Date: _____

Ambient CHIROPRACTIC P.A.

Patient information

First Name: _____ Last Name: _____ Initial _____

Where is your discomfort?: _____

When did this symptom(s) begin?: _____

How did the pain begin?: ❍ unknown ❍ overexertion ❍ sleeping wrong ❍ fall ❍ slip ❍ lifting ❍ work comp ❍ auto

How did the injury occur?: _____

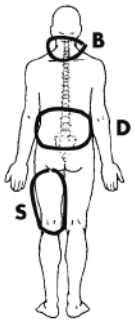
Since the problem began, are your symptoms: ❍ better ❍ worse ❍ the same

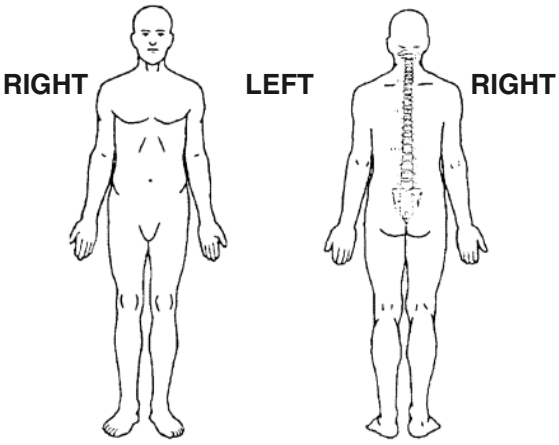
Using the symbols provided in the Pain Index Box, mark the areas on the illustrations below ...

Pain Index Box

D Dull Nagging Ache
B Burning
S Sharp / Stabbing
N Numbness / Tingling
R Radiating

For example: The image to the right illustrates a burning pain in the neck, a dull ache in the lower back, and a sharp pain in the left thigh.





Check those activities below during which you experience difficulty or pain:

❍ Lying down
❍ Change in position
❍ Lying flat on stomach
❍ Dressing self / Self care
❍ Pushing / Pulling / Lifting
❍ Athletic act / Exercise
❍ Household chores
❍ Driving
❍ Working
❍ Sitting
❍ Bending
❍ Walking
❍ Standing for long periods
❍ Computer use
❍ Other: _____

What relieves the discomfort? **Example:** ice, ibuprofen, rest _____

When is the discomfort at it's worst?

❍ With activity ❍ Afternoon ❍ Evening ❍ Morning ❍ Before bed

Please be sure to fill in todays date at the top left hand corner of page, Thank you.

What is the **MOST INTENSE** the symptom has been on a scale of 0-10 since it began?

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain			Severe Pain			Emergency Room		

What is the **LEAST INTENSE** the symptom has been on a scale of 0-10 since it began?

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain			Severe Pain			Emergency Room		

What is it at **PRESENT** moment?

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain			Severe Pain			Emergency Room		

What is the frequency of the discomfort you are feeling?

❍ Occasionally, up to 25% ❍ Intermittently, up to 26-50%
❍ Frequently, up to 51-75% ❍ Continuously, 76-100%

Have you experienced these symptoms before? ❍ Yes ❍ No When? _____

Have you seen another doctor for this condition? ❍ Yes ❍ No Doctor's Name: _____

Name of primary physician: _____ Facility: _____

Prior healty history - mark all that apply …

❍ Fatigue
❍ Fever
❍ Weight Gain/Loss

❍ Blurred Vision
❍ Change in Vision
❍ Glaucoma
❍ Macular Degeneration
❍ Wears Glasses or Contacts

❍ Difficulty Swallowing
❍ Hearing Loss
❍ Loss of Smell
❍ Sinus Infections
❍ Snoring
❍ Ringing in Ears

❍ Asthma
❍ Emphysema
❍ Oxygen needed
❍ Shortness of Breath

❍ Strokes
❍ Heart Problems
❍ High Blood Pressure
❍ High Cholesterol
❍ Irregular heartbeat
❍ Shortness of Breath
❍ Varicose Veins

❍ Abdominal Pain
❍ Constipation
❍ Heartburn
❍ Hemorrhoids
❍ Indigestion
❍ Nausea
❍ Abnormal Stool Consistency
❍ Ulcer

Female:
❍ Birth Control Therapy
❍ Hormone Therapy
❍ Irregular Menstruation
❍ Abnormal Bleeding
❍ Currently Pregnant
❍ Pregnant in the past

Male:
❍ Erectile Dysfunction
❍ Hesitancy/Dribbling
❍ Prostate Problems

❍ Diabetes
❍ Excessive Thirst
❍ Frequent Urination
❍ Goiter
❍ Hair Loss

❍ Bruises easily
❍ Itching
❍ Numbness, tingling
❍ Rash
❍ Sores won't heal

❍ Dizziness
❍ Headaches
❍ Limb Weakness
❍ Loss of Memory
❍ Numbness
❍ Seizures
❍ Stress
❍ Strokes
❍ Tremors

❍ Anxiety
❍ Confusion
❍ Dementia
❍ Depression
❍ Memory Loss
❍ Mood Changes

❍ Allergies (Please list)
_____
_____
_____

❍ Anemia
❍ Blood Clotting
❍ Bruises easily
❍ Fatigue
❍ Lymph Node Swelling

❍ Childhood Illnesses
❍ ADD/ADHD
❍ Asthma
❍ Bedwetting
❍ Diabetes
❍ Ear Infections
❍ Chicken Pox
❍ Measles
❍ Mumps
❍ Food Allergies
❍ Headaches
❍ Scoliosis

Other childhood diseases:
_____
_____
_____

Adult Illnesss:
❍ Arthritis
❍ Cancer
❍ Crohn's/Colitis
❍ Cystic Kidney disease
❍ Depression
❍ Emphysema
❍ Fibromyalgia
❍ Hypertension
❍ Liver Disease
❍ Parkinson's Disease
❍ Seizure Disorder
❍ Shingles
❍ Thyroid Problems
❍ Vertigo

Other Adult diseases:
_____
_____
_____

Surgeries (Please list ...)
_____
_____
_____

Family history
_____
_____
_____

Past injuries
_____
_____
_____

Personal Information

Preferred Language: _____

Address: _____

City / State / Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Mobile Phone: ( ) _____ E-mail: _____

Social Security #: _____ Birth Date: _____ Age: _____ Sex ❍ M ❍ F

Occupation: _____ Employer's Name: _____

Work Address: _____

City / State / Zip: _____

Marital Status: ❍ S ❍ M ❍ D ❍ W Spouse's Name _____ # of Children _____

How were you referred to Ambient Chiropractic P.A.? _____

Insurance Type: _____

Policyholder: _____ DOB: _____

Smoking Status: (Circle One) Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Race (Circle One): American Indian or Alaska Native / Asian / Black or African American
White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Emergency Contact

Name: _____ Relation: _____

Home Phone: _____ Work Phone: _____

Address/ City / State / Zip: _____

Areas of Interest

❍ Nutritional Supplements
❍ Detoxification
❍ Headaches
❍ Weight Loss Information
❍ Women's Health
❍ Neck / Body Pillows
❍ Decompression
❍ Acupuncture
❍ Wellness Care
❍ Children's Care
❍ Ear Infection / Colic / ADD
❍ Massage
❍ Others (Please List ...)

_____

_____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have been informed, understand and agree to the Notice of Privacy Practices of Ambient Chiropractic P.A. which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice. I have be offered the full policy pamphlet. Date: _____

Sign Here Signature: _____ Print Name: _____

Are you currently taking any medications? (Please include regulary used over the counter medications)

Medication Name	Dosage and Frequency (i.e 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Sign Here

❍ I Choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient's Signature: _____

Authorization & Assignment

I authorize Ambient Chiropractic P.A. to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

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 to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Ambient Chiropractic P.A. authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Sign Here

Date: _____ Patient's Signature: _____

Informed Consent

I hereby authorize physicians and staff at Ambient Chiropractic P.A. to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Ambient Chiropractic P.A. responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness - Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is normal and acceptable accompanying response to chiropracticcare and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

Soft Tissue Injury - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft-tissue injury.

Rib Injury - Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is preformed carefully to minimize such risk.

Physical Therapy Burns - Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

Stroke - Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems - There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any question concerning this form or the above statements, please ask your doctor.
Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Sign Here

Date: _____ Patient's Signature: _____