TYSDAL CHIROPRACTIC

Patient Information **Acct # _____**

Today's Date:_____

Full Name:_____ Preferred Name:_____ Sex: ◯ Female ◯ Male

Address: _____ Apt./Unit Number_____

City:_____ State:_____ Zip Code:_____

Cell Phone #:_____ Home Phone #:_____

Email:_____ Birth Date:_____ (Age:_____) SS#: _____

Occupation:_____ Employer:_____

Marital Status: □ Single □ Married □ Other Name of Spouse:_____

Names/Ages of Children Living At Home:_____

Name and Number of Emergency Contact:_____

How were you referred to Tysdal Chiropractic?

□ Family Member □ Friend □ Doctor □ Internet □ Newspaper □ Phone Book □ Other_____

Please give us the name of the family member, friend or doctor that referred you:_____

Insurance Information

Insurance Company:_____ Policy Number: _____Group Number:_____
Policy Holder's Name:_____ Policy Holder's Birth Date:_____
Policy Holder's Relationship to the Patient: □ Self □ Spouse □ Parent/Guardian □ Other_____

Chiropractic History

Have you been under Chiropractic care before? □ Yes □ No If yes, date of last visit?_____

Was your chiropractic experience positive, negative, neutral?_____

Reason:_____

Current and Past Conditions

*Please indicate if you have or have had any of these conditions

□ Headaches	□ Back Pain	□ Neck Pain	□ Pins/ Needles in Arms/Legs
□ Shoulder Pain	□ Stress	□ Muscle Tension	□ Overall Joint Pain/Stiffness
□ Difficulty Walking/Sitting	□ Difficulty Driving	□ Difficulty Working	□ Difficulty Lifting/Bending
□ Weakness	□ Loss of Balance/Dizziness	□ Fatigue	□ Loss of Coordination
□ Frequent Colds/Flu	□ Ringing in Ears	□ Sinus Problems	□ Diarrhea/Constipation
□ Indigestion	□ Sleeping Problems	□ Allergies	□ Asthma
□ Anxiety	□ Depression	□ Moody/ Irritable	□ Lack of Concentration
□ High Blood Pressure	□ Vision Problems	□ Poor Memory	□ Menopausal Difficulties
□ Fertility Dysfunction	□ Prostate Dysfunction	□ Sexual Dysfunction	□ Menstrual Difficulties

Surgeries:_____

Serious illness or injury:_____

Allergies:_____

Habits: Smoking/Tobacco use? □ Yes □ No Alcohol use? □ Yes □ No If yes, how many drinks per week? _____

Medications taken within the last two months (include over the counter and vitamins):_____

_____

Occupational Stresses:_____

Are there any other issues concerning your health that you would like the doctor to be aware of?_____

Have you had any other significant traumas? (Auto accidents, falls, etc…): □ Yes □ No

If Yes, Please Describe: _____

_____

The MAJOR Symptom/Complaint

Major Complaint: _____

Have you had this problem before? □ Yes □ No When did the problem start? _____

How did this problem start? _____

Is the problem related to an auto/work accident? □ Yes □ No

If yes, what is the date of the accident? _____

Please describe your current pain:

□ Sharp □ Dull Ache □ Numb □ Shooting □ Burning □ Tingling

□ Other _____

Since your problem began, is the pain...

□ Increasing □ Decreasing □ Not Changing

How frequently does your pain occur?

□ Constantly □ Frequently □ Occasionally □ Intermittently

What makes your problem better? _____

_____

What makes your problem worse? _____

_____

Please list other health care providers consulted for this condition:

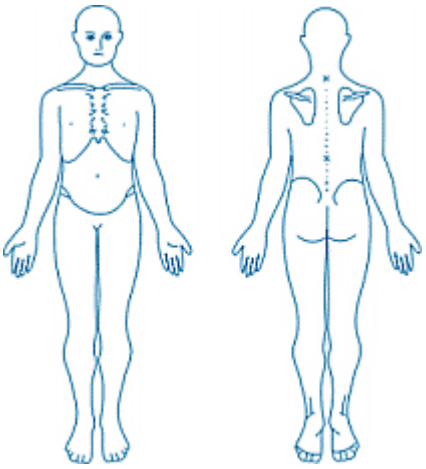
_____

Date of last physical examination: _____

Women: Are you/ is there a possibility that you may be pregnant? □ Yes □ No

If yes, what is the due date? _____

Please mark the location(s) where you have pain or other symptoms.



*Please rate the severity of your pain

None Unbearable

0 1 2 3 4 5 6 7 8 9 10

THE STATEMENTS MADE ON THESE FORMS ARE ACCURATE TO THE BEST OF MY RECOLLECTION AND I AGREE TO ALLOW THIS OFFICE TO EXAMINE ME FOR EVALUATION.

Signature: _____Date: _____

If under 18, Parent/Guardian Signature: _____Date: _____

HIPPA PRIVACY PRACTICE

I acknowledge that Tysdal Chiropractic, LLC. “Notice of Privacy Practices” has been made available to me, upon request. I understand I have the right to review Tysdal Chiropractic’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations at Tysdal Chiropractic, LLC.
The Notice of Privacy Practice is provided upon request at the front desk. This Notice of Privacy Practices also describes my rights and Tysdal Chiropractic, LLC’s duties with respect of my protected health information. Tysdal Chiropractic, LLC, reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

INFORMED CONSENT

Chiropractic care centrally involved what is known as a chiropractic adjustment. Potential benefits of an adjustment include: restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, oculosympathethetic palsy, costovertebral strains and separation. Rare complications include but are not limited to a stroke. The most common complication or complaint following a spinal manipulation is an ache or stiffness at the site of adjustment. The doctors are aware of these complications, and in order to minimize their occurrence will take precautions. These precautions include, but are not limited to the doctor taking a detailed clinical history and examining you for any defect which would cause a complication.

This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should let us know when the doctor takes your clinical history.

ACKNOWLEDGEMENT OF UNDERSTANDING

By signing below, I understand that I am financially responsible and agree to pay any health insurance deductibles, co-insurance, co-pays, and amounts not covered by insurance or Medicare. If my account is delinquent, I agree to pay all expenses incurred by this office to collect the account.
My signature also authorizes the payment be made directly to Tysdal Chiropractic for any and all insurance benefits or reimbursements for services rendered by this company as well as authorizes the release of information concerning my health and health care services to my insurance companies, health plan or Medicare.
I acknowledge that I have been provided a copy of the Tysdal Chiropractic Payment Policy, upon request. I have also been notified of the HIPPA Policy and Privacy Practices utilized in this office which is provided by request at the front desk.
I authorize the staff at Tysdal Chiropractic to perform any necessary services needed during diagnosis and treatment. I also certify that no guarantee has been made as to the results that may be attained through such treatment.
I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I provided.

Signature: _____ Date: _____