ICON CONSTEAD CHIROPRACTIC

CHIROPRACTIC

Patient Care Form

Identification

Name: _____ Date: _____

Friends call you: _____ Social Security Number: _____

Personal Information

Address: _____ Marital Status (Circle): Single Married Widowed

City: _____ State: _____ Zip Code: _____

Home #: _____ E-mail: _____

Cell #: _____ Birthdate: ____/_____/_____

Work #: _____

Employer: _____ Occupation: _____

Age: _____ Gender: _____ Spouse's Name: _____

Emergency Contact Name: _____ Emergency Number: _____

How did you hear about us: _____

Section A: Auto-Accident / Personal Injury

Is condition due to an accident? _____ If Yes, Date of Injury: _____

Type of Accident (circle) Auto Accident Workman's Comp Other

Claim Number: _____

Attorney Name (if applicable): _____ Phone #: _____

Insurance Company: _____ Contact Name: _____

Insurance Phone #: _____Adjuster Phone #: _____

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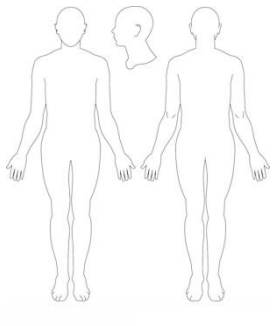
Section B: Patient Condition

Major Complaint: _____

When did your symptoms appear: _____

Is this condition getting progressively worse (circle one)? Yes No Not Sure

Mark X on the picture area where you feel discomfort / pain:



Rate the Severity of the pain from 1(least pain) to 10 (severe pain): _____

Type of Pain (Circle): Sharp Dull Throbbing Numbness Aching
Burning Tingling Shooting Cramps
Stiffness Swelling Other

How often do you have this pain? _____

Is the pain (circle one)? Constant Comes and Goes

Does it interfere with your (circle)? Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform (circle): Sitting Standing Walking
Bending Lying Down

Section C: Health History

Have you seen anyone else for this condition? _____

What type of treatment did you receive (Circle)? Medications Surgery
Chiropractic P. Therapy
Other

Name of Doctor who treated you: _____ Phone: _____

Have you ever had chiropractic care before (circle)? Yes No

Have you had X-rays before (circle one) Yes No When? _____
What areas? _____

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Section D: Health History

If you have had any of the following, circle all that apply:

Aids / HIV
Alcoholism
Allergy Shots
Anemia
Anorexia
Appendicitis
Arthritis
Asthma
Bleeding
Disorders
Breast Lump
Bronchitis
Bulimia
Cancer
Cataracts
Chemical
Dependency
Chicken Pox
Diabetes
Emphysema
Epilepsy
Fractures
Glaucoma
Goiter
Gonorrhea
Gout
Heart Disease
Hepatitis
Hernia
Herniated Disc
Herpes
High Cholesterol
Kidney Disease
Liver Disease
Measles
Migraine
Headaches
Miscarriage
Mono
Multiple Sclerosis
Mumps
Osteoporosis
Pacemaker
Parkinson's Disease
Pinched Nerve
Pneumonia
Polio
Prostate Problems
Psychiatric Care
Rheumatoid Arthritis
Rheumatic Fever
Scarlet Fever
Stroke
Suicide Attempt
Thyroid Problems
Tonsillitis
Tuberculosis
Tumor Growths
Typhoid Fever
Ulcers
Venereal Disease
Whooping Cough
Other _____

For Women Only (Circle all that apply):
Vaginal Infections
Menstrual Pain
Cramping
Irregularity

Date of Last Period: _____
Pregnant (circle)?: Yes No
How Long? _____

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Section E: Health History

Have you had any broken bones, if so which? _____ When? _____

Have you had any surgeries, if so which? _____ When? _____

Section F: Exercise	**Section G: Work Activity**	**Section H: Habits**
Circle One:	Circle One:	Circle One:
Little to None	Sitting	Smoking
Moderate	Standing	Alcohol
Daily	Light Labor	Coffee / Energy Drinks
Heavy	Heavy Labor	High Stress

In Addition to the main reason for your visit today, what additional health objectives, do you have for the future?

_____

_____

Have you ever been on a Health Development Program (circle)? Yes No Not Sure

If yes, what strategies have you used? _____

Will you be healthy (or healthier) as you are today, 5 years from now? Yes No Not Sure

If Yes, what strategies will be implemented? _____

If No, what strategies could you implement? _____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to perform an assessment on me in order to make as complete an evaluation as possible.

Signed: _____ Date: _____/_____/_____

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/ or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and 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 doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is my best interests.

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.

Date: _____

PATIENT SIGNATURE: _____
(or patient representative , indicate Relationship if signing for patient)

OFFICE SIGNATURE: _____

24-Hour Appointment Cancellation Policy

ICON Chiropractic LLC has a 24 hour cancellation/ rescheduling policy.

If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you will be charged $45.

This policy is in place out of respect for our therapists and our clients. Cancellations with less than 24 hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Icon Chiropractic, LLC as described above.

Thank you for your understanding and cooperation.

_____ _____

Printed Name Signature

_____

Date

Consent For Photography, Videotaping, or Other Imaging for Media or Educational Purposes

PATIENTS NAME: _____

PATIENT'S DATE OF BIRTH: _____

I give my consent to have photographs, videotaped images or other images made of me and/or my family members. I understand and agree that these images may be used by ICON Chiropractic LLC for the purposes outlined below.

- Teaching purposes, which includes being shown to other patients, children at school, conventions, and/or expos.
- Advertisements by ICON Chiropractic LLC
- Placement on social media websites such as YouTube, ICON Chiropractic LLC's website, but not limited to thereof.

If, for any reason, the media shown is unsatisfactory or I wish the media to no longer be shared, a written notice must be written and submitted to ICON Chiropractic LLC. The media will then be taken down and removed within 7 days upon receipt of notice.

Print Name: _____

Signature: _____

Date: _____

If Legal Representative—Relationship to patient: _____

Signature of Witness: _____

Date: _____