



QUEEN CITY CHIROPRACTIC & SPORTS PERFORMANCE

Confidential Patient Information

Full Name: _____ DOB: _____ Nickname: _____

Address _____
Street Apt# City State Zip Code

Marital Status: S M D W Age: _____ SS#: _____ Gender M F

Home Phone: _____ Cell Phone: _____ Email: _____

Occupation: _____ Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone Number: _____

Who may we thank for your referral? Family Friend Community Ad Postcard Provider Other

Please specify _____

YOUR PRESENT COMPLAINT _____

When did this current episode begin? Be specific (give a date) if possible: _____

Have you been treated by a physician for this condition in the last year? Yes No

Which word describes the frequency of your symptom? (check one)

- Constant (76% - 100% of awake time) Intermittent (26% - 50% of awake time)
 Frequent (51% - 75% of awake time) Occasional (0% - 25% of awake time)

Which phrases best describe *changes* in your symptoms during the day? (check all that apply)

- It is worse in the morning It is worse in the afternoon It is worse at night
 It changes with the weather It does not change

What helps *relieve* your symptoms? (check all that apply)

- Ice Heat Medication Nothing helps Other _____

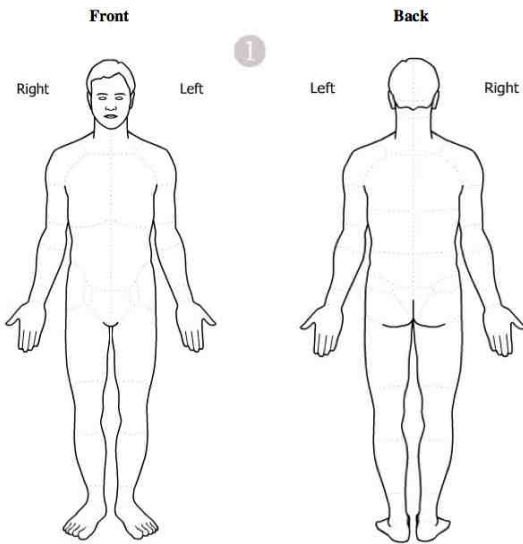
What activities are limited by your discomfort? (check all that apply)

- Bending Pulling Turning Head
 Coughing/ Sneezing Pushing Twisting at waist
 Driving Reading Walking
 Getting up Sitting Working
 Lifting Sleeping Other _____
 Lying Down Standing



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Identify your areas of discomfort by marking
the affected body parts in the illustration.



Smoking status: Every day Some day Former Never

How many alcoholic beverages do you consume per week? _____

How many days do you exercise each week? _____

Have you ever been diagnosed with any allergies? No Yes

If yes, please explain _____

Are you pregnant? No Yes Date of last cycle: _____

List all over-the-counter medications being taken. _____

List all vitamins or other dietary supplements being taken. _____

List all prescription medications being taken. _____

Describe any operations you have had and the dates: _____

Have you ever been diagnosed with cancer? No Yes If yes, please explain: _____

Has anyone in your family ever been diagnosed with cancer? No Yes If yes, please explain _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Queen City Chiropractic extends credit to me and I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Queen City Chiropractic and whomever they may designate as assistants, to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination and treatment. I certify that the above information is true and correct.

Patient's Signature: _____

Date: _____



INFORMED CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

NOTICE: Refusal to consent to the integrative and complementary procedure should not affect your right to future care or treatment.

I (We) voluntarily request Dr. Ashley Schatzman / Dr. Chad Robertson as my physician, and such associates, technical assistants, and other health care providers as they may deem necessary, to treat my condition, which has been explained to me as: neck, mid or low back muscle, ligamentous or disc injury, "pinched nerve" with vertebral or sacroiliac subluxation.

I (We) understand that the following integrative and complementary procedure(s) is planned for me and I (We) voluntarily consent and authorize these procedures: spinal adjustments and/or spinal manipulation, physical therapy modalities also known as ultrasound, electrotherapy, heat or ice, diathermy, and spinal traction.

I (We) understand that no warranty or guarantee has been made to me as to the result of care.

I (We) realize that just as there may be risks and hazards in continuing my present condition without conventional medical treatment, there are also risks and hazards related to the performance of the integrative and complementary treatment, alternative forms of treatment, risks of treatment, risks of non-treatment, procedures to be used, and the risks and hazards involved, and I (We) believe that I (We) have sufficient information to give this informed consent.

I (We) certify this form has been fully explained to me, that I (We) have read it or have had it read to me and that I (We) understand its contents.

Signature

Date

Witness

Date