CONFIDENTIAL PATIENT INFORMATION

JointFit Chiropractic & Sports Medicine Center
2004 Clock Tower Place, Suite 110
Manhattan, KS 66503

Phone: 785-320-6868
Fax: 785-320-6861
jointfitchiropractic@gmail.com

Date: _____/_____/_____ Date of Current Injury: _____/_____/_____

Patient's Full Name: _____ Date of Birth: _____/_____/_____

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

Cell Phone: _____-_____-_____ Home Phone: _____-_____-_____ Email: _____

Male _____ Female _____ Married _____ Single _____ Widowed _____ Divorced _____ Separated _____

Spouse's Name: _____ Number of Children/Ages: _____

How did you hear about us?

◇ Existing Patient
Who? _____

◇ Physician
Who? _____

◇ Friend
Who? _____

◇ Local Ad _____
◇ Google
◇ Social Media _____
◇ Office Website
◇ ACBSP Website
◇ Other:_____
_____

Primary Care Provider: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____-_____-_____ Fax: _____-_____-_____

Is it okay for us to update your PCP? ◇ Yes ◇ No

Social Security Number: _____-_____-_____ Status: ◇ Employed ◇ Student ◇ Retired ◇ Unemployed

Occupation: _____ Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Phone: _____-_____-_____

Previous Chiropractic Care: ◇ **Yes** ◇ **No** **If yes, for what problem:** _____

Chiropractor's Name: _____ **City:** _____ **State:** _____

Is Today's Visit Due to a Work Related Injury?: ◇ Yes ◇ No **Is Today's Visit Due to an Auto Accident?** ◇ Yes ◇ No

(If yes to either question above, please check with the receptionist, additional information is needed.)

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, the patient, I agree to the following:

- You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
- I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
- I hereby assign and transfer to JointFit the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to JointFit for the charges made for service. I authorize JointFit to prosecute said action either in my name. I further authorize JointFit to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts JointFit does not collect from insurance companies, whether it be all or part of what was due, **I personally owe to JointFit**.
- In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Kansas.
- I agree to allow JointFit and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile devices concerning any and all aspects of my account.
- I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you (JointFit) are **paid in full.**

Patient (or Guardian) Signature: _____ **Date:** _____/_____/_____

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Dear Patient, please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your care. Thank you!

Present complaint(s): _____

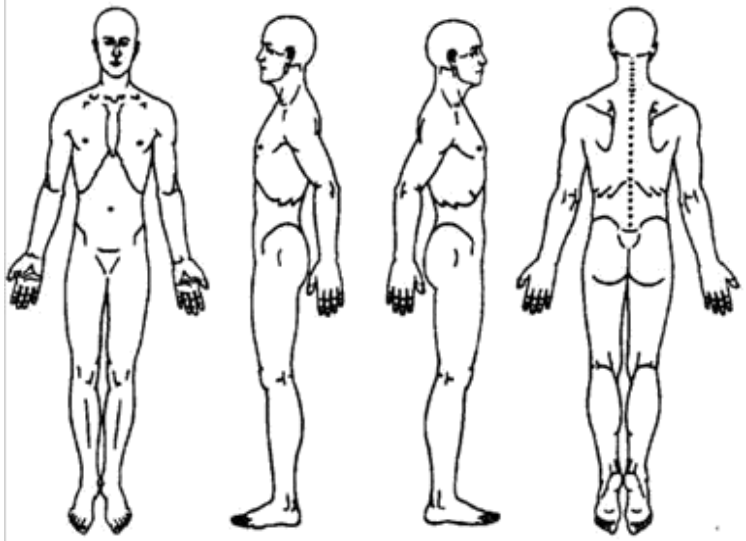
When did your symptoms begin? (Specific date if possible): _____

How did your symptoms begin? (i.e. Lifting, bending, etc.): _____

In the past have you had anything similar to this? ◇ Yes ◇ No If yes, please explain: _____

PAIN CHART

Please mark the areas of pain on the diagram below, then describe you pain(s) separately in each box.



DESCRIBE YOUR PAIN

#1 Complaint: _____

(Rate your level of pain, Scale 0-10)

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable

Check all that apply to your #2 complaint:

◇ Sharp ◇ Ache ◇ Tingling
◇ Stabbing ◇ Soreness ◇ Numbness
◇ Burning ◇ Weakness ◇ Dull
◇ Shooting ◇ Throbbing ◇ Constricting

How often is this complaint present?

◇ Constant, 100% of the time ◇ Frequently, 75% of the time
◇ Intermittent, 50% of the time ◇ Occasional, 25% of the time

DESCRIBE YOUR PAIN

#2 Complaint: _____

(Rate your level of pain, Scale 0-10)

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable

Check all that apply to your #1 complaint:

◇ Sharp ◇ Ache ◇ Tingling
◇ Stabbing ◇ Soreness ◇ Numbness
◇ Burning ◇ Weakness ◇ Dull
◇ Shooting ◇ Throbbing ◇ Constricting

How often is this complaint present?

◇ Constant, 100% of the time ◇ Frequently, 75% of the time
◇ Intermittent, 50% of the time ◇ Occasional, 25% of the time

DESCRIBE YOUR PAIN

#3 Complaint: _____

(Rate your level of pain, Scale 0-10)

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable

Check all that apply to your #3 complaint:

◇ Sharp ◇ Ache ◇ Tingling
◇ Stabbing ◇ Soreness ◇ Numbness
◇ Burning ◇ Weakness ◇ Dull
◇ Shooting ◇ Throbbing ◇ Constricting

How often is this complaint present?

◇ Constant, 100% of the time ◇ Frequently, 75% of the time
◇ Intermittent, 50% of the time ◇ Occasional, 25% of the time

* Check each following box that applies to your pain(s), and place the Complaint # next to its corresponding box:

Is your pain:

◇ Increasing
◇ Decreasing
◇ Not changing
◇ Varies

Was the onset:

◇ Gradual
◇ Sudden

Pain is aggravated by:

◇ Walking ◇ Lifting
◇ Sitting ◇ Bending
◇ Riding in a car ◇ Stretching
◇ Standing ◇ Twisting

Pain is improved by:

◇ Medication ◇ Chiropractic Treatment
◇ Rest ◇ Other: _____
◇ Exercise
◇ Therapy _____

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What **non-prescription** medication are you currently taking?

- ◇ Tylenol
- ◇ Aspirin
- ◇ Ibuprofen
- ◇ None
- ◇ Other _____

How often?

◇ Daily ◇ Weekly ◇ Other: _____

What **prescription** medication are you currently taking?

- ◇ Anti-Inflammatory
- ◇ Pain Killers
- ◇ Muscle Relaxers
- ◇ Blood Pressure
- ◇ Blood Thinners
- ◇ Birth Control
- ◇ Cholesterol
- ◇ Insulin
- ◇ Tranquilizers
- ◇ Diet Pills
- ◇ Nerve Pills
- ◇ HRT
- ◇ Sleeping Aid
- ◇ Other _____ ◇ None

Specific names if possible: _____

FAMILY HISTORY AND HEALTH STATUS: List any diseases, disorders, or major illnesses. If deceased, from what? (This information may help determine your familial susceptibilities to illness, disorders, etc., and help us better treat your condition.)

Mother: _____ Father: _____

Brother(s): _____ Sister(s): _____

Grandparents: _____ Grandparents: _____

Other: _____ Other: _____

Do you have any other health concerns or diseases? (ex. Heart disease, hypothyroidism, asthma, allergies, etc.): _____

_____

_____

Do you have any specific dietary guidelines you follow? ◇ Gluten Free ◇ Dairy Free ◇ Vegetarian ◇ Vegan
◇ Other: _____

◇ Yes ◇ No **Do you consume artificial sweeteners? If so, please specify:** ◇ Sweet N Low/Sugar Twin ◇ Splenda/Sucralose ◇ Equal/NutraSweet/Aspartame ◇ Sweet One/Swiss Sweet
◇ Other: _____

◇ Yes ◇ No **Do you consume *diet* beverages such as soda, sports drinks, tea, or others?**
If so, please specify types: _____

◇ Yes ◇ No **Do you consume alcohol?**

◇ Yes ◇ No **Do you exercise?** If so, what is you routine? _____

◇ Yes ◇ No **Do you belong to a local gym, sports team/league, etc.?**
If so, please specify: _____

◇ Yes ◇ No **Would you like more information on nutrition and/or supplement recommendations?**

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◇ Yes ◇ No **Is pain affecting your ability to work or be active?** If so, please explain: _____

_____

_____

◇ Yes ◇ No **Any change in bowel or bladder (bathroom) function?** If so, please explain: _____

_____

_____

◇ Yes ◇ No **Any fever or chills?** If so, please explain: _____

◇ Yes ◇ No **Any dizziness associated with symptoms?** If so, please explain: _____

◇ Yes ◇ No **Have you experienced any unexplained weight loss, fatigue, or blood loss?** If so, please explain: _____

_____

_____

◇ Yes ◇ No **Are your complaints affecting your sleep?** If so, please explain: _____

◇ Yes ◇ No **Have you had any tests for this complaint?** (ex. X-rays, MRI, CT) If so, please explain: _____

◇ Yes ◇ No **Any past or recent falls / accidents / surgeries / broken bones?** If so, please explain: _____

_____

◇ Yes ◇ No **Have you seen any other physicians in the past 6 months?** If so, please explain: _____

_____

◇ Yes ◇ No **Have you had any prior treatment for this or related complaint, including any chiropractic or physical therapy?**
If so, who? _____ What treatment? _____

◇ Yes ◇ No **Have you ever been in the hospital or had surgery for any reason?** If so, please explain: _____

_____

◇ Yes ◇ No **Have you ever been in an accident?** If so, please explain: _____

_____

◇ Yes ◇ No **Did/do you smoke?** If so, how much? _____
If you have quit, when did you quit? _____

What type of care are you interested in? ◇ Pain Relief Only ◇ Healing of current condition ◇ Optimizing your health ◇ All three

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain your informed consent before starting treatment.

I, _____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware the there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

Functional Dry Needling: Involves inserting a tiny monofilament needle in a muscle or muscles in order to release shortened bands of muscle to decrease trigger point activity. This technique is used to resolve pain and muscle tension, and promote healing. The most serious risk with FDN is accidental puncture of lung, although this is very rare. If this were to occur, it may likely require a chest x-ray and no further treatment. With my signature below, I here-by consent to the performance of this procedure. You have the right to refuse this procedure at any time during treatment.

Please answer the following questions before receiving the dry-needling procedure.

Are you pregnant? ◇ Yes ◇ No

Are you taking blood thinners? ◇ Yes ◇ No

Are you immune-compromised? ◇ Yes ◇ No

Do you have an auto immune disease? ◇ Yes ◇ No

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Patient (or Guardian) Signature: _____ **Date:** _____/_____/_____