone Number _____-_____-_____ *Date of Birth _____/_____/_____ Sex: M / F Age_____

*Address _____ *City _____ Occupation _____

*State_____ *Zip_____ *Email Address _____ SSN _____

Emergency Contact: Name _____ Phone _____

***Primary Care Physician (PCP)**_____ Phone _____

*PCP Address _____ City_____ State _____ Zip_____

How did you hear about us? (Circle one) ☐ Newspaper AD ☐ Facebook ☐ Instagram ☐ Google ☐Tictok ☐Drive By

Were you referred by: An existing Patient? _____ A Physician? _____

Is your injury related to an automobile or work-related accident? Yes / No

**<u>*PRIMARY COMPLAINT</u>: _____**

When did it start? _____ Have you had this condition before? ☐ Yes ☐ No

Type of pain (please circle one): sharp, dull, aching, shooting, numbness, tingling

Does the pain travel? ☐ Yes ☐ No If yes, from where to where? _____

How often does the pain occur (please circle one)? Constant? Episodic? Occasional?

How many times a (please circle one) day/week/month? Is condition getting worse? ☐ Yes ☐ No

Rate the pain from 1-10: At its worst _____ At the present time ____ At least severe _____

What makes it feel better? _____ What make it feel worse? _____

What do you think caused the problem?_____

List the activities that this condition prevents you from doing: _____

List past treatment for this condition and if they helped: _____

**<u>SECOND COMPLAINT</u>: _____**

When did it start? _____ Have you had this condition before? ☐ Yes ☐ No

Type of pain (please circle one): sharp, dull, aching, shooting, numbness, tingling

Does the pain travel? ☐ Yes ☐ No If yes, from where to where? _____

How often does the pain occur (please circle one)? Constant? Episodic? Occasional?

How many times a (please circle one) day/week/month? Is condition getting worse? ☐ Yes ☐ No

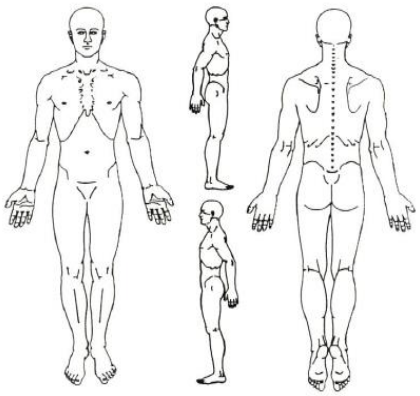
Rate the pain from 1-10: At its worst _____ At the present time ____ At least severe _____

What makes it feel better? _____ What make it feel worse? _____

What do you think caused the problem?_____

List the activities that this condition prevents you from doing: _____

List past treatment for this condition and if they helped: _____



## Indicate pain on Diagram

- ❑ Headaches
- ❑ Wrist or hand pain
- ❑ Stomach Problems
- ❑ Depression
- ❑ Knee Pain
- ❑ Numbness/tingling
- ❑ Ringing in ears
- ❑ Anxiety
- ❑ Neck Pain
- ❑ Chest Pain
- ❑ Loss of balance
- ❑ Shoulder pain
- ❑ Low back pain
- ❑ Heart Conditions
- ❑ Nervousness
- ❑ Hip Pain
- ❑ High blood pressure
- ❑ Cancer
- ❑ Fatigue
- ❑ Shortness of breath
- ❑ HIV
- ❑ Arthritis
- ❑ Vertigo
- ❑ Loss of smell/taste
- ❑ Dizziness
- ❑ Joint swelling
- ❑ Jaw pain
- ❑ TMJ
- ❑ Insomnia
- ❑ Stomach/GI
- ❑ Diabetes (Insulin)
- ❑ Diabetes (No Insulin)

**Do you currently have, or have you had any of the following conditions or symptoms? Check all that apply:**

**Other conditions not listed**: _____

LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:

_____
_____
_____
_____

LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:

_____
_____
_____

LIST FAMILY HISTORY, SOCIAL HISTORY, EXERCISE LEVEL, SMOKING, STRESS LEVEL:

_____
_____
_____

Is there any other information that you feel would be relevant to your current condition(s) that was not covered?
Please explain in the following section any information that you feel would be helpful to the doctor.

_____
_____
_____

## Informed Consent and Terms of Acceptance

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

## Patient Acknowledgement of HIPPA Notice

**Notice to Patient:**
We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

**1)** May we confirm your appointments by email, text or phone? Yes No
**2)** May we leave a message on your answering device at home or cell phone? Yes No
**3)** May we discuss your condition with any members of your family? Yes No
If yes, provide names: _____
**4)** May we use any pictures or videos captured in our office, in regard to your treatment, on social media for marketing purposes? Yes No

**Patient Acknowledgement:**
I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

_____ _____
**Patient Printed Name** **Patient Signature (or legal representative)**

_____ _____
**Date** **If legal rep, state relationship**