



### ABOUT YOU ...

Name: \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Sex: **M F**

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

How did you hear about Elite Sport & Spine Center? \_\_\_\_\_

Name and No. of Emergency Contact: \_\_\_\_\_

Have you ever received chiropractic care? **Y N** With whom? \_\_\_\_\_

WOMEN: Are you pregnant? **Y N** Date of last monthly period: \_\_\_\_\_

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### CURRENT HEALTH CONDITION

Current health complaints/reason for consulting our office:

1. \_\_\_\_\_ For how long? \_\_\_\_\_

2. \_\_\_\_\_ For how long? \_\_\_\_\_

3. \_\_\_\_\_ For how long? \_\_\_\_\_

In addition to the main reason for your visit today, what additional health goals do you have? \_\_\_\_\_

Were other doctors seen for this condition? **Y N** Who? \_\_\_\_\_ Results: \_\_\_\_\_

Has this condition occurred before? **Y N** Are the injuries a result of an accident? **Y N**

If yes, how did it occur? \_\_\_\_\_

Please list any medications/supplements currently taking (include dosage/frequency): \_\_\_\_\_

Please list any allergies AND reactions to medications: \_\_\_\_\_

Please describe your daily activities for work, home, or school such as sitting, standing, lifting, phone use: \_\_\_\_\_

### PAST HEALTH HISTORY

Have you had an accident, even as a passenger, in a(n): **(Give dates)**

Automobile: \_\_\_\_\_ Motorcycle: \_\_\_\_\_ Bicycle: \_\_\_\_\_ Other: \_\_\_\_\_

Medical interventions: **(Circle all that apply)**

Hospitalizations PT Surgery Heart Appendix Hysterectomy Spinal Eye Organ Removal Other

Explain with dates: \_\_\_\_\_

Injuries: Have you ever had... **(Circle all that apply)**

Broken Bones Spinal/Nerve Disorder Used a crutch/walker Used Neck/Back Bracing Been Unconscious

Sports Injuries

Explain with dates: \_\_\_\_\_

Do you consume: Alcohol/Coffee/Caffeine Water Intake If so, how much: \_\_\_\_\_

Please Circle your smoking status: Everyday Some Days Former Never

Exercise: None Moderate Daily

**Have you ever had/have any of the following diseases? (Circle all that apply)**

Heart Diabetes Cancer Thyroid Issues Lymes Tuberculosis Hepatitis Chicken Pox STD AIDS MS

**Circle any of the following conditions you have had in the past six months:**

**Musculo-skeletal**

- Arthritis/RA/Gout
- Low Back Pain
- Neck/Arm Pain
- Shoulder Pain
- Joint Pain/Stiffness
- Knee Pain
- Walking Difficulties
- Difficulty Chewing/TMJ
- General Stiffness

**Nervous System**

- Anxiety
- Headaches/Migraines
- Numbness/Tingling
- Paralysis
- Dizziness/Fainting
- Forgetfulness
- Confusion/Depression
- Fibromyalgia
- Convulsions

**Sensory**

- Cataracts/Glaucoma
- Sore Throat/Frequent Colds
- Earaches/Hearing Trouble
- Stuffy Nose/Congestion
- Ringing In Ears

**Male/Female**

- Menstrual Irregularity/Cramps
- PMS
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Prostate Issues/ED
- Sexual Dysfunction

**Digestive**

- Heartburn/Acid Reflux
- Diarrhea/Constipation Ulcer
- Nausea/Vomiting
- Poor/Excessive Appetite
- Excessive Thirst
- Hemorrhoids
- Liver/Gall Bladder Issues
- Sudden Weight Change
- Food Sensitivities
- IBS/GERD/Colitis

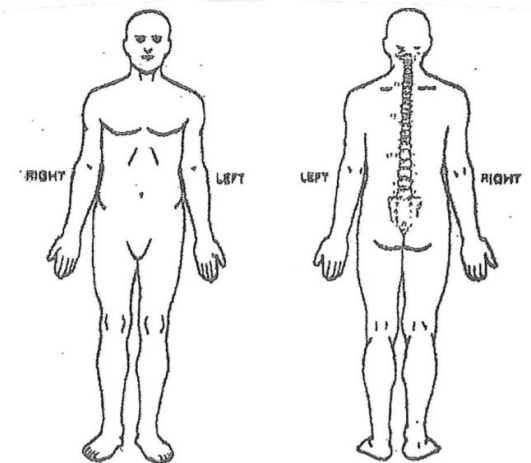
**Cardiovascular/Respiratory**

- Shortness of Breath
- High Blood Pressure
- High Cholesterol
- Heart Problems
- Irregular Heartbeat/ Pacemaker
- Chest Pains
- Varicose Veins/Poor Circulation
- Ankle Swelling
- Emphysema/Pneumonia

**Urinary**

- Frequent Urination/Leakage
- UTI
- Kidney Stones

**Please outline the area(s) of your discomfort...**



**Quality of Symptoms**

(Please circle how it feels)

- |           |           |
|-----------|-----------|
| Numbness  | Burning   |
| Tingling  | Shooting  |
| Stiffness | Throbbing |
| Aching    | Sharp     |



## Activities of Daily Living Questionnaire

When you experience difficulties from a painful or restrictive condition, you may find it difficult to do some of the things you normally do. In order to properly assess your condition, we must understand how much your problems have affected your ability to manage everyday activities.

For each item below, please rate how well you can do the following activities with the following:

**0= NO ISSUES**

**1=MILD**

**2=MODERATE**

**3= SEVERE**

\_\_\_\_\_ Bending

\_\_\_\_\_ Climbing Stairs

\_\_\_\_\_ Lifting

\_\_\_\_\_ Sitting

\_\_\_\_\_ Standing

\_\_\_\_\_ Walking 20 + minutes

\_\_\_\_\_ Lying Down

\_\_\_\_\_ Rising out of chair

\_\_\_\_\_ Turning over in bed

\_\_\_\_\_ Housework

\_\_\_\_\_ Driving/riding

\_\_\_\_\_ Dressing

\_\_\_\_\_ Sleeping

\_\_\_\_\_ Exercise

\_\_\_\_\_ Work activities

\_\_\_\_\_ Running

\_\_\_\_\_ Cycling

Chiropractic Goals: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## INFORMED CONSENT FOR THE CHIROPRACTIC PATIENT

**To the Patient:** Please read the document and sign. It is important that you understand the information contained in this document.

**The nature of the chiropractic adjustment:** The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The doctor will use that procedure to treat you. He or she may use her hands or 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 part of the analysis, examination and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpation, trigger point massage, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, ultrasound, cold therapy, biofreeze application, electric muscle therapy, and traction therapy.

**The risks inherent in chiropractic adjustment:** As with any other healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy that are very rare such as fractures or minor muscle pulls. It is common to feel stiffness or soreness following the first few days of treatment. Fractures are very rare occurrences and generally result from some underlying weakness of the bone. Stroke or vertebral artery dissection caused by chiropractic manipulation of the neck has not been proven but continues to be anecdotal. The doctor will make every reasonable effort during the examination to screen for contraindications to care, however if you have a condition that would not come to the Doctor’s obvious attention, it is your responsibility to inform the doctor.

**Authorization for the release of patient information:** I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I hereby authorize Elite Sport & Spine Center to provide other health care providers with information regarding my healthcare as deemed appropriate. I give my permission for the use of medical records, including x-rays and information shared during the process of examinations and treatment to be released to insurance companies, other doctors, health consultants and or staff involved in my care. Do not sign until you have read and understand the above.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have had all 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 understand the treatment recommended. I hereby give my consent to chiropractic treatment and authorize any pertinent medical records exchange. I understand this consent to be effective until I am notified otherwise.

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Signature (Patient/Parent/Legal Guardian)

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Relation to Patient

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Printed Name

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Date



## MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Elite Sport & Spine Center. When you schedule an appointment with Elite Sport & Spine Center, we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Any established patient who fails to show or cancels/reschedules an appointment for another day and has not contacted our office with at least 24-hour notice will be charged a **\$25.00 fee**.
- Any new patient who fails to show for their initial visit will not be rescheduled.
- The fee is charged to the patient and is due at the time of the patient's next office visit.
- As a courtesy, when time allows, we make reminder calls/texts for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. You may contact Elite Sport & Spine Center 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

**Elite Sport & Spine Center (571)531-0825**

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

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Signature (Patient/Parent/Legal Guardian)

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Relation to Patient

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Printed Name

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Date