Complete Chiropractic

Patient Information

1635 Overland Ave • Burley, ID • 678-2629

Dr. Ron Christensen

Confidential Patient Information

Date_____

Name_____Nick Name_____ Gender (M or F) _____

Marital Status: (Circle one) Single Married Widowed Divorced Other

Social Security #_____Under 18? Legal Guardian's S.S. #_____

Birthday (mo/day/year) _____

How would you prefer being contacted: (circle one) Home number Cell number

Home Phone ( ) _____Cell Phone ( ) _____

Mailing Address_____

City_____State_____Zip_____

Email Address_____

Electronic Communication Consent

May we contact you via text and/or email? Yes / No

including: appointment reminders, marketing and promotions, online review requests, birthday wishes

Employment Information: (Patient or Parent if patient is a minor)
Company Name _____
Phone ( ) _____
Address_____City_____State_____ Zip_____

Spouse/Parent (or legal guardian) Name_____
Birthday (mo/day/year)_____
Employer_____ City_____ State _____Zip_____
Phone ( ) _____

Emergency Contact

_____(Relationship) _____Phone ( ) _____
May we share medical information with this person? Yes / No

How did you hear about our office?_____

Preferred Language (circle one): English Spanish Other: _____

Have you ever smoked or vape? Yes / No

If yes (circle one): Every Day Some Days Former

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Patient Information pg 2

Name:_____ Date:_____

Patient History

Reason for your visit _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?_____
  - o Did the symptom begin suddenly or gradually? (circle one)
  - o How did the symptom begin?_____
- What makes the symptom worse? (circle all that apply):
  - o Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):_____
- What makes the symptom better? (circle all that apply):
  - o Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - o Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): _____
- Does the symptom radiate/travel to another part of your body (circle one): yes no
  - o If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - o Morning Afternoon Evening Night Unaffected by time of day

Second Condition if any _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?_____
  - o Did the symptom begin suddenly or gradually? (circle one)
  - o How did the symptom begin?_____
- What makes the symptom worse? (circle all that apply):
  - o Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):_____
- What makes the symptom better? (circle all that apply):
  - o Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - o Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): _____
- Does the symptom radiate/travel to another part of your body (circle one): yes no
  - o If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - o Morning Afternoon Evening Night Unaffected by time of day

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Patient Information pg 3

Name:_____ Date:_____

Is your visit due to an accident? Yes / No. If yes, please describe:_____

_____

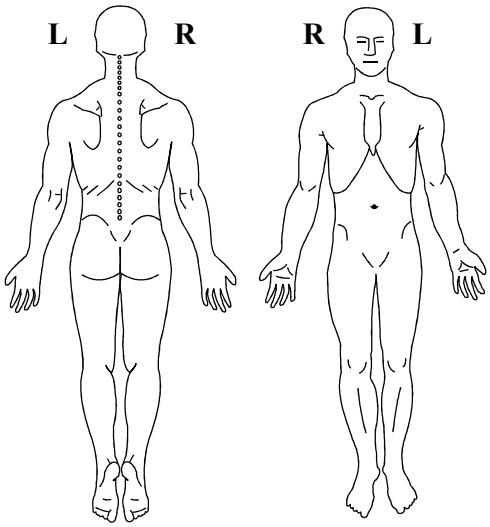
Responsible party: _____

Please list other doctors seen for this condition: _____

_____

Are you still under care? Yes No

Please shade in areas of pain.



Are you taking any prescription medications? Yes/No

If yes please list. Please describe what you are taking the medications are for.
(If you have a list written down we can copy that)

Medication Dose/frequency Reason for taking

_____

_____

_____

_____

Are you allergic to any medication or latex (ie. lotions, cremes or other topicals)? Yes/No, if yes please list.

_____,_____,_____

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Name:_____ Date:_____

Medical History

_____Cancer (type:_____)
_____Digestive Disorders (type:_____)
_____Sinus Trouble
_____Heart Trouble
_____Diabetes
_____Dizziness
_____Depression
_____High Blood Pressure

_____Concussion
_____Neck Pain
_____Numbness
_____Back Pain
_____Asthma
_____Arthritis (type:_____)
_____Headaches
_____Migraines

_____Osteoporosis
_____Herniated Disc
_____Scoliosis
_____Stroke
_____Heart Attack
_____Broken Bones
_____Serious Injury
_____ Other:

Relevant family history:_____

Describe and provide dates for any surgeries or serious injuries you have had that pertain to your chiropractic care. (Hip replacement, knees, back, neck, shoulders, hysterectomy, etc.)

_____

_____

Have you been treated by a physician for any health conditions in the past year? Yes/No
Please describe what this treatment was for:_____

_____

Date of last physical exam_____.

Female Patients
Are you pregnant? Yes/No If yes please give due date, (mo/day/yr)_____.

Patient signature_____Date _____

Is the patient a minor?
Parent or guardians signature_____Date_____
Are you the parent____ or guardian____ for this patient?
Print name if signed on behalf of patient (parent, guardian, etc)_____

Complete Chiropractic

1635 Overland Rd • Burley, ID 83318 • ph: 208.678.2629

Consent Form

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electro therapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to , soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments, (manipulation) is debated. These complications include injury, to the arteries in the neck which may be associated with stroke, and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5 - 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side-effects, complications and effectiveness of spinal adjustment is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

_____

(Signature) (Today's Date)

Please read the following carefully and initial each statement.

_____ I understand that if I have any prosthetics or surgical implants (including breast implants and artificial joints ect.), I should discuss this with the doctor it may effect care.

_____ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Complete Chiropractic reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans.

Notice of Privacy Practices

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Dr. Ron Christensen, DC.

Our notice of Privacy Practices describes in more detail how your health information may be used and disclosed, as well as how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Signature of patient or legal guardian _____Date _____

Printed name if signed on behalf of patient (parent, guardian, etc.)_____

This form will be retained in your medical record as a digital image.

Complete Chiropractic

Financial Agreement

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Dr. Ron Christensen

Do you have insurance? Yes____ No____

We would like to have a copy of your card on file.
If we copy your card you only need to fill out information on the policy holder if it is someone besides yourself.

Name of Insurance carrier_____

Primary card holder_____Date of Birth ___/___/____

Home address if different from patient_____

Policy holder's employer_____

ID Number _____Group Number_____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports, forms and claims as a curtsy to assist me in making collection from my insurance and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I agree to bring all checks in that my insurance sends to me if I have a balance on my account. I permit this office to endorse co-issued remittances for the conveyance of credit to my account.

I clearly understand that I am personally responsible for payment on my account.

I understand that Complete Chiropractic can make no guarantee that the services rendered will cure any complaint and that I am responsible for payment for services rendered regardless of clinical outcome.
It is my understanding that my credit may be checked if Complete Chiropractic extends credit to me, I also understand that if I suspend or terminate my care and treatment, any fees for services rendered to me will be immediately due and payable, unless prior arrangements are made.
I hereby authorize the doctor at Complete Chiropractic and whomever they may designate as their assistants, to administer treatment as they so deem necessary and also authorize the release of any information acquired in the course of my examination or treatment.
I understand that payment is due at the time service is rendered unless prior arrangements have been made.
I understand that I have 30 days from the time my insurance replies to Complete Chiropractic to pay all remaining due, I understand that after that time 10% interest may be added monthly to the remaining amount on the 15th of every month. If no insurance is filed the interest will be charged in the same manner.
I understand that if I present a check to Complete Chiropractic and it does not clear my bank I will be charged a fee of $15.00 at the time the check is returned and a $15.00 fee on the 15th of each month afterwards until the matter is taken care of.
I understand that the last thing Complete Chiropractic wants to do is turn my account over to a collection agency, however if I make no effort and they are forced to do so I personally am responsible for any and all legal fees that may arise.
I certify that the above information I am supplying is true and correct and that I have read and understand the financial agreement between Complete Chiropractic and myself.

Patient Signature _____Date _____

If signing as a legal guardian of a minor please print your name here _____