Patient Information

Name _____Date _____

Address _____ City _____ Zip _____

Age _____ Date of Birth _____/_____/_____ Marital Status **M S D W** # of Children _____

Social Security #_____ Driver's License # _____

May Ashby Chiropractic Clinic communicate with you by: Telephone Y:◯ N:◯ Email Y:◯ N:◯ Fax Y:◯ N:◯

Home # _____ Work # _____ Cell # _____

Email address _____

Employer: _____ Occupation _____

Whom may we thank for referring you ? _____

Date of last physical _____/_____/_____ Primary Care Physician (PCP): Name _____

Telephone #:_____

Current Medications/supplements: _____

_____

Purpose of this appointment _____

How long has this current episode been ? _____

Have you lost any days from work ? Yes ◯ No ◯ If yes, how many _____

Have you been treated for any other condition in the past 12 months ? Yes ◯ No ◯

If yes, please describe _____

Education Level: _____ Employment Status : (FT)◯ (PT)◯ (Unemployed) ◯

Main work activity (check all that apply)

- ☐ Heavy labor
- ☐ Light labor
- ☐ Mostly sitting
- ☐ Mostly standing
- ☐ Mostly walking/moving about
- ☐ Driving or operating a vehicle

Do you smoke ? Yes ◯ No ◯ If yes, how many packs per week ? _____

Do you drink ? Yes ◯ No ◯ If yes, quantity per week ? _____

Have you ever had x-rays taken ? Yes ◯ No ◯ Chest ☐ Neck ☐

Low back ☐ Other _____

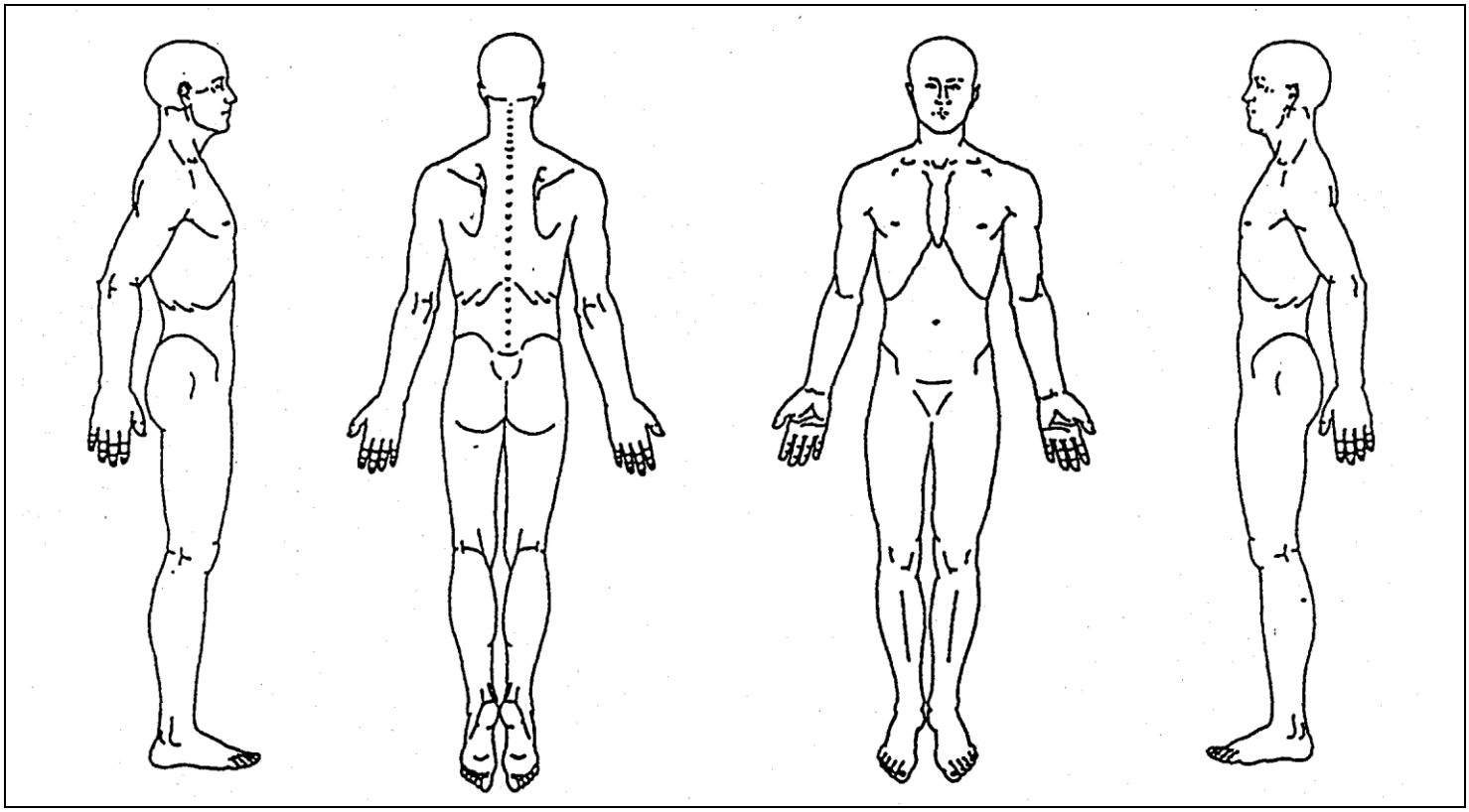
Emergency contact: _____Telephone #: _____

Patient Name _____Date _____

Please accurately complete all the areas which you feel best describe your **current** concerns/complaints.

Please mark this form with all letters from the key that best describe your current concerns/complaints

Dull/Aching = A Burning = B Cramping=C Numb = N Stabbing/Cutting= S Tingling = T



Please mark the pain/discomfort level for this **EPISODE of TREATMENT**

Current Number _____ Worst Number _____ Average Number _____

(Mild) 0-1 (Nagging) 2-3 (Moderate/Intense) 4-5 (Severe/Horrible) 6-7-8 (Unbearable/Dying) 9-10

Please indicate any additional information not addressed in this space:

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Patient Name _____Date _____

Insurance Information

Who is responsible for this account ? Self _____ Spouse _____ Parent _____ Other _____

If other, please provide - Their name _____Telephone number _____

Address _____City _____Zip code_____

Policy holder's name _____ Relationship _____

Social security # _____ Date of birth _____/_____/_____

Employer _____ Group # _____

If automobile accident:

Are you filing personal injury protection [PIP] insurance ? Yes _____No _____ If yes, please provide

Insurance Company _____Telephone number _____

Address _____City _____Zip code _____

Policy # _____Claim # _____Adjuster's name _____

Other parties insurance information:

Their name _____ Telephone number _____

Address _____City _____Zip code_____

Policy # _____ Claim # _____ Adjuster's name_____

Assignment and release

I, the undersigned certify that I have insurance coverage with the above referenced insurance carrier. I understand and agree that health and/or accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore I understand that this office will prepare any forms to assist me in obtaining reimbursement from the insurance carrier for services rendered. I assign directly to Dr. Michael D. Ashby and/or Ashby Chiropractic Clinic all insurance benefits, or payment from my attorney for services rendered to me. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I hereby authorize this office to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Effective 04-14-2003 the federal government has mandated HIPAA regulations. Copies of the HIPAA regulations are available for your review in the lobby or a copy for your convenience upon request. Ashby Chiropractic Clinic and all associated with the clinic will safeguard your patient privacy and security through confidentially and medical records. Patient information will be shared with other providers as needed for continued care; i.e. consultations, outside radiology (imaging), for payment or collections etc. If you should choose not to have this information released you may do so now or may do so or revoke your consent at a later date.

Assignment of benefits - Patient's signature _____

HIPAA regulations - Patient's initials_____ Date _____/_____/_____

Disclosure and Consent for Chiropractic Adjustments and Care

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is an effort to make you better informed so you may give or withhold your consent to the procedure.

I herby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by

Dr. Michael Ashby and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for Dr. Michael Ashby.

I have had the opportunity to discuss my diagnosis, the nature and purpose of the proposed treatment procedures, and alternatives if available.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

_____
Print name

_____
Signature Date

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or physically or legally incapacitated:

_____
Print name of patient's representative

_____
Signature of patient's representative (relationship) Date

To be completed by doctor or staff:

_____
Witness to patient's signature Date

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Medical History

Name: _____ Date _____

Personal History

Check any of the following you have had and when:

	NO	YES	
Pulmonary Embolism	○	○	_____
Blood Clots/DVT	○	○	_____
Rheumatic Fever	○	○	_____
Thyroid Disease	○	○	_____
High Blood Pressure	○	○	_____
Circulatory Problems	◉	○	_____
Heart Disease	○	○	_____
Heart Murmur	○	○	_____
Hepatitis	○	○	_____
Chemotherapy	○	○	_____
Excess Bleeding	○	○	_____
Diverticulosis	○	○	_____
Emphysema	○	○	_____
Jaundice	○	○	_____
Arthritis	○	○	_____
Cirrhosis	○	○	_____
Cancer	○	○	_____
Colitis	○	○	_____
Diabetes	○	○	_____
Ulcer	○	○	_____
Epilepsy	○	○	_____
Anemia	○	○	_____
Stroke	○	○	_____
Asthma	○	○	_____
Hernia	○	○	_____
Glaucoma	○	○	_____

Have you had?	NO	YES
Joint replacement?	○	○

If yes, when? Month/Year _____

Which joint (s)? _____

Have you had?	NO	YES
Breast Augmentation?	○	○
Breast Reduction?	○	○

Family History

	No	Yes	Family Relation
Pulmonary Embolism	○	○	_____
Blood Clots/DVT	○	○	_____
Diabetes	○	○	_____
Tuberculosis	○	○	_____
Lung Disease	○	○	_____
Heart Disease	○	○	_____
Stroke	○	○	_____
Kidney Disease	○	○	_____
High Blood Pressure	○	○	_____
Cancer	○	○	_____
Bleeding Tendency	○	○	_____

	NO	YES
Have you had any surgeries?	○	○

Year _____ What? _____
Year _____ What? _____
Year _____ What? _____
Year _____ What? _____
Year _____ What? _____

Have you had any serious injuries (sprains, fractures, dislocations, etc.)? ○ NO ○ YES

If yes, when? Month/Year _____

Where? _____

_____
_____
_____
_____

Do you use alcohol?	NO	YES
	○	○

If yes, how often? _____ Approx. years? _____

Do you use tobacco?	NO	YES
	○	○

If yes, how often? _____ Approx. years? _____

If you have quit, when? _____

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Review of Systems

Name: _____ Date _____

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING?

CONSTITUTIONAL	NO	YES
Recent change in weight	☐	☐
How many pounds?		
Gained: _____		
Lost: _____		
Since when?		
Loss of appetite	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Night Sweats	☐	☐

HEAD	NO	YES
Frequent headaches	☐	☐
Seizures	☐	☐
Head injury	☐	☐
(If yes, when? ____/____/_____)		

EYES	NO	YES
Trouble with vision	☐	☐
Wear corrective lenses	☐	☐

EARS, NOSE AND THROAT	NO	YES
Trouble hearing	☐	☐
Hoarse voice	☐	☐

GASTROINTENSTINAL	NO	YES
Heartburn	☐	☐
Feel bloated after eating	☐	☐
Have difficulty swallowing	☐	☐
Nausea and vomiting	☐	☐
Have vomited blood	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Black stools	☐	☐
Hemorrhoids	☐	☐
Rectal bleeding	☐	☐
Have pain in stomach	☐	☐
After eating?	☐	☐
Have pain elsewhere		
In abdomen	☐	☐

GENITO-URINARY	NO	YES
Burning with urination	☐	☐
Blood in urine	☐	☐

MUSUKOSKETAL	NO	YES
Stiff or painful joints	☐	☐

RESPIRATORY	NO	YES
Shortness of breath	☐	☐
Coughing	☐	☐
Coughing up blood	☐	☐
Wheezing	☐	☐
Bronchitis more than once		
Per month	☐	☐

CARDIOVASCULAR	NO	YES
Chest pain or tightness	☐	☐
Difficulty in breathing	☐	☐
Heart palpitations	☐	☐
Have you had a stress test?	☐	☐
(If yes, when? ____/____/_____)		

SKIN	NO	YES
Changes in coloration of		
Your skin	☐	☐
Any lumps noticed:		
Under your arms?	☐	☐
Groin area?	☐	☐
Breast?	☐	☐

NEUROLOGIC	NO	YES
Convulsions	☐	☐
Muscular weakness	☐	☐
Paralysis	☐	☐
Any loss of sensation, tingling		
Numbness, in your fingers,		
toes, limbs?	☐	☐

MOOD	NO	YES
Depressed?	☐	☐
Anxious?	☐	☐
Trouble Sleeping?	☐	☐

SLEEP	NO	YES
Sleep Apena	☐	☐
(If so, do you use a CPAP?)	☐	☐
Date of last study? ____/____/_____		