RETURN TO HEALTH

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____ / _____ / _____

GENDER (circle one): **Male Female Non-Binary Other:** _____ MARITAL STATUS (circle one): **S M D W**

ADDRESS: _____CITY: _____STATE: _____ZIP: _____

PHONE #: _____ EMAIL: _____

SOCIAL SECURITY NUMBER: _____-____-_____

EMERGENCY CONTACT NAME: _____ PHONE #: _____

RELATIONSHIP TO PATIENT: _____

WORKER'S COMPENSATON CLAIM INFORMATION

CLAIM #: _____ DOI: _____/_____/_____

EMPLOYER: _____ YEARS EMPLOYED: _____ to _____
JOB TITLE: _____

(STATE WORK COMP ONLY)
INSURANCE CO.: _____
ADJUSTER NAME: _____ PHONE: _____ EXT._____

How did the accident/injury occur?

_____
_____
_____
_____
_____
_____
_____

What were your symptom(s) after the accident/injury?

_____
_____
_____
_____
_____
_____
_____
_____

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CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of land-based and aquatic physiotherapy on me or on the patient named below, for whom I am legally responsible) by Dr. Andrew Garrett, DC and/or other licensed Doctor of Chiropractic who now or in the future work at Return to Health, LLC.

I have had an opportunity to discuss with Dr. Andrew Garrett, DC and/or with other clinic personnel the on the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the health care providers at Return to Health, LLC to be able to anticipate and explain all risks and complications, and I wish to rely upon healthcare providers to exercise reasonable judgment during the course of the procedure, based upon the information I have provided to them, and the facts then known by my healthcare providers.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at Return to Health, LLC.

PATIENT / GUARDIAN SIGNATURE: _____ DATE: _____

PRINT PATIENT NAME: _____

WITNESS / STAFF SIGNATURE: _____ DATE: _____

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HIPAA – Release of Information

Name: _____ DOB: _____ /_____ /_____

Release of Information:

_____ I authorize the release of information including the diagnosis, records, examination performed, treatment rendered to me, appointment scheduling, and claims information.

This information may be released to:

NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____

_____ Information is NOT to be released to anyone.

How may we contact you? *(check all that apply):*

____ Phone Calls to Personal/Cell #

____ Text Message to Personal/Cell #

____ Email

____ Work #: _____

If unable to reach me:

[ ] you may leave a detailed message.

[ ] please leave a message asking me to return your call.

[ ] _____

The best time to reach me is (days)_____ between (times)_____.

This Release of Information will remain in effect until terminated by me in writing.

Legal Representative or Patient Signature: _____Date:____/____/_____

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PATIENT HISTORY FORM

Name: _____ Height: _____ Weight: _____

Are you **pregnant** or think you could be? [ ] **YES** [ ] **NO**

Do you have a **pacemaker**? [ ] **YES** [ ] **NO**

Have you **fallen** within the past 6 months? [ ] **YES** [ ] **NO**

Medical/Surgical History

Please check if you **have ever had** or **currently have**:

MUSCULOSKELETAL	*NEUROMUSCULAR*	*CARDIO/PULMONARY*	*OTHER*
__ Arthritis (Osteo/Rheumatoid)	__ Stroke/TIA	__ Heart Attack	__ Cancer
__ Osteoporosis	__ Head Injury	__ Hypertension	__ Diabetes
__ Fractures or Broken Bones	__ Parkinson Disease	__ Heart Disease	__ Autoimmune
__ Spinal Surgery	__ Fibromyalgia	__ COPD	__ Infectious Disease
__ Back / Neck Pain	__ Nerve Pain/Damage	__ Asthma	
__ Joint Pain	__ Seizures	__ Vascular Issues: _____	
__ Bone or Joint Surgery			

Other Problems Not Listed: _____

_____

Please list surgeries and the dates performed: _____

_____

_____

Please list all current medications and dosages (*you can also provide a list that we can scan into your e-chart)*:

Medication Name	**Dosage**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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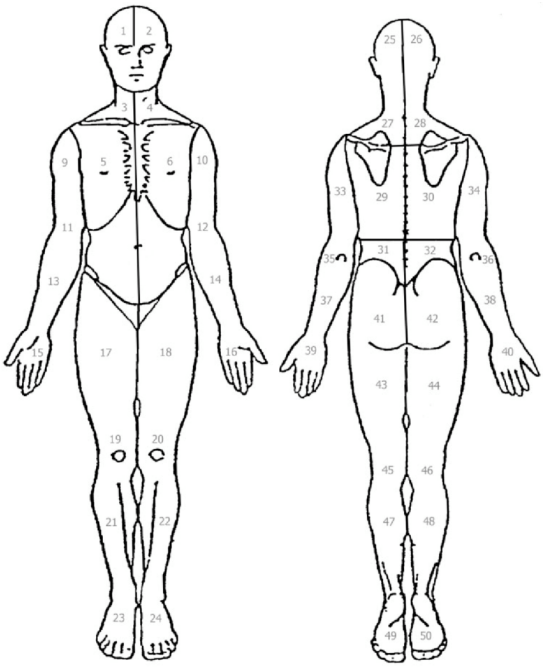
Please rate your pain level **MOST** (85 – 100%) of the time over the past **7 DAYS**:

[0 = no pain ---10 = worst pain imaginable] **0 1 2 3 4 5 6 7 8 9 10**

Indicate areas of pain, tightness, numbness, or tingling on the diagram.



Briefly describe the reason for your visit today:

_____
_____
_____

Please list anything you have found that **aggravates**, or makes your pain/symptoms *worse*:

_____
_____
_____

Please list anything you have found that **relieves**, or makes your pain/symptoms *less*:

_____
_____
_____

In the past **6 months**, have you had any of the following diagnostic tests for your injury/condition? (Check all that apply.)

__ X-Ray (DATE: _____) __ Nerve Study (DATE: _____)

__ MRI (DATE: _____) __ Ultrasound (DATE: _____)

__ CT Scan (DATE: _____) __ Bone Scan (DATE: _____)

__ OTHER: _____ (DATE: _____)

Do you regularly see a Pain Management Specialist for your injury/condition?

____ YES ____ NO

In the past 6 months, have you received any pain management procedures such as injections or nerve ablations for your injury/condition?

____ YES ____ NO