CHIROPRACTIC PATIENT UPDATE

Please complete Parts A & C in all cases. Part B should be completed only if the information has changed since you were last in our office.

Thank You!

PART A

Name:	Phone:
Email addresses:	Cell Phone:
Address:	Fax:
Purpose of this appointment:	
Is this the same problem you were originally under care for? ( ) Yes ( ) No	
If yes, are there any additional symptoms?	
Other doctors seen for this condition:	
What medications or drugs are you taking?	

PART B

Occupation:	Work Phone:
Employer:	Employer's address:
Spouse:	Spouse's Employer:

PART C

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of (16%).

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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.

Date Signed:	Signature:
Health Insurance Coverage: ( ) Yes ( ) No	Company:

Patient Name:	Doctor:	Date:

CONSULTATION QUESTIONNAIRE

What is your major symptom?				
What does this prevent you from doing or enjoying?				
If this is a recurrence, when was the first time you noticed this problem?				
How did it originally occur?				
Has it become worse recently?	Yes / No ☐	Same ☐	Better ☐	Gradually Worse ☐
How frequent is the condition?	Constant ☐	Intermittent ☐	Daily ☐	Night Only ☐
How long does it last?	All Day ☐	Few Hours ☐	Minutes:	
Are there any other conditions or symptoms that may be related to your major symptom?	Yes / No			
If yes, describe:				
Are there other unrelated health problems?	Yes / No			
If yes, describe:				
Describe the pain:	Sharp	Dull	Burning	Stabbing
	Numbness	Tingling	Aching	
Other:				
Is there anything you can do to relieve the problem?	Yes / No			
If yes, describe:				
If no, what have you tried that did not help:				
What makes the problem worse?	Standing	Sitting	Lying	Bending
	Lifting	Twisting	Other:	
List any major accidents you have had other than those that might be mentioned above:				
WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?	Yes / No	Uncertain		
Remarks:				

NO SYMPTOMS EXTREME SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

Doctor's Signature:	Date:

Williams Family Chiropractic
& Rehabilitation Center

INFORMED CONSENT

PATIENT NAME _____

Clinic Name _____

Doctor's Name _____

Address _____

Phone _____ Fax _____

Williams Family Chiropractic
& Rehabilitation Center
110 W. Choctaw
Lindsay, OK 73052
405 756 3182
405 756 3183

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you 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 tell me when I take you clinical history.

DATE _____

_____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)