DR. RON REDMAN
CHIROPRACTIC

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____

Date of Birth: _____ Age: _____ Marital Status: M S D W

Social Security #: _____ Occupation: _____

Employer: _____ Phone: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Spouse Name: _____ Age: _____ Occupation: _____

How many children do you have? _____

Have they or any other members of your family received Chiropractic Care? _____

Do you have health insurance? Y N

Name of Company: _____ Policy #: _____

List any surgeries or hospitalization: _____

List any medications (prescriptions & over the counter) that you are currently taking or have taken in the last 6 months.

_____

Dailey intake: Coffee _____ Tea _____ Alcohol _____ Tobacco _____

Have had chiropractic car in the past? Y N If yes, Dr. _____

Date of last visit: _____ Date of last X-Rays: _____

Please mark (C) for current or (P) for past conditions for the following:

_____ Fractured bones

_____ Auto Accident
- _____ 0-1 years
- _____ 1-5 years
- _____ More than 5 years ago

_____ Knocked unconscious

_____ Slip/Fall

_____ Sporting injury

_____ Work Accident/Injury

_____ Headaches

_____ Neck Pain

_____ Low Back Pain

_____ Mid Back Pain

_____ Shoulder Pain

_____ Pain/Numbness in the arms

_____ Hip Pain

_____ Pain in the legs

_____ Heart Problems

_____ Stroke

_____ High Blood Pressure

_____ Lung Problems

_____ Cancer

_____ Diabetes

_____ Constipation

_____ Digestive Problems

DATE: _____

ACCT: _____

PATIENT: _____

PATIENT HISTORY

1. What is your **main complaint?** _____
2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

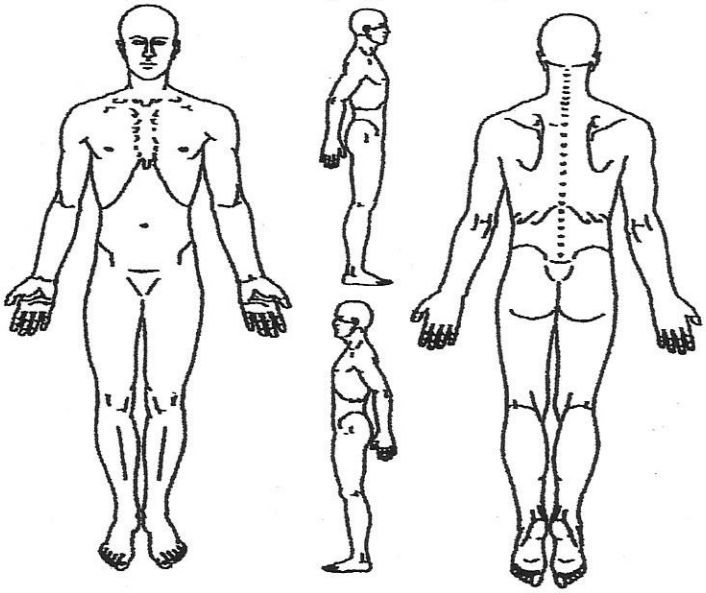
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

3. On the scale below please **circle** the **percentage of time** you experience your **main complaint:**

	Occasional			*Intermittent*			*Frequent*			*Constant*	
0	10	20	30	40	50	60	70	80	90	100	%

4. How **long** have you been experiencing your **main complaint?** _____
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



6. When do you notice it most? ☐ AM ☐ PM
   How long does it last? _____Mins _____Hrs
7. What makes it feel better? _____
8. What makes it feel worse? _____
9. Have you ever had this problem in the past? ☐ Yes ☐ No
10. I have ☐ been hospitalized ☐ been treated by another chiropractor ☐ been treated by another specialty provider ☐ never received care for this problem.
11. Have you lost time from work because of it? ☐ Yes ☐ No
    Dates?_____ to _____
12. Are you Pregnant? ☐ Yes ☐ No
13. What was the first day of your last menstrual cycle? _____
14. Number of pregnancies? _____ Miscarriages? _____

Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

personal care ____
lifting ____
reading ____
concentrating ____
work ____
driving ____
sleeping ____
recreation ____
walking ____
sitting ____
standing ____
social life ____

Signature:_____

Date: ____/____/____

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CHIROPRACTIC

Insurance Notice

As a courtesy to you, this office will submit claims to your insurance company and prepare any necessary reports and forms to assist you in making collections from the insurance company. Any amount authorized to be paid directly to this office will be credited to your account. Some of the care and services you receive may not be covered by your insurance. If we knowledge that a service or product is not covered by your insurance company, we will do our best to notify you in advanced. However, your insurance policy is a contract between YOU and the INSURANCE COMPANY. You are ultimately responsible for payment in full if the carrier determines that a service or product in not covered by your insurance, we will do our best to notify you in advance. You are ultimately responsible for payment in full if your carrier determines that a service or product is not covered by your policy.

I, _____, attest that I have read and fully understand the above statements.

Patients Signature: _____ Date: _____

X-RAY CONSENT

The purpose of the x-ray examination is to analyze the spine for vertebral subluxation, rate, and level of degeneration of the spine, and to determine the appropriateness of spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing the x-rays, I will be informed and must determine if I should seek further advice from an additional healthcare provider. I fully understand that this should not interfere with the subluxation correction care provided by this office. I fully understand the above and consent to chiropractic spinal x-rays.

Patient Signature_____ Date: _____

PREGNANCY RELEASE

This is to certify to the best of my ability, I am not pregnant and REDMAN CHIROPRACTIC has my permission to perform an x-rays evaluation. I understand the risk of taking an x-ray to an unborn child.

Date of last menstrual period: _____

Patient Signature: _____ Date: _____

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CHIROPRACTIC

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have the right to privacy regarding my protected health information. I understand that this information can and will be used:

- Conduct, Plan and directly treat and follow-up among the multiple health care providers who may be involved directly and indirectly with treatment.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read and understand your notice of privacy practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its police practices from time to time and that I may contact this organization at any time at the above address to receive a current copy of the notice of privacy practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients Name: _____

Signature: _____

Date: _____ Relationship to patient: _____

Witness: _____

DR. RON REDMAN
CHIROPRACTIC

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

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, 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 work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other 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 and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

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.

Clinic and Doctor: REDMAN CHIROPRACTIC, Dr. Ron Redman

To be completed by the patient: **To be completed by the patient's representative, if necessary, (eg: if the patient is a minor or is physically or mentally incapacitated)**

Patient Signature_____ **Date** ____/_____/_____

Witness Signature _____ **Date** ____/_____/_____

Physician Signature _____ **Date** _____/_____/_____

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