River City Chiropractic Center

Confidential Patient Information

731 Sabrina Dr. E. Peoria , IL 61611 **Phone (309) 699-7222** **Website: www.RiverCityChiropracticCenter.com**

Office Use Only:
Patient ID Number:_____
DX:_____,_____,_____,_____,_____,_____
Payment Per Visit: $_____

Date:_____/_____/_____

Patient's Full Name _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

☐ Male ☐ Female Age:_____ Date of Birth:_____/____/_____ Social Security # _____ - _____ - _____

Mailing Address:_____ City:_____ State:_____ Zip:_____

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced Number of Children _____

Occupation:_____ Hours/Week_____ Employer:_____ Business Phone_____

Spouse's Name:_____ Employer:_____ Business Phone_____

Emergency Contact:_____ Relationship:_____ Phone: _____

Address:_____ City:_____ State:_____ Zip: _____

Family Physician: _____ City: _____ State:_____ Phone_____

Do You Have Health Insurance? _____Company Name_____

Previous Chiropractic Care: ☐ Yes ☐ No If Yes, for what Problem: _____

Doctor's Name _____ City: _____ State: _____

Referred By (Friend, Relative, or Physician) :_____

Is Today's Visit Due To A Work Related Injury: ☐ Yes ☐ No
Is Today's Visit Due To A Personal Injury or Auto Accident: ☐ Yes ☐ No
(If yes to either questions above, please check with receptionist, additional information is needed)
Date Of Injury:_____

Person Responsible for Account: _____ Phone: _____

Address:_____ City:_____ State:_____ Zip: _____

Method of Payment Preferred: ☐ Cash ☐ Check ☐ Credit Card

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition and/or health history to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the **direct payment to you** of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services **refuses to make such payment** upon demand by you , I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. However, it is understood that all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what was due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Illinois
5. I further agree that this Authorization and Assignment is irrevocable until all moneys owed River City Chiopractic Center LLC are paid in full.

Patient Signature_____ Date_____

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Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Date:_____/_____/_____

Office use only:
Patient Number:_____

Patient's Name: _____

Chief complaint_____

Secondary or related complaint(s) if any:_____

Date of Onset: _____ Was the Onset ☐ Gradual ☐ Sudden Since onset, has it gotten: ☐ Worse ☐ Better

Describe what caused the pain:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP EXPLAIN YOUR **CHIEF COMPLAINT:**

Describe the quality of the complaint/pain:
- ☐ sharp
- ☐ dull/ache
- ☐ throbbing
- ☐ tingling/numbness
- ☐ other:_____

Does any of the following make the pain worse:
- ☐ lifting/bending/pushing/pulling
- ☐ cough/sneeze/bowel movement
- ☐ driving/riding/sitting
- ☐ walking/running/standing
- ☐ other:_____

Describe if pain is in a single spot or does is spread out:
- ☐ radiating dull, deep ache
- ☐ pin point
- ☐ burning, sharp stabbing, tingling, numb
- ☐ other:_____

Does any of the following make it better:
- ☐ rest/laying down
- ☐ sitting
- ☐ walking/exercise
- ☐ other:_____

How often are you aware of the pain:
- ☐ intermittent (less than 25% of time when awake)
- ☐ occasional (25-50% of time when awake)
- ☐ frequent (50-75% of time when awake)
- ☐ constant (75-100% of time when awake)

Does it interfere with your daily activities:
- ☐ minimal (annoyance, no impairment)
- ☐ slight (tolerated, some impairment)
- ☐ moderate (marked impairment)
- ☐ marked (preclude any activity)

Have you detected any possible relationship of your current complaint with any of the following:

☐ Muscle Weakness ☐ Bowel/Bladder problems ☐ Digestion ☐ Cardiac/Respiratory ☐ Other:_____

Have you tried any self-treatment or taken any medication (over the counter or prescription): ☐ Yes ☐ No

If yes, explain;_____Results:_____

Are you currently pregnant? ☐ Yes ☐ No Are you currently taking anti-coagulant or blood thinning medication? ☐ Yes ☐ No

What type of care are you interested in: ☐ Pain relief only ☐ Healing of current condition ☐ Optimizing your health ☐ All three

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OFFICE NP1 NP2 NP3 NP4 OV1 OV2 A1 A2 A3 EM MED1 TE NMED ES M15 M30 MT XC3 XC5 XC7 XT2 XL2 NOTES

_____

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Patient ID Number:_____

Patient's Name: _____

In general, would you say your health is (check one): ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

PAST HEALTH HISTORY:

1. Have you ever experienced your present problem before for which you are consulting us: ☐ Yes ☐ No If yes, When: _____

   Was treatment provided: ☐ Yes ☐ No If yes, By whom:_____ Outcome: _____

2. Have you **ever** had a **stroke** or issues with **blood clotting**? ☐ Yes ☐ No

3. Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries?** ☐ Yes ☐ No

Date	Injury/Fracture/Illness/Surgeries	Treatment	Results

3. Are you presently taking any **prescription drugs**, over-the-counter drugs, vitamins, or supplements? ☐ Yes ☐ No

SYSTEMS REVIEW QUESTIONS:

Product/Drug	Reason	Dosage	Frequency

Do you or have you ever had any problems with the following areas? (Please mark **Y** for yes or **N** for no in each of the following:)

1. _____ Eyes
2. _____ Ears, Nose, Mouth, Throat
3. _____ Heart
4. _____ Lungs/ Breathing
5. _____ Intestines/Bowels
6. _____ Urinary
7. _____ Muscles
8. _____ Nerves
9. _____ Joints/Bones
10. _____ Skin
11. _____ Internal Organs
12. _____ Blood
13. _____ Allergies
14. _____ Psychological/Emotional

Females only:

15. _____ Gynecological/Menstrual/Breast

Males Only:

17. _____ Prostate/Testicular/Penile

Please explain any above **Yes** answers: _____

_____

_____

_____

_____

_____

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SOCIAL HISTORY:

Recreational Activities (Hobbies):_____

_____

Your education level: ☐ Highschool ☐ Some college ☐ College Graduate ☐ Post Graduate ☐ Other: _____

Yes	No		
☐	☐	Do you exercise? _____	times per week
☐	☐	Do you smoke? _____	packs per day If you have quit smoking, when did you quit?_____
☐	☐	Do you use other forms of tobacco?	What/How much per day? _____
☐	☐	Do you consume alcohol?	How many drinks per week? _____
☐	☐	Do you eat a balanced low fat diet?	If no, explain: _____
☐	☐	Do you get adequate sleep?	If no, explain: _____
☐	☐	Is work stressful to you?	If yes, explain: _____
☐	☐	Is family life stressful to you?	If yes, explain: _____
☐	☐	Do you use recreational drugs?	If yes, explain: _____

FAMILY HISTORY AND HEALTH STATUS: list any diseases, disorders, or major illnesses. If deceased, from what?

1. Mother: _____
2. Father: _____
3. Sisters: _____ How many? _____
4. Brothers:_____ How many? _____
5. Other: _____

OTHER INFORMATION:

How do you sleep ☐ Back ☐ Side ☐ Stomach Do you use a pillow : ☐ Yes ☐ No

Do you wear orthotics or arch supports ☐ Yes ☐ No

Females: Date of last gynecological and breast exam:_____

For Purposes of X-Ray: Possible pregnancy? ☐ Yes ☐ No

Date of last menstrual cycle: _____

Please read and sign:
I hereby state that all information that I have provided Allied Chiropractic is complete and truthful and that I fully disclosed my health history.

SIGNED: _____ Date_____

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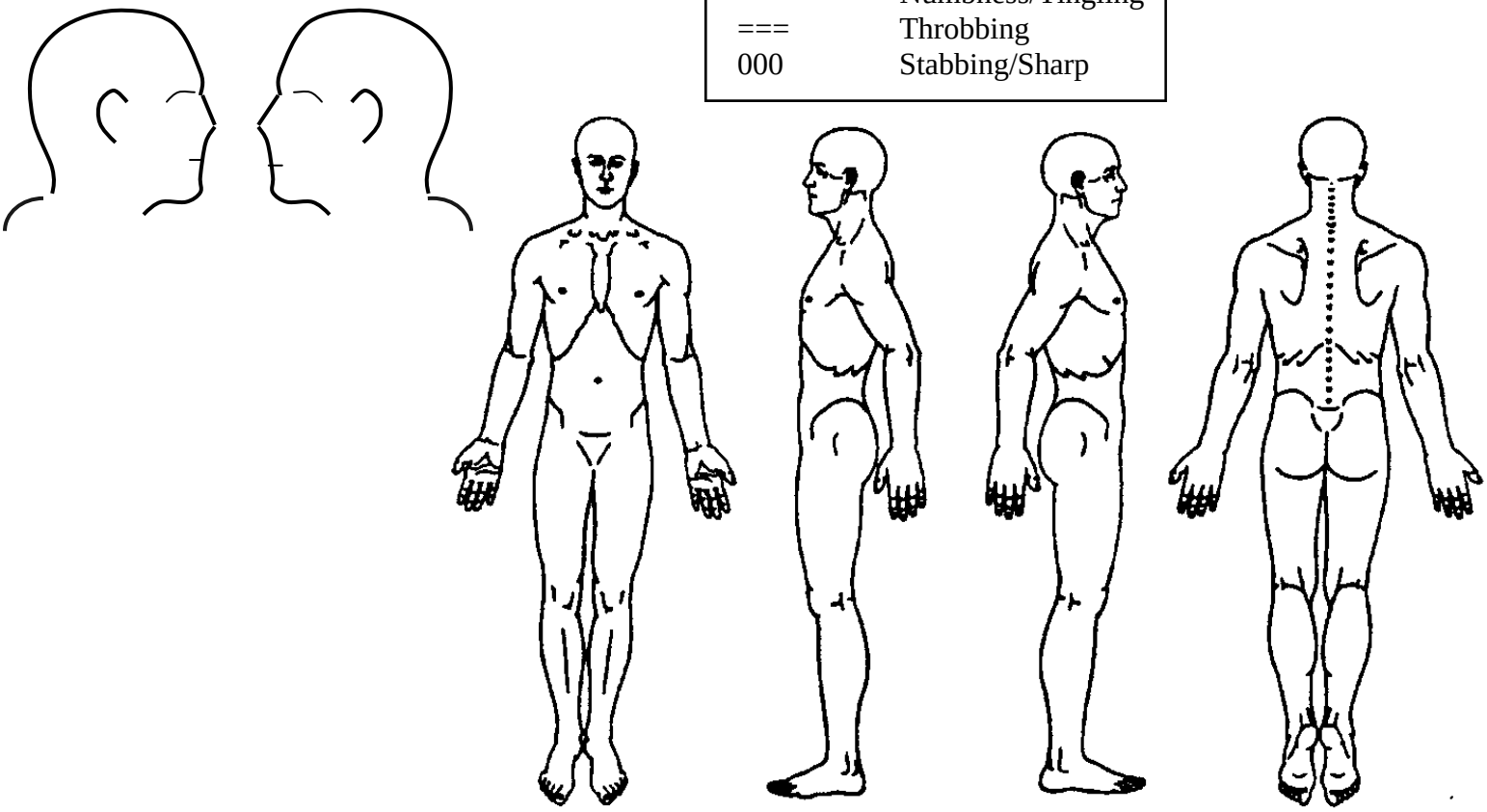
Please Mark Area Of Pain on the Drawing Using The Codes Listed Below

Right **Left**

+++	Burning
###	Dull/Ache
***	Numbness/Tingling
===	Throbbing
000	Stabbing/Sharp



SEVERITY OF PAIN

List region of pain and circle the number which represents the intensity of your pain

Example:

Ex.Complaint:_____low back pain_____

0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

1. Complaint:_____
0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

2. Complaint:_____
0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

3. Complaint:_____
0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

4. Complaint:_____
0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

5. Complaint:_____
0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

6. Complaint:_____
0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal and extremity 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 as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising 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 disc, 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 a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once 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 in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be 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 such other persons 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 instability or serious disc 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 increased 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.

I have read or 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.

_____ Signature of Patient Date_____

_____Signature of Parent or Guardian (if a minor) Date_____

_____Signature of Witness Date_____

To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously because it can make a difference between responding to treatment or not. Usually your referring doctor and/or therapist have prescribed a set frequency of treatment. If you show up for treatment, it will enable you to get better. Other than that all you need to do is follow your doctor's instructions, and you should achieve your treatment goals.

We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get the full number of prescribed treatments that week whenever possible.

There is a **$20 charge for a cancellation or no-show without proper notice.** This charge will not be covered by you insurance, but will have to be paid by you personally.

For **Workmen's Compensation and Personal Injury patients,** documentation of any missed appointments is forwarded to your case manager and primary physician. This could jeopardize your claim.

You may occasionally need to see another physician other than the one who normally sees you if you do need to re-arrange your appointment. All of our physicians are experienced professional and they will study your chart. You may return to your original physician at the next appointment.

Please understand that your pain will probably increase and decreases as your course of treatment progresses and before it is finally eliminated. Either condition should not be a reason not to come in: 1) Your pain is gone or 2) Your pain is worse. If the pain is gone, now is the time to really begin rehabilitating the injured area to prevent recurrence. If your pain is worse, we can do something to help.

When you don't show as scheduled, three people are hurt. 1) You, because you didn't get the treatment you need as prescribed by your doctor; 2) The doctor who now has a hole in their schedule; 3) The person that couldn't get in when you had your appointment scheduled.

Thank you for cooperating with us on this matter. We are looking forward to working with you.

_____ _____

patient signature **date**

River City Chiropractic Center

Bradley Davis, D.C.

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

_____

_____

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