OPTIMUM CHIROPRACTIC SPINE & INJURY OFFICE

CONFIDENTIAL PATIENT INFORMATION

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Full Name ______________________ Social Security # ______________

Address ______________________ City ______________ State ________ Zip ________

Telephone: Home ______________ Work ______________ Cell ______________ Marital Status: M S W D

Date of Birth: Month _____ Day _____ Yr _____ # Children _______ Spouse's Name ______________

Occupation ______________________ Whom may we thank for referring you ______________

FEMALES: Are you pregnant? __________ Email Address ______________________

HEALTH INFORMATION

Have you had previous chiropractic care? Yes ☐ No ☐

Reason for this visit ______________________

____

Other complaints ______________________

How long have you had this condition? ______________________

Have you had similar conditions in the past? ______________________

Does this condition affect your work? Yes ☐ No ☐

Does this condition affect your family or social life? Yes ☐ No ☐

What aggravates this condition? ______________________

____

Other Doctors seen for this condition ______________________

____

Are you taking any medication? Yes ☐ No ☐

If so, what kind? ______________________

What helps your symptoms? ______________________

Have you ever had surgery? Yes ☐ No ☐ When __________

Please describe ______________________

Have you ever broken any bones? Yes ☐ No ☐ When __________

Please describe ______________________

Date of last physical examination ______________________

INSURANCE INFORMATION

Is this condition due to:

A work related injury? Yes ☐ No ☐

An automobile accident? Yes ☐ No ☐

If you answ er yes to either of the above questions, please complete page 2.

Are you covered by Medicare? # ______________________

Do you have Major Medical Health Insurance? Yes ☐ No ☐

Company ______________________

Who will be responsible for payment? ______________________

Do You Suffer From

	Yes	No
Headaches	☐	☐
Neck Pain	☐	☐
Arm Pain	☐	☐
Shoulder Pain	☐	☐
Back Pain	☐	☐
Leg Pain	☐	☐
Chest Pain	☐	☐
Abdominal Pain	☐	☐
Hip Pain	☐	☐
Sinus Problems	☐	☐
Heart Problems	☐	☐
Circulatory Problems	☐	☐
High/Low Blood Pressure	☐	☐
Female Problems	☐	☐
Prostate Disorder	☐	☐
Kidney Problems	☐	☐
Bladder Problems	☐	☐
Lung/Bronchial Disorders	☐	☐
Digestive Disorder	☐	☐
Constipation	☐	☐
Loose Stool	☐	☐
Diabetes	☐	☐
Swollen Joints	☐	☐
Insomnia	☐	☐
Dizziness	☐	☐
Numbness	☐	☐
Nervousness	☐	☐
Depression	☐	☐
General Fatigue	☐	☐
Anemia	☐	☐
Poor Memory	☐	☐
Hot Flashes	☐	☐

I hereby authorize release of information necessary to file a claim with my insurance company and or attorney and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

A COPY OF THIS SIGNATURE IS VALID AS THE ORIGINAL

Patient's Signature: ______________________ **Date:** __________

Guardian's Signature if Under 18: ______________________ **Date:** __________

Information Taken By: ______________________ **Date:** __________
(If someone else completes form)

Complete only for:

JOB INJURY INFORMATION: Date ______________ Time ___________ Location ________________________________

Description of accident ____

____

____

Workman's Compensation Case # ____

Insurance Company ________________________________ Address ________________________________

Insurance Company Case # ____

Employer's Name ________________________________ Address ________________________________

Hospitalized? ____________ Name of Hospital ________________________________ X-rays taken ______________

Other Doctors seen ____

Are you working now? ________________________________

Time lost from work ________________________________ to ________________________________ **(dates)**

Complete only for:

ACCIDENT INFORMATION: Date ____________ Time ___________ Location ________________________________

How did accident occur? Auto Collision ☐ Other ☐

If not an auto collision, please describe the circumstances: ________________________________

____

____

If auto accident, were you Driver ☐ Passenger ☐ Pedestrian ☐

If auto collision, were you struck from Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto was Parked ☐

Did your car strike the other(s) involved? Yes ☐ No ☐

Or did the other car strike yours? Yes ☐ No ☐ Undetermined ☐

As a result of the accident, were traffic citations issued to you? Yes ☐ No ☐

To the driver of the other car? Yes ☐ No ☐

To the driver of your car? Yes ☐ No ☐

List the extent of the injuries as you know them ________________________________

____

____

Did you require post-accident hospitalization? Yes ☐ No ☐

Check symptoms you have noticed since accident:

☐ Headache	☐ Dizziness	☐ Light Bother Eyes	☐ Diarrhea
☐ Neck Pain	☐ Head Seems Too Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiff	☐ Pins and Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Sleeping Problems	☐ Pins and Needles in Legs	☐ Face Flushed	☐ Stomach Upset
☐ Back Pain	☐ Numbness in Fingers	☐ Buzzing in Ears	☐ Constipation
☐ Nervousness	☐ Numbness in Toes	☐ Loss of Balance	☐ Cold Sweats
☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatigue	☐ Loss of Smell	☐ ______________
☐ Chest Pain	☐ Depression	☐ Loss of Taste	☐ ______________

Symptoms other than above ____

Have you lost any days of work? Yes ☐ No ☐ Dates: ________________________________

Insurance Companies involved: ________________________________

My Company ________________________________

Company of person responsible for injuries? ________________________________

Have you ever been contacted by an insurance adjuster or company representative regarding this claim? Yes ☐ No ☐

Do you have an attorney that has advised you in this case? Yes ☐ No ☐

Name ____

Address ________________________________ Telephone ________________

OPTIMUM CHIROPRACTIC

SPINE AND INJURY OFFICE

Patrick Del Salto DC

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www.delsaltochiropractic.com

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays and/or other tests on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. 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 upon the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Patient Signature: **X**	Date:

(Or Patient Representative)
(Indicate relationship if signing for patient)

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PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

____________________________ hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone, or by e-mail.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for *all future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

___________________________________ ___________________________________
Name of Patient/Individual (Please print) Signature of Patient/Individual (Date Signed)

___________________________________ ___________________________________
Signature of Legal Representative Relationship to Patient
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)