Today's Date:____/____/____

## Confidential Patient Information

Name: ______________________________________________ Date of Birth: ____ / ____ / ____

Address: _________________________________ City: _________________ State: ________ Zip: __________

Phones: Home: ____________________ Cell: _____________________ Work: ______________________

Email: ______________________________________________ SS: __________ / _____ / ___________

Employer: ___________________________________ Occupation: _________________________________

Marital Status: M S D W Other Spouses Name: ______________________ # of Children: _________

Emergency Contact: ___________________________ Relationship: ___________ Ph: ______________________

Insurance Co: ________________________________ Insurance ID #: _________________________________

Who referred you to our office? _________________________ Primary Dr. __________________________________

## Primary & Secondary Complaints

**Primary Complaint:** ______________________________________________________________________

**Pain / Discomfort**: 0 1 2 3 4 5 6 7 8 9 10 **Discomfort affects me _________% of my day**

**Describe Discomfort**: Dull Sharp Throbbing Burn Deep Aching
Tingling Stabbing Cramping Numbness Radiating Stiffness

**Onset of Complaint**: Date: ______________ How long have you had this symptom? _________

**What makes symptoms worse**? ______________________________________________________________

**What makes symptoms better?** ______________________________________________________________

**Important history about this complaint**: ______________________________________________________

**Secondary Complaint**: ____________________________________________________________________

**Pain / Discomfort**: 0 1 2 3 4 5 6 7 8 9 10 **Discomfort affects me _________% of my day**

**Describe Discomfort**: Dull Sharp Throbbing Burn Deep Aching
Tingling Stabbing Cramping Numbness Radiating Stiffness

**Onset of Complaint**: Date: ________________ How long have you had this symptom? _________

**What makes symptoms worse**? ______________________________________________________________

**What makes symptoms better**? ______________________________________________________________

**Important history about complaint history**: ___________________________________________________

# General Health History

***Please check any health challenges you currently have or have experienced in the past***

## Musculoskeletal History

- ❑ Low back pain
- ❑ Neck pain
- ❑ Headaches / Migraines
- ❑ Upper/ mid back pain
- ❑ Shoulder pain ( R or L)
- ❑ Foot Pain ( R or L)
- ❑ Knee Pain ( R or L)
- ❑ Sciatic Pain ( R or L)
- ❑ Elbow Pain ( R or L)
- ❑ Arm / Hand Tingling or Pain
- ❑ Leg / Foot Tingling or Pain
- ❑ Plantar Fasciitis ( R or L)
- ❑ Numbness in hands / feet (R or L)
- ❑ Osteoporosis / Weak bones
- ❑ Rheumatoid arthritis
- ❑ Arthritis
- ❑ Joint disease
- ❑ Painful joints
- ❑ Spinal Curvature
- ❑ Muscle Cramps
- ❑ Bruise Easily
- ❑ Broken bones ___________________
- ❑ ________________________________

### Neurological

- ❑ Slurred Speech
- ❑ Ringing in ears
- ❑ Altered taste or smell
- ❑ Night blindness
- ❑ Stroke
- ❑ Parkinson's
- ❑ Forgetfulness
- ❑ Chronic pain
- ❑ Fibromyalgia
- ❑ Autoimmune Disease
- ❑ Blurred vision
- ❑ Multiple sclerosis
- ❑ Pace maker

### Cardiovascular

- ❑ Chest pain
- ❑ Palpitations/racing heart
- ❑ Swelling in hands or feet
- ❑ Anemia / low iron
- ❑ Respiratory infections
- ❑ High cholesterol
- ❑ Swelling of ankles
- ❑ Heart Attack
- ❑ Wheezing / Asthma
- ❑ Heart Disease
- ❑ Difficulty breathing
- ❑ High blood pressure
- ❑ COPD
- ❑ Emphysema

### Gastrointestinal

- ❑ Frequently Sick
- ❑ Stomach pains
- ❑ Constipation
- ❑ Diarrhea
- ❑ Hearth burn
- ❑ Crohn's / Colitis
- ❑ Hemorrhoids
- ❑ Gas or bloating
- ❑ Nausea / vomiting
- ❑ Hypoglycemia
- ❑ Diabetes (1 or 2)
- ❑ Excessive thirst
- ❑ Liver problems
- ❑ Pain over stomach

### Skin

- ❑ Eczema
- ❑ Dermatitis
- ❑ Rashes
- ❑ Hair loss
- ❑ Bleeding disorders
- ❑ Varicose veins
- ❑ Excessive acne
- ❑ ________________

### Ears /Nose /Throat

- ❑ Sore throat
- ❑ Gingivitis
- ❑ Recurrent sinus pain
- ❑ Nose bleeds
- ❑ Allergies
- ❑ Dry eyes
- ❑ Corrective lens
- ❑ Chronic cough
- ❑ Pneumonia
- ❑ Sinus infections
- ❑ Hoarseness
- ❑ Eye pain
- ❑ Ringing in ears
- ❑ Ear Infections

### Weight

- ❑ Decreased appetite
- ❑ Weight gain
- ❑ Trouble losing weight
- ❑ Binge eating
- ❑ Water retention
- ❑ Hypothyroidism
- ❑ Hyperthyroidism
- ❑ Excessive hunger
- ❑ Exercise weekly
- ❑ Crave sugar
- ❑ Alcohol weekly
- ❑ Crave salty foods
- ❑ Tobacco use

### Genitourinary

- ❑ Uterine fibroids
- ❑ Ovarian cysts
- ❑ Cancer _________
- ❑ Prostate problems
- ❑ Problems urinating
- ❑ Kidney infections
- ❑ Decrease urine flow
- ❑ Painful urination
- ❑ Frequent urination
- ❑ Incontinence

### Energy /Emotion

- ❑ Fatigue
- ❑ Hyperactivity
- ❑ Restlessness
- ❑ Insomnia
- ❑ Decreased libido
- ❑ Chronic stress
- ❑ Anxiety
- ❑ Irritable
- ❑ Depression
- ❑ Low testosterone
- ❑ Memory Loss

## Women's Health

- ❑ Hot flashes
- ❑ Lump in breast (R or L)
- ❑ Menopause
- ❑ Vaginal discharge
- ❑ Birth control: __________________________________
- ❑ Are you currently on Hormone Therapy? Y N

Menstrual cycle: Reg ____ Irreg ____
Pain/cramping ____ Length of cycle: ________
1st day of last period: __________________
Are you pregnant? Y N How many weeks? _____
Date of last Mammogram / Thermography: _____
Date of last PAP: _______________

**Family History**

- ❑ Anemia / low iron
- ❑ Asthma
- ❑ Cancer ____________________________________
- ❑ Arthritis
- ❑ Thyroid disease
- ❑ High cholesterol
- ❑ Arteriosclerosis / hardening of arteries
- ❑ Diabetes (1 or 2)
- ❑ C.O.P.D
- ❑ Neurological ____________________________________
- ❑ Heart disease
- ❑ Stroke
- ❑ Osteoporosis
- ❑ Multiple sclerosis
- ❑ Obesity
- ❑ Digestive disorders _______________________________

Spouse, parents, brother/sister with similar health problems? __________________________________________________
______________________________________________________________________________________________________

When was your last physical exam? __________________________

How is most of your day spent? Standing _____ Sitting _____ Other: ____________________________

Complaint(s) interfere with: Work ____ Sleep ____ Hobbies ____ Daily Routine ____ Enjoying life____

Please list all surgeries: _________________________________________________________________________________
______________________________________________________________________________________________________

Current Medications/Supplements (prescription and over the counter): __________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________

**List all known allergies:**________________________________________________________________________________

**Please check all options you have previously tried to assist in the above complaint(s):**

- ❑ Over the counter medications
- ❑ Prescription Medication
- ❑ Dietary Changes
- ❑ Exercise
- ❑ Consult with specialist
- ❑ Supplements
- ❑ Chiropractic / Massage / Physical therapy
- ❑ Other _______________________________________

Have you been under care within the last 30 days for the above complains? Yes No

What are your health goals? _______________________________________________________________________________

How do you expect to achieve these goals? __________________________________________________________________

**Lifestyle**

Do you use tobacco? ____ yes ____ no ____ previous user If yes, how often? _______________________________

Do you drink alcohol? ___ yes ____ no ____ previous user If yes, how often? _______________________________

# Legal and Clinic Policies

I authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered to me or the person I have signed for during the period of such care to third party payers and/or other health practitioners and/or collection agency in the event to get an account paid and/or to benefit the patient in achieving better health goals. I authorize and request my insurance company to pay directly to the provider or provider's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. ***I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf.***

**Missed or Cancelled Appointments**: As a courtesy, please give us 24 hours' notice for ALL changes to scheduled appointments. Missed or cancelled appointments without 24 hour advanced notice may be subject to a "cancellation fee" of 50% of the standard appointment rate.

**Returned Checks**: There will be a $25 administrative fee for all returned checks.

**Assignment of Benefits**: Since we are financing your care by waiting for payment from your insurance company, this form instructs your insurance company to send their payments directly to this office. If your insurance company sends you payments for services provided by this office, you shall bring in person or send certified mail the endorsed original insurance check immediately. A $25 administration charge for any original checks cashed or not returned to this office within 10 days, along with interest will apply.

**Release of Information**: Your insurance reserves the right to deny payment if certain information relative to your care is not provided. If you're insurance company requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim.

# Notice of Privacy Practices

As required by the Privacy Regulations, Alliance has made me aware of the "NOTICE OF PRIVACY PRACTICES". I understand that Alliance follows H.I.P.A.A guidelines.

_______ I wish to receive a paper copy of Privacy Notice.

_______ I do not request a copy of the Privacy Notice, at this time. I acknowledge that I can request a copy at any time in the future.

# Informed Consent for Treatment and Care

I hereby request and consent to the performance of Physical Medicine procedures, Chiropractic adjustments, muscle therapies and other usual and customary medical procedures, including examination tests, diagnostic x-rays, and other physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the Nurse Practitioner, Doctor(s) of Chiropractic named and/or other therapists of Alliance Physical Medicine or Alliance Soft Tissue Center who render treatment or recommendations to me.

I understand that, as with any health care procedures, there are certain complications that may arise during a physical medicine visit, Chiropractic adjustment or muscle therapy session. The clinical procedures performed are usually beneficial to the patient and seldom cause any problem. In rare cases the following may occur, but are not limited to; fractures, disc injuries, bruising, tenderness from treatment, redness at injection site, rare reactions from taping, sprain / strains and discomfort from procedures. I have relayed all pertinent health information to the best of my knowledge and I do not expect the doctor or nurse practitioner to be able to anticipate all risks and complications. I wish to rely on the staff's expertise and exercise judgment during the course of the procedures at the time and based upon the facts then known, and in my best interest.

The patient assumes all responsibility/liability if the patient does not report on the health forms any past medical history, illnesses, medications or allergies.

I understand I will have an opportunity to ask questions and discuss with the Doctors and Nurse Practitioner of Alliance and/or with office personnel. The nature, purpose and risks and other recommended procedures and have had my questions answered to my satisfaction. I understand that results are not guaranteed.

I have read (or have had read to me) the above explanation. 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 treatment recommended and hereby give my consent to said treatment. I intend this consent form to cover the entire course of treatment for my (or the patient whom I am legally responsible for) present condition and for any future conditions for which I may seek treatment.

**Do not sign until you have read and understood the above information**

Patient Name: ____________________________________________

Patient / Guardian Signature: ______________________________________ Date: ____________________

I authorize Alliance to communicate my health information with my Primary health care provider listed above; _______

## Consent to Contact a Minor

I agree and give my permission as the parent or guardian to allow Alliance to contact the minor listed above for communication that regard their appointments.

Please initial: ___________