Health Status Questionnaire **Patient Information** **Date** _____

Name _____ Sex M / F Birthdate _____ SSN _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell _____ Work _____

Email _____

Employer _____ Occupation _____

Please Circle - Single Married Separated Divorced Widowed Number of Children _____

Spouse Name _____ Work Phone _____

Emergency Contact _____ Phone _____

Referred to our office by _____

Insurance:
Name of Primary Insured _____ **Birthdate** _____

Insurance Company & Address _____

Contract / ID number _____ Group number _____

Are you covered by Medicare? Yes / No Medicare # _____

Health Complaints:
Neurological and Vascular Questionnaire:
NOTE: If you answer YES to any of these questions, please CIRCLE the appropriate bold/italicized words

1. Do you suffer from ***neck pain*** with pain in the ***shoulder***, ***arms*** *or* ***hands***? Yes / No
2. Do you have ***weakness***, ***numbness*** *or* ***burning*** in the ***shoulder***, ***arms*** *or* ***hands***? Yes / No
3. Do your ***hands*** or ***arms*** fall asleep regularly? Yes / No
4. Do you have ***reduced feeling*** (sensation) or ***swelling*** in the ***hands*** *or* ***arms***? Yes / No
5. Do you suffer from a loss of handgrip strength? Yes / No
6. Do you suffer from ***back pain*** with pain in the ***buttocks***, ***legs*** *or* ***feet***? Yes / No
7. Do you have ***weakness***, ***numbness*** *or* ***burning*** in the ***buttocks***, ***legs*** *or* ***feet***? Yes / No
8. Do your ***legs*** or ***feet*** fall asleep regularly? Yes / No
9. Do you have ***reduced feeling*** (sensation) or ***swelling*** in the ***legs***, *or* ***feet***? Yes / No
10. Do you suffer from cold ***hands*** *or* ***feet***? Yes / No
11. Do you suffer from ***headaches***, ***dizziness*** *or* ***memory loss***? Yes / No
12. Do you have difficulty maintaining your balance? Yes / No
13. Do you suffer from ***vertigo*** *or* ***blurred vision***? Yes / No
14. Do you suffer from a reduced hearing capacity? Yes / No
15. Do you suffer from ringing in your ears? Yes / No
16. Do you have ***bladder*** *or* ***bowel*** control problems on a regular basis? Yes / No

Musculoskeletal	No	Yes	Since when (date)		No	Yes	Since when (date)
Headaches	( )	( )	_____	Wrist/Hand pain	( )	( )	_____
Neck pain	( )	( )	_____	Arm pain	( )	( )	_____
Upper back pain	( )	( )	_____	Hip pain	( )	( )	_____
Mid back pain	( )	( )	_____	Knee pain	( )	( )	_____
Lower back pain	( )	( )	_____	Ankle pain	( )	( )	_____
Shoulder pain	( )	( )	_____	Leg pain	( )	( )	_____
Elbow pain	( )	( )	_____	Foot pain	( )	( )	_____

Other _____

Patient Name _____ **Date** _____

Review of Symptoms:
Please mark any of the symptoms you are currently suffering from.

( ) General Fatigue	( ) Chronic Nasal Infection	( ) Vomiting (excessive)
( ) Anxiety	( ) Chronic cough	( ) Diarrhea (excessive)
( ) Dizziness	( ) Skin Rash	( ) Chest Pain
( ) Depression	( ) Chronic wheezing	( ) Constipation (excessive)
( ) Fainting	( ) Difficulty Breathing	( ) Bruise easily
( ) Loss of Sleep	( ) Abdominal Pain	( ) Heartburn/indigestion
( ) Memory Loss	( ) Skin Itching/Dryness	( ) Inability to hold urine
( ) Weight change	( ) Swollen Extremities	( ) Frequent urination
( ) Nose/Sinus Pain	( ) Excess Gas	( ) Irregular Menstruation
Hearing Trouble R / L	( ) Eczema	( ) Painful menstruation
Vision Trouble R / L	( ) Varicosities	( ) Impotence

Please indicate if you **now have** or **have had** any of the following illnesses:

Now Have	In Past		Now Have	In Past	
( )	( )	Sinus Trouble	( )	( )	Polio
( )	( )	Hay Fever	( )	( )	Multiple Sclerosis
( )	( )	Allergies	( )	( )	Ulcer
( )	( )	Asthma	( )	( )	Liver Trouble
( )	( )	Emphysema	( )	( )	Kidney Trouble
( )	( )	Tuberculosis	( )	( )	Prostate Trouble
( )	( )	Cancer	( )	( )	Arthritis
( )	( )	Diabetes	( )	( )	Scoliosis
( )	( )	Epilepsy	( )	( )	Dislocated Joints
( )	( )	Thyroid Trouble	( )	( )	Spinal Disc Disease
( )	( )	High Blood Pressure	( )	( )	Bone Fracture
( )	( )	Low Blood Pressure	( )	( )	Mental/Emotional Difficulty
( )	( )	Heart Trouble	( )	( )	Sex. Trans. Disease
( )	( )	Pacemaker	( )	( )	HIV
( )	( )	Stroke	( )	( )	AIDS/ARC
( )	( )	Aortic Aneurysm	( )	( )	Other: _____
( )	( )	Anemia			
( )	( )	Rheumatic Fever			

Do you have any other complaints or health concerns that are not listed on this form?

_____

Habits / Activities: Please circle

Smoking (packs per day) -	Never	<1	1 – 2	2 – 3	3 – 4	5 +
Caffeinated Drinks (glasses per day) -	Never	<1	1 – 2	2 – 3	3 – 4	5 +
Alcohol Consumption (glasses per day) -	Never	<1	1 – 2	2 – 3	3 – 4	5 +
Drug / Substance Abuse -	Yes	No				
Exercise -	Never	<1	1 – 2	2 – 3	3 – 4	5 +
Type of exercise:	Walking		Jogging	Cycling	Swimming	

Other: _____

Medical History:
Do you have a family physician? Yes / No Date of last exam: _____
Name, Phone, Address: _____
_____

Please list all doctors (with phone number and address) and the conditions treated in the last 3 years.

_____
_____

Patient Name _____ **Date** _____

Have you been hospitalized in the past? Yes / No
Date and reason for hospitalization: _____

Have you ever had surgery?
Date, reason and results of surgery: _____
_____

Have you ever had a serious injury? Please Circle – Auto / Work-related / Personal / Sports / Other
Please Describe: _____
_____

Please list all medications you are currently taking and the conditions they are treating.
_____
_____

Are you allergic to any medications? Yes / No If yes, please list.
_____

Please list any vitamins or other supplements you are currently taking.
_____

Women Only:
To your knowledge, ARE YOU PREGNANT? Yes / No
If pregnant in the past, were pregnancies normal? Yes / No
Are you seeing an OB-GYN regularly? Yes / No
Date of last exam: _____
Physician's name and address: _____

Family History:

	Cancer	Diabetes	Heart Trouble	High Blood Pressure	Stroke	Kidney Disease	Anemia	Mental Illness	Headaches	Osteoporosis	Arthritis	Joint Problems	Scoliosis	Back Problems	Disc Problems	Congenital Defects	Genetic Disease	Other	Deceased
Father																			
Mother																			
Brothers																			
Sisters																			
Children																			

Other: _____

Is your condition due to an auto accident? Yes/No
Date of accident: _____
Have you filed an accident report? Yes / No

Is your condition due to a job injury? Yes / No
Date of injury: _____
Have you filed an accident report? Yes / No

I understand and agree that health and accident policies are an arrangement between an Insurance Carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the Insurance Company and that any amount authorized to be paid directly to this Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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.

Patient signature Date

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize **All American Medical & Chiropractic** to release healthcare information of the patient named above to the following **doctors/medical facilities/family member/attorney/other:**

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

_____ _____

Patient Signature Date Witness Date

IRREVOCABLE ASSIGNMENT, LIEN AND AUTHORIZATION
INSURANCE BENEFITS

To Whom It May Concern:

I hereby authorize and direct you, my insurance carrier to pay directly to All American Medical & Chiropractic such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident, workers compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect All American Medical & Chiropractic. I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by All American Medical & Chiropractic. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due All American Medical & Chiropractic for services rendered. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance carrier or adjuster to facilitate collection under this Assignment, Lien and Authorization.

Patient Signature Date

HIPAA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____Date _____

Address:_____

I have been given a copy of All American Medical & Chiropractic's *Notice of Privacy Practices ("Notice*"), which describes how my health information is used and shared. I understand that All American Medical & Chiropractic has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Facility Privacy Official, or by visiting the web site at www.allamericanchiro.com.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

   _____

   _____

2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgement:*

   _____

   _____

   Completed by:

   _____ _____
   Signature of Facility Representative Date

   _____
   Print Name

Patient Name: _____ Date of Birth: _____ Date: _____

Social Security # _____ Patient/Clinic ID# _____ Admit. Date: _____

Patient Informed Consent

Congratulations on choosing chiropractic health care. This clinic believes it is the safest, most natural health care delivery system in the world today. Chiropractic adjustments (chiropractic manipulative therapy: CMT) and other care procedures are safe and cost effective.

All health care professionals (anesthesiologists, chiropractors, dentists, medical doctors, osteopaths, pharmacists, surgeons, etc.) are regulated by laws and boards. These health care professionals are required to give you, the patient, advanced notice of any care risks, because health care is not an exact science. It is not reasonable to expect any doctor to foresee all risks and/or complications. Informed consent information regarding any risks such as: paraplegia, quadriplegia, brain damage, stroke, disc injury, breaks, fractures, dislocations, drug reactions, death or loss of function of any organ or limb, or disfiguring scars associated with physical care, drugs, surgery and/or treatment is an undesirable result, but it does not necessarily indicate an error in clinical judgment. No guarantee of cure or results has been made to you, the patient in this clinic. Your care may involve the making of recommendations based upon facts known to the doctor at this time. Chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions.

For your information, the following is furnished to all patients who request and/or accept chiropractic care in this clinic. Again, chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions. This clinic is staffed with graduate chiropractors who are licensed and recognized by government agencies regulating all the aforementioned healing arts.

Chiropractic is the science that concerns itself with the relationship between the brain, central nervous system, spine and the function of the body. Any alteration of this relationship can cause the biomechanical and neurophysiological dynamics of the contiguous spinal and paraspinal structures to be disrupted. This can cause neuronal disturbances in the form of the vertebral subluxation complex (V.S.C.) with its physical and chemical components, which can then interrupt the body's inherent recuperative powers.

The practice of chiropractic can include exams and diagnostic testing. In some cases, this includes the utilization of specialized instrumentation, lab tests, radiological exams, nutritional and/or physical therapy, and rehabilitation procedures, etc. There is a special procedure unique to chiropractic: the chiropractic adjustment (chiropractic manipulative therapy – C.M.T.). Adjustments are made by chiropractors to correct and/or reduce and/or stabilize vertebral or extremity subluxation complexes. The goal of chiropractic health care is to reduce and/or stabilize vertebral or extremity subluxation complexes. The goal of chiropractic health care is to reduce and/or stabilize the nerve interference caused by the VSC and its component parts. There are over 200 different adjusting techniques, some using specialized equipment. Adjustments are usually performed by hand, but may be performed by hand-guided instruments. A C.M.T. is the application of a specific force, applied to a segmental contact point, usually on a vertebra, to reduce or stabilize the V.S.C. and its component parts.

You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited inherent risks. These occur seldom enough to contraindicate care, but should be considered in your informed decision to receive chiropractic care.

All health care procedures have some risks. With C.M.T.'s, these risks may include aggravating a pre-existing condition, musculoskeletal sprain/strain, disc injuries, dislocations, fractures, neurological deficits, Horner's Syndrome, Vertebral Artery Syndrome (V.A.S.), stroke, etc. The chances of this occurring have been estimated by experts to be approximately only 1 per 400,000 treatments, to 1 per 1,000,000 treatments.

Appropriate tests will be performed to identify if you may be susceptible to these risks, and you will be notified, in that case. If you have any questions about these issues, please do not hesitate to speak with your doctor of chiropractic.

I have read (or have had read to me) the above information. I wish to rely on the doctor's judgment during my course of care, based on the facts then known. I have also had opportunity to ask questions regarding the above information and possible consequences and risks. By signing below, I now agree to have the chiropractic care procedures recommended and performed. I have no questions, and I acknowledge no guarantee of cure has been made to me concerning results, care and treatment.

_____ _____

Patient Name Printed *Patient Signature* *Date*

_____ _____

Patient/Guardian Signature (if minor) *Staff/Witness Signature* *Date*

Arbitration Agreement
Physician/Patient Out-Patient Form

Arbitration is a way to decide disputes without going to court.

By signing this agreement, my doctor(s) and I are choosing arbitration rather than going to court as a way of resolving any future claim about my chiropractic care. This agreement only applies to the care that I receive in this office during the next year from the undersigned chiropractor, associate or any office assistants or substitutes, employed by or assigned to my care by my chiropractor immediately following the execution of this form or during the time when this form is in effect. This agreement *does not* apply to disagreements over the fees charged.

If I select arbitration, my case will be decided by court appointed arbitrator instead of a judge or jury.

I am choosing arbitration of my own free will. This agreement applies to me, my heirs and my legal representatives. This agreement also applies to any professional corporation or partnership that my doctor belongs to or works for.
In most cases, a decision by an arbitration panel is final and cannot be appealed.

If you have a dispute you must submit notice to All American Medical & Chiropractic within seven days. Thereafter you must agree and submit to binding arbitration within 45 days and pay your pro rata share. The American Arbitration Associations rules are adopted by reference and are incorporated herein as if copied by extension.

This agreement to arbitrate is not a prerequisite to health care or treatment.

_____ _____

Offered by: *Patient Name Printed or Typed*

_____ _____

Signature of Chiropractic Representative *Patient Signature* *Date*

I CERTIFY THAT I AM THE PARENT OF THE MINOR CHILD, THE GUARDIAN, OR OTHER LEGAL REPRESENTATIVE OF THE PATIENT INVOLVED.

_____

Parent/Guardian/Legal Representative Signature *Date*

CONSENT TO CARE

A patient coming to the doctor gives his/her permission and authority to care for them in accordance with appropriate test, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses or deformities, which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

_____ _____

Patient's Signature Date

X-ray Questionnaire: For Women Only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name _____

____ There is a possibility that I may be pregnant at this time.

____Yes, I am definitely pregnant

____No, I am definitely NOT pregnant at this time

____I request that x-ray films not be taken because _____

_____

Date of last menstrual period: _____

_____ _____

Patient's Signature Date

Restriction of the Activities of Daily Living (ADL)

Patient Name: _____ Date: _____

PLEASE CHECK MARK EACH QUESTION THAT APPLIES…

(1) HEALTH CARE:

Are you experiencing:	**Difficulty or Pain**	**Unable to Perform**
Bathing	YES ( )	YES ( )
Getting into or out of the bathtub	YES ( )	YES ( )
Getting on or off the toilet	YES ( )	YES ( )
Washing or shampooing your hair	YES ( )	YES ( )
Grooming your hair	YES ( )	YES ( )
Putting on your pantyhose	YES ( )	YES ( )
Putting on or taking off your shoes	YES ( )	YES ( )
Putting on a bra	YES ( )	YES ( )
Applying body lotion or suntan lotion	YES ( )	YES ( )
Brushing your teeth	YES ( )	YES ( )

(2) ACTIVITIES INVOLVING POSTURE:

Are you experiencing:	**Difficulty or Pain**	**Unable to Perform**
With prolonged standing	YES ( )	YES ( )
With prolonged sitting	YES ( )	YES ( )
With prolonged walking	YES ( )	YES ( )
Stair climbing	YES ( )	YES ( )
Crawling	YES ( )	YES ( )
Stooping	YES ( )	YES ( )
Bending	YES ( )	YES ( )
Laying on your stomach	YES ( )	YES ( )
Laying on your back	YES ( )	YES ( )
Kneeling	YES ( )	YES ( )
Squatting	YES ( )	YES ( )

(3) TRAVEL/DRIVING ABILITIES

Are you experiencing:	**Difficulty or Pain**	**Unable to Perform**
Turning your head while backing up	YES ( )	YES ( )
Rotating your body while backing up	YES ( )	YES ( )
With prolonged sitting as a driver/passenger	YES ( )	YES ( )
When driving on a bumpy road	YES ( )	YES ( )

Patient Name: _____ Date: _____

(4) SOCIAL AND RECREATIONAL ABILITIES

Are you experiencing:	**Difficulty or Pain**	**Unable to Perform**
Dancing	YES ( )	YES ( )
Playing sports	YES ( )	YES ( )
Participating in aerobic sports	YES ( )	YES ( )
Weight lifting/body building	YES ( )	YES ( )
Running/Jogging	YES ( )	YES ( )

(5) SLEEP HABITS

Are you experiencing:	**Difficulty or Pain**	**Unable to Perform**
Do you take longer to fall asleep	YES ( )	YES ( )
Is your sleep interrupted due to pain	YES ( )	YES ( )
Are you awakened early due to pain	YES ( )	YES ( )
You cannot fall asleep without medication	YES ( )	YES ( )

(6) HOUSEHOLD RESPONSIBILITES

Are you experiencing:	**Difficulty or Pain**	**Unable to Perform**
Scrubbing the tub	YES ( )	YES ( )
Scrubbing floors	YES ( )	YES ( )
Vacuuming	YES ( )	YES ( )
Sweeping	YES ( )	YES ( )
Taking out the trash	YES ( )	YES ( )
Standing while washing dishes	YES ( )	YES ( )
Preparing meals or cooking	YES ( )	YES ( )
Carrying groceries	YES ( )	YES ( )
Putting away groceries	YES ( )	YES ( )
Carrying a laundry basket	YES ( )	YES ( )
Doing the laundry	YES ( )	YES ( )
Gardening	YES ( )	YES ( )
Washing the car	YES ( )	YES ( )

(7) SEXUAL FUNCTIONS

Are you experiencing:	**Difficulty or Pain**	**Unable to Perform**
Participating in sexual activities	YES ( )	YES ( )

I have read the above questions and have answered them to the best of my knowledge.

_____ _____

Patient Signature Date