GARDNER CHIROPRACTIC
Family • Sports • Rehabilitation

GARDNER CHIROPRACTIC, PLLC
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PATIENT INFORMATION FORM

DATE: ___/____/____ PATIENT NAME: _____ _____
FIRST/LAST NICKNAME/PREFERRED NAME

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

TEXT MESSAGES?
CELL PHONE #: (____) ____-_____ YES ☐ NO ☐ SECONDARY PHONE #: (____) ____-_____

E-MAIL: _____ DATE OF BIRTH: ___/___/___ AGE: _____ SEX: M F

EMPLOYER:_____ OCCUPATION:_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

SPOUSE'S NAME (IF APPLICABLE): _____ SPOUSE'S EMPLOYER:_____ _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-

PRIMARY CARE DOCTOR: _____ LAST VISIT DATE: _____

HOW DID YOU FIND US? FRIEND: _____ FACEBOOK ☐ WEBSITE ☐ GOOGLE ☐ OTHER ☐

WHO ARE WE BILLING FOR YOUR TREATMENT?

YOU/YOUR SPOUSE ☐ PERSONAL HEALTH INSURANCE ☐ MEDICARE ☐ MEDICAID ☐

WORKER'S COMPENSATION ☐ AUTO INSURANCE ☐

PLEASE PROVIDE INSURANCE CARD SO THAT WE MAY COPY IT FOR OUR RECORDS

SOCIAL HISTORY

USE OF **ALCOHOL**: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF **TOBACCO**: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF **RECREATIONAL DRUGS**: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ SCOLIOSIS ☐ GENETIC DISORDER/DISEASE _____
☐ OTHER _____

(OFFICE USE ONLY) PATIENT NAME: _____ **DATE OF BIRTH:** ____/____/_____

YOUR MEDICAL HISTORY

HEIGHT: _____ WEIGHT: _____

PLEASE LIST (OR PROVIDE A COPY OF) ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

_____ _____ _____
_____ _____ _____
_____ _____ _____

PLEASE LIST ALL PRIOR SURGERIES OR HOSPITALIZATIONS:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS/ANESTHESIA_____
☐ FOODS _____ ☐ TAPE ☐ LATEX ☐ SHELLFISH
☐ IODINE ☐ OTHER _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING (PLEASE CHECK ALL THAT APPLY)?

ACID REFLUX		FIBROMYALGIA		NEUROPATHY	
ANEMIA		GOUT		OSTEOPOROSIS	
ARTHRITIS		HEART ATTACK		PNEUMONIA	
ASTHMA		HEART DISEASE/FAILURE		POLIO	
BACK TROUBLE		HEPATITIS		RHEUMATIC FEVER	
BLADDER INFECTIONS		HIV+/AIDS		SCOLIOSIS	
ABNORMAL BLEEDING		HIGH BLOOD PRESSURE		SICKLE CELL DISEASE	
BLOOD CLOTS		KIDNEY DISEASE		PSORIASIS	
BLOOD TRANSFUSION		LIVER DISEASE		SLEEP APNEA	
BRONCHITIS/EMPHYSEMA		LOW BLOOD PRESSURE		STOMACH ULCERS	
CANCER		MIGRAINE HEADACHES		STROKE	
DIABETES		MARFAN'S SYNDROME		THYROID DISEASE	
EHLER'S DANLOS		RHEUMATOID ARTHRITIS		TUBERCULOSIS	
GENETIC DISORDER		LUPUS			
OTHER CONDITIONS:					

FOR WOMEN: ARE YOU PREGNANT? YES ☐ NO ☐ IF YES, HOW MANY WEEKS ALONG ARE YOU? _____
WHAT IS YOUR DUE DATE? _____

(OFFICE USE ONLY) PATIENT NAME: _____ DATE OF BIRTH: ____/____/_____

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

HAVE YOU HAD THIS CONDITION IN THE PAST? YES ☐ NO ☐ IF YES, WHEN? _____

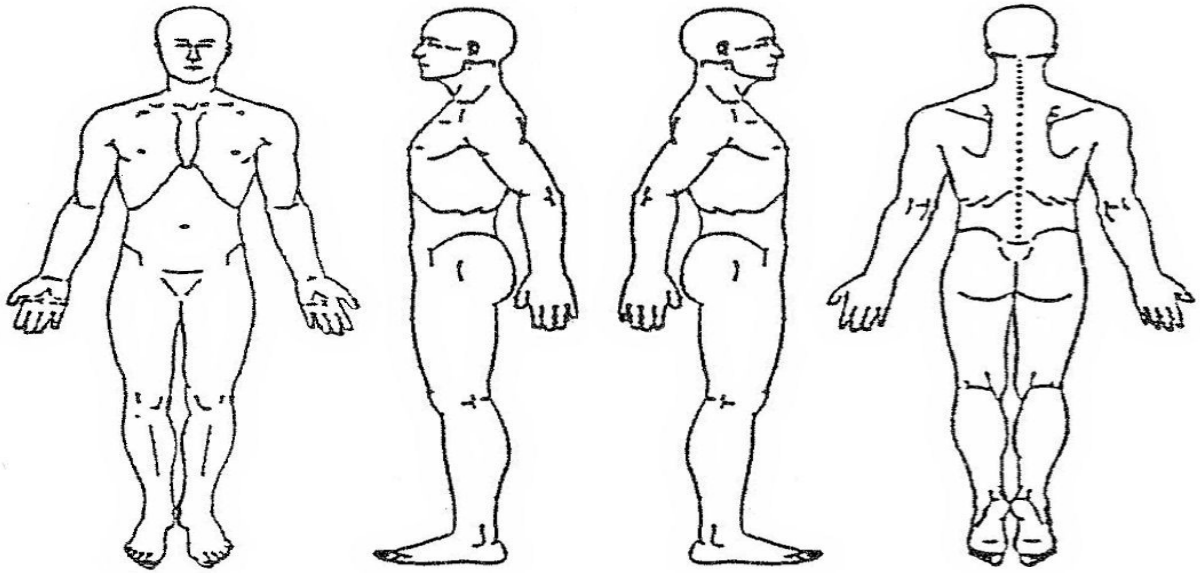
DID YOU SEEK TREATMENT FROM ANY OTHER MEDICAL PROVIDER FOR THIS CONDITION? YES ☐ NO ☐

IF YES, BY WHOM? _____ WHAT TREATMENT DID YOU RECEIVE? _____

HAVE YOU HAD ANY RECENT X-RAYS OR OTHER IMAGING RELATED TO YOUR CURRENT PROBLEM? YES ☐ NO ☐

HAVE YOU EVER SEEN A CHIROPRACTOR BEFORE? YES ☐ NO ☐

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

HOW DID YOUR PAIN OR PROBLEM START? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

HOW WOULD YOU DESCRIBE YOUR SYMPTOMS? ☐ NUMBNESS/TINGLING ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING ☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER_____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES ☐ RESTING ☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

(OFFICE USE ONLY) PATIENT NAME: _____ DATE OF BIRTH: ____/____/_____

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

We will attempt to verify benefits for services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

It is our policy to assess a $15.00 missed visit fee to patients who cancel appointments with less than a 24-hour notice. This fee may be waived at our discretion. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others. Your insurance company does not cover this fee.

I acknowledge I have had the opportunity to receive a copy of Gardner Chiropractic's Privacy Notice (available at front desk).

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy. The chiropractic treatment may be performed by the Aaron Gardner, DC and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for Aaron Gardner, DC.

I have had the opportunity to discuss with Aaron Gardner, DC, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:
·Broken bones ·Increased symptoms and pain ·Dislocations ·No improvement of symptoms or pain
·Sprains/strains ·Burns or frostbite (physical therapy) ·Injuries to spinal discs

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

SIGNATURE OF PATIENT OR GUARDIAN DATE