



PERFORMANCE SPINE & REHABILITATION CENTER

Please complete this questionnaire. Your answers will help determine if chiropractic or physical therapy can help you. If we do not sincerely believe your condition will respond satisfactory, we will not accept your case.

Name: _____ Sex _____ Marital Status _____ Age _____ Birthday _____

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

Social Sec #: _____ Occupation: _____ Company Name: _____

(indicate if child, student, housewife, retired)

Cell Phone: _____ Home Phone: _____ Work Phone: _____

How did you hear about our office? _____

HEALTH INFORMATION

Have you received chiropractic care or physical therapy before? _____ For what condition? _____

What is your major complaint? _____

Other complaints: _____

How long have you had this condition? _____ Have you had a similar condition in the past? _____

What aggravates your condition? _____

What improves your condition? (i.e. ice or medication): _____

Is the problem constant It comes and goes Is the condition getting progressively worse? yes no

Other doctors who treated this condition: _____

Do you have a primary care physician? yes no Name: _____ Phone#: _____

List surgical operations and years: _____

Drugs you now take: Nerve pills Pain Killers Muscle relaxers "Pep" pills Tranquilizers
Insulin Birth Control Others _____

Are you wearing: Heel lifts Sole lifts Inner soles Arch supports

Have you been in an auto accident?: Past year Past 5 years Over 5 years

Describe: _____

Have you had any other personal injury or accident?: Past year Past 5 years Over 5 years

Describe: _____

HEALTH HISTORY:

Please indicate for each on the questions below by use of the following codes: 1-previously had; 2-presently have.

MUSCULOSKELETAL SYSTEMS

- low back problems
- pain between shoulders
- neck problems
- arm problems
- leg problems
- swollen joints
- painful joints
- stiff joints
- sore muscles
- weak muscles
- walking problems
- ruptures
- broken bones

GENITOURINARY SYSTEMS

- bladder trouble
- excessive urination
- frequent urination
- painful urination
- discolored urine
- difficulty w/stream

FEMALE

- vaginal discharge
- vaginal bleeding
- vaginal pain
- breast pain
- lumps on breast
- Are you pregnant?
- yes no
- Date of last menstruation:

GASTROINTESTINAL SYSTEM

- poor appetite
- excessive hunger
- difficulty chewing
- difficulty swallowing
- excessive thirst
- nausea
- vomiting food
- vomiting blood
- abdominal pain
- diarrhea
- constipation
- black stool
- bloody stool
- hemorrhoids
- liver trouble
- gall bladder problems
- weight trouble

NERVOUS SYSTEM

- numbness
- loss of feeling
- paralysis
- dizziness
- fainting
- headaches
- muscle jerking
- convulsions
- forgetfulness
- confusion
- depression

CARDIOVASCULAR SYSTEM

- chest pain
- pain over the heart
- difficulty breathing
- persistent cough
- coughing phlegm
- rapid heartbeat
- high blood pressure
- heart problems
- lung problems
- varicose veins

EYE, EAR, NOSE AND THROAT

- eye strain
- eye inflammation
- ear pain
- ringing in ears
- ear discharge
- hearing loss
- nose pain
- nose bleeding
- nose discharge
- sore gums
- dental problems
- sore mouth
- sore throat
- hoarseness
- difficult speech

FAMILY HEALTH INFORMATION

Many health problems are the result of heredity, thus the information about your family members will give us a better picture of your total health.

RELATION

PAST AND PRESENT HEALTH PROBLEMS

MOTHER _____

FATHER _____

GRANDMOTHER _____

GRANDFATHER _____

SIBLINGS _____

Please take a moment to read over and sign/date the following:

INFORMED CONSENT

The chiropractic adjustments, physical therapy, and other clinical procedures are usually beneficial and seldom cause any problem. Although the incidences of complications associated with our services is very low, anyone undergoing adjustments, physical therapy or manipulative procedures should know the possible hazards and complications which may be encountered or result. These include, but are not limited to, fractures, disk injuries, stroke, dislocations, sprains, strains, and those that relate to physical aberrations unknown or reasonably undetected by the doctor.

Patient's Signature _____ Date _____

INSURANCE INFORMATION

Do you have health insurance: Yes No
Is this condition due to an auto accident on job related injury? Yes No

I hereby authorize the _____ Insurance Company to pay by check made out and mailed directly to Performance Spine & Rehabilitation for the medical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. The payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

Patient's Signature _____ Date _____

OFFICE POLICY

FEE FOR SERVICE:

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself, and any charges accrued in this office are ultimately my responsibility. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office and will be credited to my account on receipt. However, I clearly understand and agree that I am personally responsible for payment, which can be charged to my credit card. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable. Should this account be referred to an attorney for collections the undersigned will be liable for all reasonable attorney fees and collection expenses.

MISSED APPOINTMENT:

I understand that 24-hour notice is required on all cancellations, and that otherwise there will be a fee for missed appointments. I also understand that any appointment in which I arrive 20 minutes after the scheduled time is deemed a missed appointment. However, there is no fee for rescheduled appointments, and I may call the office up to the actual scheduled appointment time to reschedule without penalty. Any fees for missed appointments must be paid on or before the subsequent visit.

Patient's Signature _____ Date _____

Parent or Guardians Signature _____ Date _____

I certify to the best of my knowledge I am not pregnant and Performance Spine and Rehab has my permission to take x-rays of me.

Patient's Signature _____ Date _____

I hereby give consent to Performance Spine and Rehabilitation to examine, x-ray and treat my child or ward.

Patient's Signature _____ Date _____

Parent or Guardians Signature _____ Date _____