

RIFKIN CHIROPRACTIC & WELLNESS CENTER

CONSENT FOR EXAMINATION: I hereby authorize Rifkin Chiropractic & Wellness Center and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I also wish to rely on the practice doctors to make these decisions about my care, based on the facts then known, that they believe are in my best interest. **Initial** _____

INSURANCE ASSIGNMENT OF BENEFITS: I assign payment by my insurance company directly to Rifkin Chiropractic & Wellness Center. I understand that I am financially responsible for charges and copayments not covered by my insurance carrier. In the unfortunate event collection procedures are required to collect an outstanding account balance, the patient shall be responsible for all reasonable cost of a collection agency, attorney, and / or court costs.

RELEASE OF INFORMATION: I authorize the use and disclosure of health information that pertains to me for treatment, payment, or official operations. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. In addition I authorize Rifkin Chiropractic & Wellness Center to share findings/send reports to my family physician or other health care provider listed on my health history form.

I understand that I may revoke this authorization at any time by signing the revocation of my copy of this form and returning it to Rifkin Chiropractic & Wellness Center. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand this authorization will automatically expire at the end of my treatment cycle. I understand that I have the right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I understand that Rifkin Chiropractic & Wellness Center will receive compensation for the uses and disclosures that I have authorized.

I authorize Rifkin Chiropractic & Wellness Center to leave any message necessary at my home / work in regards to any appointments, billing or insurance issues that may occur.

I have read this consent and have had an opportunity to ask questions about the consent and understand the care and treatment I may receive. My signature below acknowledges my consent to examination, evaluation and treatment by the practice.

Patient's or Patient's Guardian's Name (Please Print)

Signature of Patient or Guardian

Date

CONSENT FOR TREATMENT

The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction. Based on current findings practice doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. The doctors have answered my questions regarding the planned treatment and course of care that I will receive.

I have also been advised that although the incidence of complications associated with chiropractic services is extremely rare, anyone undergoing adjusting or manipulative procedures should know the rare possible hazards and complications that may be encountered or result during the course of care. These include but are not limited to fractures, disc injuries, strokes, dislocations, sprains and those which relate to physical aberrations unknown or undetectable by the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that the practice doctors will advise me of any material risks in the regard.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based on the facts known to the doctor during my course of care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, or an undesirable result does not necessarily indicate an error in judgment or treatment. In addition there is no guarantee as to results with respect to any course of care or treatment.

Patient Signature

Date

Doctor Signature

Date

PERSONAL HISTORY

NAME:	DATE:	BIRTH DATE:
ADDRESS:	AGE:	HEIGHT WEIGHT
CITY:	WHO IS RESPONSIBLE FOR YOUR BILL? <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> auto ins. <input type="checkbox"/> workman's comp. <input type="checkbox"/>	
STATE/ZIP:	YOUR MAIN PHYSICIAN:	
HOME PHONE:	E MAIL:	NAME OF SPOUSE:
CELL PHONE:	SPOUSE'S SOCIAL SECURITY #:	
BUSINESS PHONE:	SPOUSE'S EMPLOYER:	
SOCIAL SECURITY#:	SPOUSE'S BUSINESS PHONE:	
DRIVER'S LICENSE #:	SPOUSE'S TYPE OF WORK:	
BUSINESS OR EMPLOYER:	PHONE # + NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY:	
TYPE OF WORK YOU DO:	EMERGENCY CONTACT'S RELATIONSHIP TO YOU:	
HEALTH INSURANCE + CARD #:	REFERRED TO OUR OFFICE BY:	
PURPOSE OF YOUR OFFICE VISIT:		

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULOSKELETAL: <input type="checkbox"/> Low back pain <input type="checkbox"/> Upper back pain <input type="checkbox"/> Neck pain <input type="checkbox"/> Arm/hand/wrist pain <input type="checkbox"/> Leg/foot/ankle/knee pain <input type="checkbox"/> Jaw pain <input type="checkbox"/> General stiffness <input type="checkbox"/> Walking problems	DIGESTIVE: <input type="checkbox"/> Gas/Bloat <input type="checkbox"/> Heartburn <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Poor appetite <input type="checkbox"/> Increased appetite <input type="checkbox"/> Abdominal cramps <input type="checkbox"/> Black/bloody stool <input type="checkbox"/> Mouth ulcers <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting	EENT: <input type="checkbox"/> Vision problems <input type="checkbox"/> Dizziness <input type="checkbox"/> Dental problems <input type="checkbox"/> Sore throat <input type="checkbox"/> Ear aches/ problems <input type="checkbox"/> Hearing difficulty <input type="checkbox"/> Stuffed nose Date of last eye exam: _____	GENERAL <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Allergies <input type="checkbox"/> Chills <input type="checkbox"/> headaches <input type="checkbox"/> Night sweats <input type="checkbox"/> Loss of sleep DATE OF: Last period: _____ Last pelvic: _____ Mammogram: _____ Pregnant: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Maybe Last Prostate Exam: _____
NERVOUS SYSTEM: <input type="checkbox"/> Nervous <input type="checkbox"/> Confusion <input type="checkbox"/> Numbness <input type="checkbox"/> Stress <input type="checkbox"/> Paralysis <input type="checkbox"/> Fainting <input type="checkbox"/> Dizziness <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Cold/tingling extremities <input type="checkbox"/> Depression	GENITO-URINARY <input type="checkbox"/> Bladder trouble <input type="checkbox"/> Painful urination <input type="checkbox"/> Excessive urination <input type="checkbox"/> Discolored urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Dribbling <input type="checkbox"/> Hesitancy	RESP./CVS <input type="checkbox"/> Chest pain <input type="checkbox"/> Short breath <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Lung congestion <input type="checkbox"/> Ankle swelling <input type="checkbox"/> Varicose veins <input type="checkbox"/> Poor circulation	MALE/FEMALE <input type="checkbox"/> Menstrual irregularity <input type="checkbox"/> Menstrual cramps <input type="checkbox"/> Vaginal pain <input type="checkbox"/> Breast pain/Infection <input type="checkbox"/> Breast lumps <input type="checkbox"/> Sexual dysfunction

DATE OF LAST PHYSICAL: _____

PAST HEALTH HISTORY:

LIST ANY SURGURIES YOU HAVE HAD:

<input type="checkbox"/> Breast Implants	

LIST ALLERGIES TO MEDICATIONS:

LIST HEALTH CONDITIONS FAMILY MEMBERS HAVE/HAD:

MOTHER:
FATHER:
BROTHER:
SISTER:
GRANDPARENTS:
CHILDREN:

LIST DRUGS /SUPPLEMENTS YOU TAKE:

CHECK ANY PAST OR CURRENT CONDITIONS YOU HAVE:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Influenza	<input type="checkbox"/> Mental disorder	<input type="checkbox"/> M.S.
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Migraines	<input type="checkbox"/> Prostatitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gout	<input type="checkbox"/> Lupus	<input type="checkbox"/> Mumps	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Back/neck pain	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Lupus	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Rheumatoid arth.
<input type="checkbox"/> Eczema	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Measles	<input type="checkbox"/> Polio	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Small pox	<input type="checkbox"/> Thyroid	<input type="checkbox"/> T.B	<input type="checkbox"/> Whooping cough	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Itchiness	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Seizures	<input type="checkbox"/> Food Allergies	

SOCIAL HISTORY:

<input type="checkbox"/> Hours sleeping per night	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/>
<input type="checkbox"/> Children: (# and ages)	<input type="checkbox"/> Smoker: (Indicate packs per week.)
<input type="checkbox"/> Drink Coffee (Indicate cups per day.)	<input type="checkbox"/> Drink alcohol: (drinks/beer per day)
<input type="checkbox"/> Commute to work (Indicate distance.)	Indicate hours worked per week. _____ Type of work: <input type="checkbox"/> Mental <input type="checkbox"/> Physical <input type="checkbox"/> Both
<input type="checkbox"/> Exercise: (Types of exercise and hours per week.)	<input type="checkbox"/> Hobbies: (List them.)

DOCTORS YOU HAVE SEEN IN THE PAST 2 YEARS:

DOCTOR'S NAME:	SPECIALTY:	DATE OF VISIT	PURPOSE OF VISIT

PATIENT SIGNATURE: _____

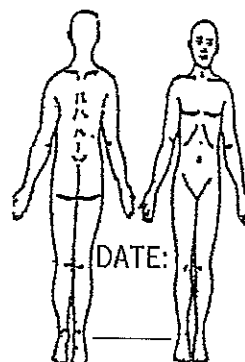
DR. SIGNATURE: _____

Symptom Survey

One painful area only per survey!!

NAME: _____ DATE: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____



1. Mark on the diagram where you hurt.
2. Give the month, day and year when your symptoms began.
Month: _____ Day: _____ Year: _____

3. Where did you symptoms begin?
Location (home work etc.): _____

4. How did you hurt yourself?

5. Did you ever have pain in this area before symptoms began? Y N If yes, give dates and explain: _____

6. Have you seen other health care providers for this problem? Y N If yes, fill out below:
Date: _____ Provider: _____ Treatment: _____
Date: _____ Provider: _____ Treatment: _____
Date: _____ Provider: _____ Treatment: _____

7. Describe your pain by checking the appropriate box.
 dull sharp radiating burning numbing
 other Explain: _____

8. How often do you feel the pain? Describe the intensity of the pain?

<input type="checkbox"/> Constant: (75% of the time or more.)	<input type="checkbox"/> Minimal: (annoying, does not stop activity.)
<input type="checkbox"/> Frequent: (50% to 75% of the time.)	<input type="checkbox"/> Slight: (slightly disrupts activity.)
<input type="checkbox"/> Occasional: (25% to 50% of the time.)	<input type="checkbox"/> Moderate: (markedly disrupts activity.)
<input type="checkbox"/> Intermittent: (25% or less of the time.)	<input type="checkbox"/> Severe: (makes some activity impossible)

9. Do you exercise? Y N If yes, check the appropriate box.
 treadmill bike elliptical weight training stretching high impact aerobics
 low impact aerobics other: _____

10. Have you missed any work due to this condition? Y N If yes, give dates: _____

11. Score function 0-10 (0well/10total disability). Check what helps to relieve your pain?
Function: score each 0 to 10 HELP:

<input type="checkbox"/> recreation	<input type="checkbox"/> lifting	<input type="checkbox"/> sitting	<input type="checkbox"/> moving	<input type="checkbox"/> sitting	<input type="checkbox"/> lying	<input type="checkbox"/> rest
<input type="checkbox"/> carrying	<input type="checkbox"/> driving	<input type="checkbox"/> pushing	<input type="checkbox"/> exercise	(type): _____		
<input type="checkbox"/> pulling	<input type="checkbox"/> walking	<input type="checkbox"/> reading	<input type="checkbox"/> medications: (type): _____			
<input type="checkbox"/> stooping	<input type="checkbox"/> sleeping	<input type="checkbox"/> social	_____			
<input type="checkbox"/> reading	<input type="checkbox"/> bending	<input type="checkbox"/> computer	_____			
<input type="checkbox"/> concentration	<input type="checkbox"/> movement		_____			

SIGNATURE: _____

Thank you!!