# Patient Information Sheet


Name _____

Today's date _____ Date of Injury_____

Address _____

City _____ State ____ Zip _____

Sex (M) (F) Age_____ Birthdate _____

Occupation _____

Employer_____

We may reach you at: Home _____

Cell _____ Work _____

E-mail address _____

In case of an emergency, contact _____

at _____ or _____

**How did you hear about us?_____**

Insurance Information

Insurance Co. _____

ID# _____

Group #_____ Effective Date_____

If you're not the policy holder, provide the following:

Holder's name _____ Relation _____

Holder's Birthdate _____ SS# _____-____-_____

Additional Coverage (Y) (N) Company_____

## Patient Condition

Reason for visit _____ When did symptom(s) appear_____

How did it occur: gradually ( ) suddenly ( ) Are symptom(s) constant (Y) (N) How long does it last_____

Activities or foods that intensify symptom(s) _____ alleviate symptom(s)_____

Have symptoms been getting worse since onset (Y) (N) better (Y) (N) or the same (Y) (N)

Has this ever happened before (Y) (N) What did you do for it then _____

Have the symptoms affected you daily activities (Y) (N) How_____

Are there other symptoms you feel might be related_____

Have you or are you currently receiving treatment for this problem (Y) (N) By whom_____

Are there any specific goals you wish to achieve by seeking treatment_____

Are symptoms the result of an accident (Y) (N) Type (Auto) (Work) (Other_____) Date of accident___/___/____

Have you reported your accident to (Auto Ins.____) (Work Comp____) (Employer____) (Attorney____)

Can you provide us with a copy of an accident report or someone to contact for this (Y) (N) _____

Are you planning, or in the process of seeking damages for this accident (Y) (N)

If Yes, you may be asked to fill out a separate patient information sheet

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage with the above carrier and assign directly to the physicians of Gold Coast Wellness all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physicians to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient's Printed Name _____ Patient's Signature _____

Legal Guardian's Printed Name _____ Legal Guardian's Signature_____

Translated By _____ Physician's Signature _____ Date _____

# Patient Health History

Have you seen a chiropractor before (Y) (N)

If yes, for what_____

Date of most recent physical ___/___/___ Blood Test___/___/___

X-ray___/___/___ Area Viewed _____

MRI, CT, Bone Scan ___/___/___ Area Viewed _____


**General**
☐Yes ☐No Fever
☐Yes ☐No Night Sweats
☐Yes ☐No Loss of Sleep
☐Yes ☐No Chronic Fatigue
☐Yes ☐No Rapid Weight Loss
☐Yes ☐No Swollen Glands
☐Yes ☐No Allergies
☐Yes ☐No Rashes/Open Wounds
☐Yes ☐No Changes in Mole(s)
☐Yes ☐No Skin Cancer
☐Yes ☐No Bruise Easily
☐Yes ☐No Bleeding Disorders
☐Yes ☐No Anemia
☐Yes ☐No Diabetes
☐Yes ☐No Cancer
☐Yes ☐No Thyroid Disease/Cancer

**Eye, Ear, Nose, and Throat**
☐Yes ☐No Eye Ailments
☐Yes ☐No Prescription Glasses
☐Yes ☐No Recurrent Ear Infection
☐Yes ☐No Loss of Hearing/Deafness
☐Yes ☐No Nosebleeds
☐Yes ☐No Sinus Trouble
☐Yes ☐No Dental Trouble
☐Yes ☐No Hoarseness

**Respiratory**
☐Yes ☐No Difficulty Breathing
☐Yes ☐No Chronic Cough
☐Yes ☐No Excessive Phlegm
☐Yes ☐No Blood in Phlegm
☐Yes ☐No Wheezing/Asthma
☐Yes ☐No Pneumonia
☐Yes ☐No Tuberculosis

**Cardiovascular**
☐Yes ☐No Irregular Heartbeat
☐Yes ☐No High Blood Pressure
☐Yes ☐No Pain in Chest
☐Yes ☐No Previous Heart Ailments
☐Yes ☐No Ankle Swelling
☐Yes ☐No Varicose Veins
☐Yes ☐No Stroke
☐Yes ☐No Angina

**Gastrointestinal**
☐Yes ☐No Diarrhea
☐Yes ☐No Constipation
☐Yes ☐No Difficulty Swallowing
☐Yes ☐No Excessive Gas
☐Yes ☐No Frequent Heartburn
☐Yes ☐No Frequent Nausea
☐Yes ☐No Ulcers
☐Yes ☐No Black or Bloody Stool
☐Yes ☐No Gallbladder Ailments
☐Yes ☐No Hernia
☐Yes ☐No Hemorrhoids

**Genitourinary**
☐Yes ☐No Frequent Urination
☐Yes ☐No Painful Urination
☐Yes ☐No Blood in Urine
☐Yes ☐No Kidney Disease
☐Yes ☐No Urinary Disease
☐Yes ☐No Incontinence
☐Yes ☐No Hesitation
☐Yes ☐No Wake to Urinate___/night
☐Yes ☐No Venereal Disease
☐Yes ☐No Sexual Difficulties

**Men Only**
☐Yes ☐No Testicular Swelling/Pain
☐Yes ☐No Prostate Ailments

**Woman Only**
☐Yes ☐No Having Regular Periods
_____ Date Last Period Began
☐Yes ☐No Painful Periods
☐Yes ☐No Excessive Flow
☐Yes ☐No Irregular Cycles
☐Yes ☐No Vaginal Burning/Itching
☐Yes ☐No Hot Flashes
☐Yes ☐No Abnormal Bleeding
☐Yes ☐No Recurrent Urinary Infections
☐Yes ☐No Recurrent Yeast Infections
☐Yes ☐No Pre-menstrual Syndrome
☐Yes ☐No Breast Lumps/Discharge
☐Yes ☐No Excessive Cramping
☐Yes ☐No Pregnant/Due_____/Child#__

**Habits**
☐Yes ☐No Smoking____packs/day
☐Yes ☐No Drinking____oz/day
☐Yes ☐No Alcohol or Drug Abuse

**Neurological**
☐Yes ☐No Weakness
☐Yes ☐No Tremors
☐Yes ☐No Headaches/Migraines
☐Yes ☐No Dizziness
☐Yes ☐No Epilepsy
☐Yes ☐No Numbness/Tingling
☐Yes ☐No Arm/Leg Pain

**Musculoskeletal**
☐Yes ☐No Herniated Discs
☐Yes ☐No Swollen Joints
☐Yes ☐No Painful Joints
☐Yes ☐No Muscle Aches/Cramps
☐Yes ☐No Arthritis_____

**Exercise (circle one)**
Not at all Occasionally Regularly

**Family History (immediate family mostly, and indicate whether ailment is on your mother or father's side)**
☐Yes ☐No Diabetes
☐Yes ☐No Thyroid Disease/Goiter
☐Yes ☐No Tuberculosis
☐Yes ☐No Kidney Disease
☐Yes ☐No Liver Disease
☐Yes ☐No High Blood Pressure
☐Yes ☐No Heart Disease
☐Yes ☐No Cancer
☐Yes ☐No Muscle/Bone/Nerve Dis.

**Medication(s)**
Name Dose Reason
_____
_____
_____
_____
_____

**Supplements**
Name Dose Reason
_____
_____
_____
_____
_____

**History of Surgeries**
Date Area Any Implants
_____
_____
_____
_____
_____

**History of Hospitalization(s)**
Date Reason Prognosis
_____
_____
_____
_____
_____
_____

# Pain Diagram and Visual Analog Scale

**Please read carefully:**

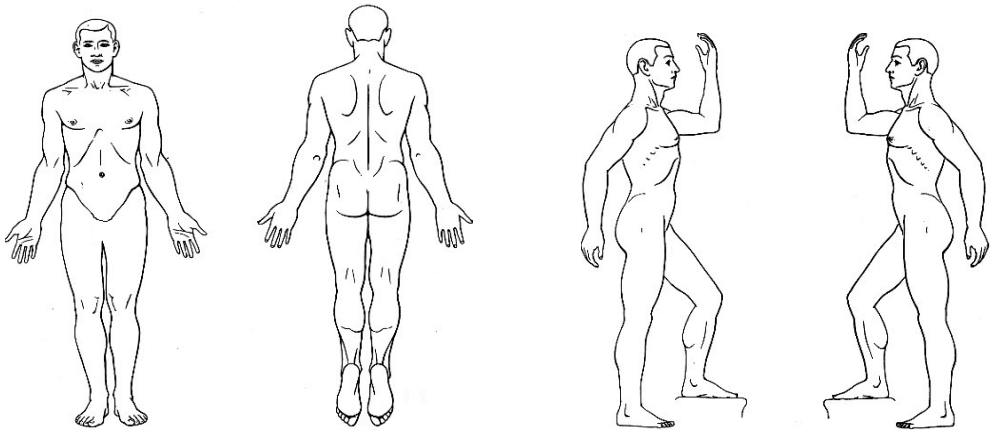
Mark the areas on the diagram below that coincide with your pain. Include all the affected areas.

Use as many individual symbols as you'd like to describe the pain intensity.

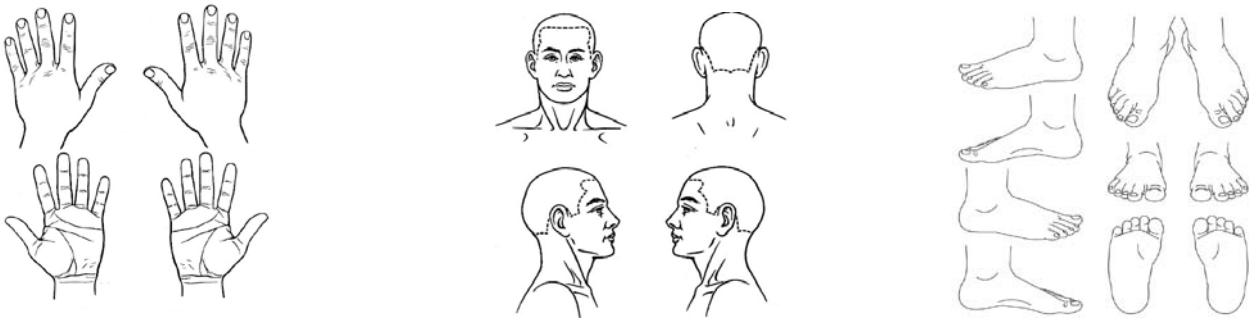
**Indicate radiation of pain by drawing an arrow (↘) from the origin of pain to where it stops.**

Use the appropriate symbol(s) listed below.

| | | | | | |
|---|---|---|---|---|---|
| ACHING | XXXX | NUMBNESS | = = = = | PINS AND | 0000 |
| | XXXX | | = = = = | NEEDLES | 0000 |
| BURNING | >>>> | STABBING | / / / / | THROBBING | + + + + |
| | >>>> | | / / / / | | + + + + |



**HEADACHES ↓**



The lines below represent the intensity of your pain. Please number each pain (1,2,3,etc.)you described above starting with your greatest complaint and list these below. Then mark the line provided at the position that best indicates the intensity of pain you feel **right now.**

#1 NO PAIN _____I_____ WORST PAIN IMAGINABLE

#2 NO PAIN _____I_____ WORST PAIN IMAGINABLE

#3 NO PAIN _____I_____ WORST PAIN IMAGINABLE


## Informed Consent to Chiropractic Health Care

By reading and signing this form, 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 doctors of chiropractic and qualified staff member's at Gold Coast Wellness (GCW) and/or other licensed doctors who now or in the future work at GCW.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures such as Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments. Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare. Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution. Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. One in a million is about the same chance as getting hit by lightening. One in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death. Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Finally, I am aware that the appropriate tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

### Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and other person of the doctor's choosing.

### Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery. Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks. Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues. Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery. Non-treatment: I understand the potential risks of refusing or neglecting care may include increases pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

### Statement of Non-Pregnancy

X-rays are a form of electromagnetic radiation that may have adverse effects on body tissue, especially rapidly dividing cells. It is during the first few months of pregnancy that the cells of an embryo are most susceptible to injury or the induction of serious congenital anomalies. Therefore, we've adopted the 10-Day Rule which recommends that woman undergoing radiographic procedures carries less risk to a develop embryo if preformed within 10 days following the onset of a menstrual period because ovulation and pregnancy are much less apt to occur during this time. However, if a radiographic examination is deemed medically necessary, it will be carried out with strict adherence to all available protective measures.

**Female patients must sign and date here**_____/_____

### Notice of Privacy Policy

We are required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information. If Applicable, we may disclose your health information, as deemed necessary by law, to: comply with state Workers' Compensation Laws, in cases of medical emergencies, to aid public health agencies such as the CDC and FDA, Governmental agencies as required by law, law enforcement officials and to comply with a court order, pre-approved agencies for purposes of organ donation or research, or to proper authorities as recognized by the state in order to assure public safety. Your rights include the ability to request (only) restrictions on certain uses and disclosures, to receive protected information by alternate means or at an alternate location, to have your physician amend your protected health information or file a statement of disagreement with you physician, and to receive an accounting of certain disclosures your physicians have made (if any). A more detailed explanation of these rights and responsibilities is readily available by us upon request, or at www.hcfa.gov/medicaid/hippa. Questions, concerns, and/or complaints should be directed to DHHS, Office of Civil Rights 200 Independence Ave., S.W. Room 509F HHH Building in Washington, DC 20201

**I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction Prior To My Signing This Consent Form. I have made my decision voluntarily and freely. To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.**

**Patient Name**_____ **Signature**_____ **Date**_____

**Witnessed (and/or translated) by** _____