Chart #

PLEASE PRINT

Legal Name____ Preferred Name________________ SSN__________________
Address____ City____________________________ State______ Zip___________
Home Phone_________________________ Cell Phone_________________________ Work Phone_________________________
Age ____ Birthdate_____________________ Sex M F Marital Status M S W D Children? Y N How Many___________
Race___________________ Preferred Language___________________ Email ____
Occupation _________________________________Employer____
Spouse's Name_____________________ Emergency Contact Name & Number____
Family Physician_______________________________________ Referred By____

Primary Insurance Company____ Policy #_______________________________
Name of Policy Holder_______________________________________ Relationship to Patient______________________________
Policy Holder's Birthdate______________________ Employer____

Secondary Insurance Company____ Policy #________________________________
Name of Policy Holder_______________________________________ Relationship to Patient______________________________
Policy Holder's Birthdate______________________ Employer____

ASSIGNMENT/AUTHORIZATION/RELEASE: I certify that I or my dependent, have insurance with the above named insurance company(s) and assign directly to Martini Chiropractic Center, all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that co pays are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Martini Chiropractic Center for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

I understand that Martini Chiropractic Center asks for 4 hour notice to cancel appointments and **may** charge $25.00 for all "no shows".

Private Pay/Cash: I acknowledge that **if I do not** have insurance, that I am financially responsible for all services at the time they are rendered.
Name of person responsible for account ____

We want to give you recognition for helping us to help others. If you refer a patient to our office, we will place your name on our TV "Referral List" in the lobby. If you are happy with the service we provide you, and would like to share a testimonial, we will use it for marketing purposes. Refusal of this consent will not affect the treatment that you receive in this office.

I **DO / DO NOT** give the office permission to place my name on the "Referral List".

By signing below, I certify the accuracy of my medical and/or accident history. I also agree to the above terms and conditions.

Patient/Guardian Signature ____ Date _________________________

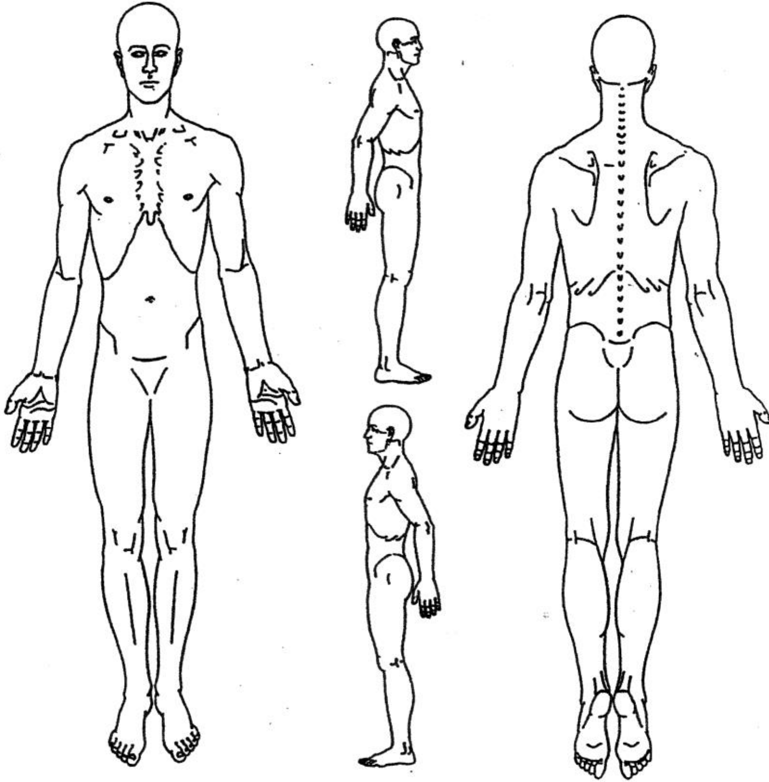
What is the reason for your visit today? ____

What caused this complaint? ____

When did the symptoms appear? _____________________ Is it getting worse? YES - NO – CONSTANT - COMES AND GOES

Have you ever had the same or similar condition in the past? YES NO If yes, when?___________________________________

What does your complaint(s) feel like**? Circle all that apply** *Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning /Cramping / Nagging /Tingling/ Numbness /Other*____



← Put P where you have pain, S where sore, SW where swollen and N where you have numbness.

For office use

Circle the severity of your main complaint right now:

No Pain			Moderate Pain				Worst Possible Pain			
0	1	2	3	4	5	6	7	8	9	10

What area(s) does the pain radiate, shoot, or travel to? (if applicable)?____

What aggravates this complaint? Circle all that apply: Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward / Bending backward / Twisting / Reaching / Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other:____

What relieves this complaint? Circle all that apply: Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Laying down / Medication / Nothing / Unknown / Other:______________________________

How often do you experience your symptoms? □ 25% of the day □ 50% of the day □ 75% of the day □ 100% of the day

Timing of complaint: Check appropriate box: □ Morning □ As day progresses □ Afternoon □ Evening □ While sleeping □ During activities □ After activities □ Symptoms are constant and do not change □ Other:______________________________

Have you seen other doctors for this complaint? □ Yes □ No *If "Yes", please provide the following information*:
Doctor's name _____________________________ Date consulted: ________________Diagnosis_________________________

Is this condition interfering with your: (Circle all that apply) Sleep / Getting in or out of bed or chair / Personal care / Travel / Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other:_________________________

Is your complaint interfering with your daily activities? □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

PRINT NAME:____ DATE:_________________________

HEALTH HISTORY

Please check ALL of the following symptoms which you now have or have had in the past.

□ Headaches (migraines) □ Neck Pain □ Low Back Pain □ Disc Herniation

□ Cancer/Tumor □ Rheumatoid Arthritis □ Depression / Anxiety □ Asthma

□ Osteoporosis / Osteopenia □ Heart Disease / Stroke □ Fibromyalgia □ High Blood Pressure

□ Osteoarthritis / Degenerative Joint Disease □ Whiplash Injury Date of Injury:

□ Joint Pain (circle location) Shoulder, Elbow, Hip, Knee, Ankle, Other ____

□ Numbness (circle location) Shoulder, Arms, Elbows, Hands, Fingers, Hips, Legs, Knees, Feet

Please check ALL conditions that run in your family (Father, Mother, Sister, Brother)

□ Rheumatoid Arthritis □ Heart Disease □ High Blood Pressure □ Cancer

SURGERIES and/or HOSPITALIZATIONS (List and Date)

____

____

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date)

____

____

Have you had an x-ray, CT scan or MRI of your back within the last year? □ Yes □ No

List any medications, including herbal, you are currently taking. ____

____

____

List any allergies to medications ____

Family Medical Doctor____ Date of last exam __________________________

Height _________________ Weight _________________ Blood Pressure (leave blank) ___________________________________

SOCIAL HISTORY

Do you currently smoke tobacco of any kind? □ Yes □ Former smoker □ Never been a smoker

Do you drink alcohol? □ Yes □ No Do you drink caffeine? □ Yes □ No

Do you take pain killers? □ Yes □ No If yes, how often? □ Daily □ Weekly □ Monthly □ Rarely

What type? □ Aspirin □ Ibuprofen □ Tylenol □ Other ____

What do your work duties include? □ Sitting □ Standing □ Light labor □ Heavy labor □ Other ___________________________

PRINT NAME:____ DATE:__________________________

INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures.

- Spinal Manipulative Therapy
- Range of Motion Testing
- Muscle Strength Testing
- Hot/Cold Therapy
- Mechanical Traction
- Palpation
- Orthopedic Testing
- Postural Analysis
- Electrical Stim
- Other____
- Vital Signs
- Basic Neurological Testing
- Ultrasound
- Radiographic Studies

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatments. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Dale Martini and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: __________________

Dated: ____________________

____

Patient's Name (PRINT)

____

Signature of Patient, Parent or Legal Guardian

____

Doctor's Name

____

Doctor's Signature

Revised 5/17