Patient File#: _____

Today's Date: ____ /____ /____

PATIENT & HEALTH INFORMATION

WELCOME: The doctor and staff welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will refer you to the appropriate healthcare provider. If you are a candidate for chiropractic care; a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete questions to the best of your ability. Be as descriptive as possible and check all descriptors that apply. If you have questions, please ask a staff member for assistance or clarification. Please inform the doctor if there are circumstances surrounding your accident that are not covered here and that you feel would be helpful.

First Name: _____ Address: _____

Middle Name: _____ Address: _____

Last Name: _____ City: _____

Birth Date: ____ /____ /____ Gender: _____ State: _____ Zip Code: _____

Primary Phone: _____ ☐ Work ☐ Cell ☐ Home SSN#: ____ - ____ - _____ Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Secondary Phone: _____ ☐ Work ☐ Cell ☐ Home Email: _____

Employment Status:_____ Occupation/Title: _____

Business Name: _____ Type of Work: _____

Business Address: _____ Is it OK to contact you at work? ☐ Yes ☐ No

City: _____ State: _____

Zip Code: _____

FAMILY INFORMATION

Spouse's Name: _____ Spouse's Occupation/Title: _____

Spouse's Business Name: _____ Primary Phone: _____ ☐ Work ☐ Cell ☐ Home

Spouse's Business Address: _____ Secondary Phone: _____ ☐ Work ☐ Cell ☐ Home

City: _____ State: _____ SSN#: ____ - ____ - _____

Zip Code: _____ Spouse's Email: _____

Birth Date: ____ /____ /____ Gender: _____

Children

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Emergency Contact Information

First Name: _____ Address: _____

Middle Name: _____ Address: _____

Last Name: _____ City: _____

Birth Date: ____ /____ /____ Gender: _____ State: _____ Zip Code: _____

GENERAL INSURANCE INFORMATION

Who, besides yourself is responsible for your bill? _____

Employer's Name: _____

Employer's Address: _____

_____

City: _____ State: _____

Zip Code: _____

Employer's Phone _____

Human Resources Manager: _____

Claim Number: _____

WHAT IS THE REASON FOR YOUR VISIT?

Is the condition due to an accident? ☐ Yes ☐ No

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other Explain: _____

ACCEPTANCE AS A PATIENT

I understand and agree that office has the right to refuse to accept me as a patient at any time before treatment begins, or terminate my care as a patient if in the course of treatment I am not following the treatment plan for my condition, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

PAST HEALTH HISTORY

This section will identify key factors and indicators about your history that may impact or contribute to your current health condition. Please give us information on any below that apply to you.

Please list any medications or nutritional supplements that you are currently taking:

Childhood Illnesses (Please list any illnesses that you have had as a child):

Please list any other doctors or providers that you have seen for this condition or for any conditions that you may be currently treating and the type of treatments provided:

Adult Illnesses (Please list any illnesses that you have had as an adult):

Surgeries (Please list all surgical procedures that have had in the past):

Injuries (Please list any significant injuries, falls, trauma, accidents that you have had in the past):

Immunizations (Please list any vaccinations that you have had):

Non-Drug Allergies and how you react to those substances:

Do you have, or have you ever had any of the following health problems? (Check all that apply)

- ☐ Headaches
- ☐ Achyness / General Pain
- ☐ High / Low Blood Pressure
- ☐ Auto Accidents
- ☐ Migraine
- ☐ Difficulty Concentrating
- ☐ Excessive Sweating
- ☐ Other Accidents/Falls
- ☐ Neck Pain/Stiffness
- ☐ Memory Loss/Forgetful
- ☐ Stomach Problems
- ☐ Sports Injuries
- ☐ Shoulder Pain/Stiffness
- ☐ Frequent Colds/Flus
- ☐ Nausea
- ☐ Work Injuries
- ☐ Numbness/Tingling Arm(s)
- ☐ Nervousness
- ☐ Ulcers
- ☐ Fainting
- ☐ Elbow Pain/Stiffness
- ☐ Irritability
- ☐ Liver/Gall Bladder Problems
- ☐ Depression
- ☐ Wrist/Hand Pain or Stiffness
- ☐ Diabetes
- ☐ Kidney Problems
- ☐ Mood Disorders
- ☐ Upper Back Pain or Stiffness
- ☐ Cancer
- ☐ Digestion Problems
- ☐ Emotional Disorders
- ☐ Mid Back Pain or Stiffness
- ☐ Vision/Eye Problems
- ☐ Diarrhea
- ☐ Tension
- ☐ Low Back Pain or Stiffness
- ☐ Hearing/Ear Problems
- ☐ Constipation
- ☐ Stress
- ☐ Hip Pain or Stiffness
- ☐ Ear Infections
- ☐ Bladder Problems
- ☐ Anxiety
- ☐ Knee Pain or Stiffness
- ☐ Sinus Problems
- ☐ Incontinence
- ☐ Poor Diet
- ☐ Ankle/Foot Pain or Stiffness
- ☐ Thyroid Problems
- ☐ Impotence
- ☐ Pain w/coughing
- ☐ Pain shooting down leg(s)
- ☐ Allergies
- ☐ Prostate Problems
- ☐ Pain w/sneezing
- ☐ Trouble Walking
- ☐ Asthma
- ☐ Bed Wetting
- ☐ Pain at stools
- ☐ Sore Muscles
- ☐ Trouble Breathing
- ☐ Menstrual Problems(PMS) Restricts Daily Activity
- ☐ Painful Joints
- ☐ Heart Problems
- ☐ Fractured Bones Restricts Exercise
- ☐ Tiredness/Fatigue
- ☐ Circulation Problems
- ☐ Dizziness
- ☐ Unable to Work

INFORMED CONSENT DOCUMENT

PATIENT NAME: _____ Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

One of the treatments that I may employ as a sports medicine chiropractor is spinal and or extremity manipulative therapy. Other treatments include, instrument assisted soft tissue techniques, myofascial release, strength and conditioning exercises, sports taping techniques, electrical modalities, ice and moist heat.

Risks:
As with any healthcare procedure, there are certain complications which may arise during sports chiropractic manipulative 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 manipulative therapy to ensure that you are a candidate for treatment; 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 NSAIDS, 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 have had read to me [ ] the above explanation of the sports chiropractic adjustment and related treatment. I have discussed it with my attending sports chiropractor 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: _____ Dated: _____

Patient's Name:_____ Doctor's Name: _____

Signature:_____ Signature:_____

Signature of Parent or Guardian (if a minor):_____

South West Health Spine & Sport
Financial Agreement

At South West Health Spine & Sport, we want you to fully understand what your financial requirements are. If you have any questions about your account, please ask to speak to our billing department.

As a courtesy, we will bill your PPO insurance company for your chiropractic services. We are currently contracted with Blue Shield of California and are out-of-network with all other insurances. We DO NOT bill for massage therapy as insurance carriers do not reimburse for those codes any longer.

If we are not included in your insurance coverage, cannot verify coverage, or you do not have insurance, payment in full is expected at the time of service. For your convenience we accept all credit cards, HSA debit cards, personal checks and cash. If you have a financial hardship, special arrangements for a payment plan may be made with our billing office. We do require a payment each month on your account until the balance is paid.

We collect co-payment and any deductible due at the time of visit. If your insurance company denies payment for a service, we will bill you for the balance due. Any amount not paid by your insurance company within 30 days may be billed to you for payment.

For patients involved in a third party auto accident claim in which there is no med-pay policy or health insurance, payment in full is expected at the time of service or you have the option of retaining our personal injury attorney, Dan Carlton. His contact information will be provided upon request.

Our staff reviews and updates insurance information on a regular basis as insurance plans and benefits change often and we want to make sure that your coverage information in accurate.

Cancellation Policy:
At South West Health Spine & Sport, we take your time very seriously in that we schedule appointments with the expectation that you will be seen by the doctor at your scheduled appointment time. We request you be present for your appointment on a timely basis. In the event that we do not receive 24 hours notice of your intent to change your appointment time, a cancellation fee will be imposed as follows. Please note, Monday appointments require 48 hours cancellation notice as our office is closed on Sundays. I am aware there is a fee of $50.00 for missed or late cancelled chiropractic appointments and a $25.00 per 1/2 hour fee for late cancellations or missed massage appointments.

I,_____, have read and understand the South West Health Spine & Sport Financial Agreement. I understand that I am ultimately responsible for all charges to my account

Patient Signature: _____ Date: _____