Consents

Consent to Bill/Collect Insurance: I consent, if I am using a third party for payment of my services (health insurance, auto accident insurance, Parent/Guardian, etc), to allow Brookwood Chiropractic to submit all necessary information needed to receive payment for the services I received to these third parties. I further consent to allow Brookwood Chiropractic to retrieve my insurance benefits. If my case is an auto accident, this would include coverage amounts for the accident as well as medpay/UIM coverage and/or canceled checks proving payment was provided. **Initials:**_____

Consent to Examination and Treatment: I give the doctor and staff of Brookwood Chiropractic permission to perform all exams, x-rays, and treatment deemed necessary. I understand that some of these procedures may be performed by either the staff or the doctor. **Initials:**_____

Consent to Retrieve Medical Records: I give the doctor and staff of Brookwood Chiropractic permission to obtain any medical records from other providers, offices or hospitals which may assist with my care. **Initials:**_____

HIPPA: A copy of the Health Information Privacy Act can be requested. In brief, it states that we will not give any information about you except as consented above. The only people we give information to are parents/guardians (if you are a minor) or whomever is responsible for your bill (i.e. insurance company, third party or attorney if you have one). Please list anyone else you would like to have access to your records:_____

Public Display of Reviews: I understand that, if I leave a review for Brookwood Chiropractic, that they may display this review online in a public forum. By signing below, I give permission for Brookwood Chiropractic to utilize my review in their digital and online marketing. **Initials:**_____

Informed Consent: The patient has been informed and understands that the practice of chiropractic includes treatment by adjustment or manipulation of the patient's body part, particularly the spine. Adjustment of the body and spine necessarily involves applying pressure, by the use of "Hands On" techniques requiring the doctor to use hands and body to cause appropriate movement within the patient's body. Manipulation is gentle and should not cause damage to the patient.
If at any time during the examination or treatment you feel uncomfortable due to body contact which occurs please inform the doctor immediately and give sufficient notice to allow the alteration of the treatment plan as appropriate. **Initials:**_____

_____ _____ _____

Patient/Guardian Name (PRINT) Patient/Guardian (SIGN) Date

Pregnancy Waiver: By my signature below, I am stating that to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this time.

_____ _____ _____

Patient/Guardian Name (PRINT) Patient/Guardian (SIGN) Date

Case History/ROS continued.....

In what position do you usually sleep and how well? _____
Do you exercise on a regular basis? _____
How do you spend your spare time? _____
Do you use caffeine? _____ Tobacco? _____ Alcohol? _____ Recreation drugs? _____
Please describe your work type: Physical labor? _____ Driver? _____
Clerical? _____ Factory? _____ Homemaker? _____
Describe your physical demands: Heavy? _____ Moderate? _____ Mild? _____Sedentary? _____
Please describe your work stress level: High? _____ Moderate? _____ Mild? _____ Low? _____
Your diet is: Balanced: _____ Fair: _____ Poor: _____ Excessive: _____ Restricted: _____

Please circle if you have any of the following issues:

Musculoskeletal: Neck pain/stiff Hand numbness/pain Upper arm pain Shoulder pain chest pain Mid back pain Arthritis Mid back burning Sore mid back Back pain Cramps Knee pain Sciatica Low back pain Leg pain Weak ankles Plantar Fasciitis Foot pain Weakness in legs Heel spurs Hip pain Spinal curvature Pain in tailbone with sitting

Neurological: Headaches Numbness Tingling Any changes in sight Any changes in smell Any changes in taste Any changes in hearing Seizures Vertigo Pins and needles Radiating pain Blurred vision Vision difficulties Balance problems

Please list any additional information here: _____
_____
_____
_____

Print Patient Name: _____ **Date:** _____

Patient Signature: _____

Case History / Review of Systems

Date: _____ **Patient Name** _____

Do you have skin, hair or nail problems? _____
Do you have mouth and/or throat problems? _____
Do you have nose and/or sinus problems? _____
Do you have ear problems? _____
Do you have eye problems? _____
Do you have chest or lung (breathing) problems? _____
Do you smoke? _____ Cigarettes per day? _____ How long have you smoked? _____
Do you have heart and/or blood vessel problems? _____
Do you have blood or lymph node problems? _____
Do you have digestive problems? _____
Do you have genital problems? (Ex. Prostate, testicular, vaginal)? _____
Do you have urinary (including kidney or bladder) problems? _____
Do you have any gland and/or hormone problems? _____
Do you have allergy or immunity problems? _____
Do you have any bone or joint diseases (Ex. osteoporosis, arthritis)? _____
Do you have any nervous system, disease and/or mental health problems? _____
_____

Have you suffered any physical injuries such as falls, auto accident, concussion, strains or broken bones? _____
List any diseases that you have had in the past including childhood disease: _____
_____

Have you ever been diagnosed with conditions such as diabetes, AIDS, etc: (If yes to diabetes is it Type 1 or 2)? _____
_____

List any surgeries you have had. (Including appendix, tonsils, ear tubes and wisdom teeth):
_____ Date: _____
_____ Date: _____
_____ Date: _____

Have you ever been hospitalized for any reason other than surgery?
_____

Patient Intake Information

Date_____

(Legal) First Name MI Last Name DOB Age

Street_____ Apt. _____

City_____ State_____ Zip_____

SS #:_____ Marital Status: [ ] S [ ] M [ ] W [ ] D Spouse_____

Contact Info: Home Ph: _____ Cell Ph: _____

Cell Carrier: _____ Email: _____

Contact Preference: ____ Home Phone ____ Cell Phone ____ Email

Emergency Contact: _____ Phone:_____

How were you referred to our office? _____

Occupation? _____ Employer_____

Insurance Information: A copy of your insurance card[s] will be made, in addition, please complete the requested below:

Are you the policy holder? [ ] Y [ ] N If no who is? __Spouse __Parent __Employer Other_____

Policy Holder's First Name MI Last Name DOB

Policy Holder's SS#_____ Policy Holder's Employer_____

Do you have a Secondary Ins? [ ] Y [ ] N If yes please complete the following:

Policy Holder's First Name MI Last Name DOB

Policy Holder's SS#_____ Policy Holder's Employer_____

Current Treating Physicians:

Primary Care: _____ Phone#: _____

OB/GYN: _____ Phone#: _____

Dentist: _____ Phone#: _____

Patient Primary Complaint Form

Name: _____ Date: _____

What is the #1 thing bothering you today? _____

Onset

What were you doing when this happened? _____

(Circle one)

Was is **sudden** or **gradual**? **OR** is it part of an ongoing problem? **NO** **YES**

Provoked

What makes the pain worse? _____

What makes the pain better? _____

Does movement cause pain? **NO** **YES** Does pressure cause pain? **NO** **YES**

Quality (Please circle your choice)

Is your pain:

SHARP **DULL** **CRUSHING** **BURNING** **TEARING** **THROBBING** **STIFF** **SORE**

Is your pain: **CONSTANT** **OFF & ON**

Region / Radiate

Where is your pain? _____

Does it radiate to any other areas? _____

Severity (Please circle your level of pain)

Mild **Moderate** **Severe**

1 2 3 4 5 6 7 8 9 10

Time

How long has this been going on? _____

Has it changed (better, same or worse) since it started? _____

Were you involved with an accident? (Auto, fall, work, etc?)

_____

_____ _____

Patient Signature Date