

Initial History – Medicare

Patient Name: _____

Date: _____

Chief Complaint (What is bothering you?):

What is the Cause or How did it happen?:

When did Condition Begin?: _____

Quality/Character (sharp, dull, ache, numb): _____

Frequency/Duration (When and how long?): _____

What makes it Better/Worse: _____

Referred Pain/Other Symptoms: _____

Previous Occurrences: _____

Secondary Complaints: _____

Previous Medical Care: _____ Last Exam _____

Previous Chiropractic Care: _____

Please list any *past* serious injuries & dates: _____

Please list any previous surgeries & dates: _____

Relative Contraindications: *Do you have any of the following conditions?*

Joint Hypermobility Osteoporosis/Osteopenia Benign Bone Tumors Bleeding Disorders Blood Thinners Progressive Radiculopathy

NOTE: *If you currently have, or have had, one of the above listed conditions, Medicare requires that we advise you that spinal manipulation and other forms of dynamic thrust **may be contraindicated** in your condition. By signing below, you consent to care and agree to inform this office if another health care provider tells you that you have one of these conditions.*

Absolute Contraindications of given area: *Do you have any of the following conditions?*

Rheumatoid Arthritis Ankylosing Spondylitis Ligament Laxity Joint Dislocation Recent/Unstable Joints Unstable/Missing Dens at C2 Spinal Cancer Spinal/Joint Infection Myelopathy/Cauda Equina Syndrome Vertebrobasilar Insufficiency Syndrome Arterial Aneurysm

NOTE: *If you currently have, or have had, one of the above listed conditions, Medicare requires that we advise you that spinal manipulation and other forms of dynamic thrust **is absolutely contraindicated** in the region of the spine that is affected. By signing below, you agree to inform this office if another health care provider tells you that you have one of these conditions.*

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Medications you are taking:

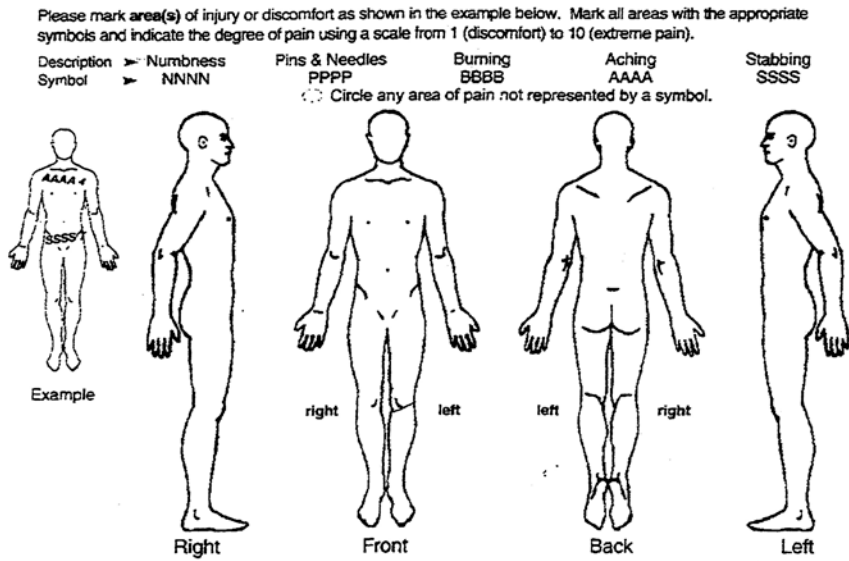
Nerve Pills Pain Killers(includes aspirin) Muscle relaxers Stimulants Blood thinners Tranquilizers Insulin

Others _____

Vitamins / Supplements _____

Relevant Family History: _____

For Internal Office Use	
Vitals: Ht: _____ Wt: _____ BP: _____ Pulse: _____	
Other History: _____	
Diet: _____	
Exercise: _____	
Occupation/Recreation: _____	
History Taken By: _____	Reviewed By Doctor: _____



Informed Consent

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly and mutual understanding between the provider and patient.
- I authorize the performance of any necessary diagnostic tests and treatments, which usually include chiropractic manipulation (CMT) for my condition(s). Like most health care procedures, CMT carries with it some risks. Unlike other medical treatments, the serious risks associated with CMT are extremely rare. Included are soreness or initial increased pain symptoms. More rare is dizziness, nausea or flushing, susceptibility of fracture with conditions like osteoporosis. Herniated or bulged discs may worsen even with CMT – it is important to notify the doctor of changes in symptoms. Extremely rare is risk of a certain type of stroke, although this risk is the same with primary medical care and is associated with the nature of neck pain and headache presented by the patient. (Detailed documentation is available upon request).
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the staff. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status or address/contact information.
- I also authorize the provider and or managed care organization to release any information required to process insurance claims.

Signature _____ Date _____