NELSON CHIROPRACTIC, PC

Patient Information

Date: _____

First Name: _____ Last Name: _____ Middle Initial: _____

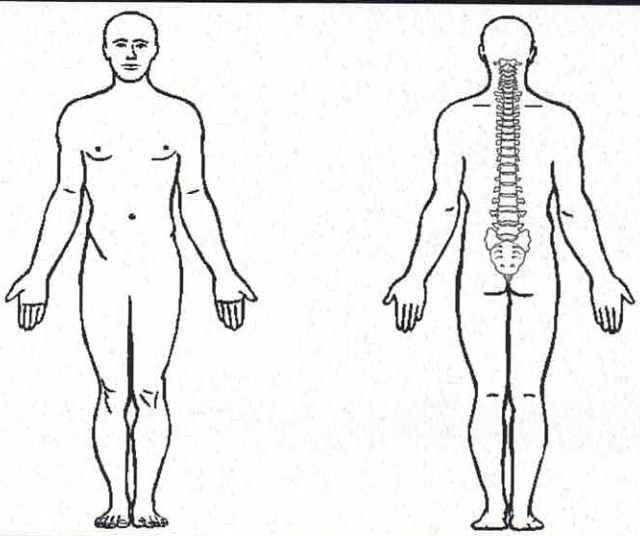
Personal Information

What is your major complaint?: _____

When did this symptom(s) begin?: _____

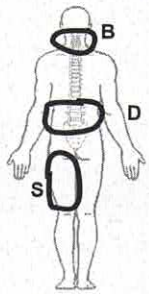
How and why did this happen?: _____

Using the symbols provided in the Pain Index box, mark the areas on the illustrations below where you are experiencing pain.



Pain Index

- **D** Dull Nagging Ache
- **B** Burning
- **S** Sharp/Stabbing
- **N** Numbness/Tingling



For example: *The image to the left illustrates a burning pain in the neck, a dull ache in the lower back, and a sharp pain in the left thigh.*

What is the pain interfering with that's most important in your life? _____

_____

Severity

On a scale of 0-10, with 0 representing no pain and 10 representing the most severe pain imaginable, use the key to the right to rate the severity of your pain.

Sitting here today, right now, what is the intensity of your pain on a scale of 0-10? (please circle)

0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

What is the most intense the symptom has been on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

Key

- **0** = None
- **1** = Minimal
- **2** = Very Mild
- **3** = Mild
- **4** = Mild to Moderate
- **5** = Moderate
- **6** = Moderate to Severe
- **7** = Moderately Severe, Restricts Some Activity
- **8** = Severe, Limits Most Activity
- **9** = Very Severe
- **10** = Excruciating

Have you experienced these symptoms before? ◯ Yes ◯ No

When? _____

What aggravates this condition? _____

What decreases the symptoms? _____

Personal Information

Address:_____

City / State / Zip:_____

Home Phone: (_____) _____ Work Phone: (_____) _____

Mobile Phone: (_____) _____ Email:_____

Social Security #:_____ Birth Date:_____ Age:_____ Sex: ◯M ◯F

Occupation:_____ Employers Name:_____

Marital Status: S M D W Spouse's Name:_____ # Children_____

How were you referred to Nelson Chiropractic, PC?:_____

Authorization & Assignment

I authorize Nelson Chiropractic, PC to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Nelson Chiropractic, PC authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Nelson Chiropractic, PC has made their financial policy available to me.

Date_____ Patient's Signature_____

Informed Consent

I hereby authorize physicians and staff at Nelson Chiropractic, PC to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Nelson Chiropractic, PC responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. while chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness - Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

Soft- Tissue Injury - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft-tissue injury.

Rib Injury - Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions are possible such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns - Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

Stroke - Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems - There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any question concerning this form or the above statements, please ask your doctor.

I have reviewed the HIPAA information presented to me.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Date_____ Patient's Signature_____