

Encompass Chiropractic Patient Information Form

Case # _____ (for office use only) Date _____

Type of case: ___ Cash ___ Insurance ___ Car Accident ___ Work Accident

Patient Name: _____ Preferred/Nickname _____

DOB: ___/___/___ Age: _____ Your SS#: ___ - ___ - ___ # of children you have _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated Sex: ___ Male ___ Female

If you are a child under the age of 18, who are your parents or guardians

Father: _____ Date of Birth: ___/___/___ Phone #: (____) _____

Mother: _____ Date of Birth: ___/___/___ Phone #: (____) _____

Guardian: _____ Date of Birth: ___/___/___ Phone #: (____) _____

Who do you normally live with? ___ Mom & Dad ___ Mother ___ Father ___ Guardian ___ None of these

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

Phone: (Home) (____) _____ (Cell) (____) _____ (Work) (____) _____

Email address: _____ May we send you a monthly newsletter? ___ Yes ___ No

Occupation: _____ Employer: _____

Spouse's Name: _____ Spouse's DOB ___/___/___

Spouse's SS# ___ - ___ - ___ Spouse's Phone (Cell) (____) _____ Work (____) _____

Spouse's Occupation: _____ Spouse's Employer: _____

Emergency contact: _____ Phone (____) _____ Relationship _____

Who may we thank for referring you to our office? _____

Primary care physician? _____ May we contact? ___ Yes ___ No Phone (____) _____

Insurance Information

Primary Insurance Company: _____ Secondary Insurance Company: _____

Policy Holder's Name: _____ Policy Holder's Name: _____

Policy Holder's DOB ___/___/___ Policy Holder's DOB ___/___/___

Policy Holder's SS# ___ - ___ - ___ Policy Holder's SS# ___ - ___ - ___

Reason for your visit today (Please list areas of pain) _____

Date of accident or beginning of symptoms: _____

Has the accident been reported? ___ Yes ___ No ___ To Worker's Comp? ___ To Auto Carrier?

Have you seen a chiropractor before? ___ Yes ___ No Chiropractor's Name _____

HABITS

Smoking: Packs per day _____ Alcohol: Drinks per day _____ Coffee/Tea: Cups per day _____

Vitamins/herbs/Prescriptions (list all being taken): _____

Exercise: ___ None ___ Moderate ___ Daily _____ Left handed ___ Right handed ___ Both

PERSONAL & FAMILY HISTORY

Has any member of your family had any of the following diseases? ___ Diabetes ___ Kidney ___ Arthritis ___ Heart ___ Cancer ___ Lung

Have you had any of the following? (Please check or place an "X" in the box & list any requested information)

<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	X-rays, MRI, CAT Scan of Spine (when & where)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Polio	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Broken Bones/Dislocations (when & where)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	AIDS	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Spinal Tap/Injection	<input type="checkbox"/>	Knocked Unconscious	<input type="checkbox"/>	<input type="checkbox"/>

Please check or place an "x" for all symptoms that currently apply to you (Place a date for surgeries).

General Symptoms	Gastro-Intestinal	EENT	Surgeries & Surgery Date	Muscle & Joints
<input type="checkbox"/> Headaches	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Poor vision	<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Stiff neck
<input type="checkbox"/> Fever	<input type="checkbox"/> Poor digestion	<input type="checkbox"/> Pain in eyes	<input type="checkbox"/> Tubes in ears	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Deafness	<input type="checkbox"/> Sinus	<input type="checkbox"/> Upper back pain
<input type="checkbox"/> Fainting	<input type="checkbox"/> Belching or gas	<input type="checkbox"/> Earache	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Middle back pain
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Ear noises	<input type="checkbox"/> TMJ	<input type="checkbox"/> Lower back pain
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Neck	<input type="checkbox"/> Arm pain
<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Gall bladder	<input type="checkbox"/> Arm numbness
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Constipation	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Stomach	<input type="checkbox"/> Arm tingling
<input type="checkbox"/> Loss of weight	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Leg pain
<input type="checkbox"/> Allergies	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Asthma	<input type="checkbox"/> Female organs	<input type="checkbox"/> Leg numbness
<input type="checkbox"/> Weakness	<input type="checkbox"/> Liver trouble	<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Leg tingling
<input type="checkbox"/> Twitching	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Back	<input type="checkbox"/> Swollen joints
	<input type="checkbox"/> Gall bladder	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Hernia	<input type="checkbox"/> Painful tailbone
		<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Cataract	<input type="checkbox"/> Foot pain
			<input type="checkbox"/> Vision correction	<input type="checkbox"/> Spinal curvature
Cardiovascular	Skin	For Women Only	<input type="checkbox"/> Breast reduction	
<input type="checkbox"/> Rapid heartbeat	<input type="checkbox"/> Itching	<input type="checkbox"/> Painful periods	<input type="checkbox"/> Mastectomy	Genito-Urinary
<input type="checkbox"/> Slow heartbeat	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Excessive flow	<input type="checkbox"/> Prostate	<input type="checkbox"/> Frequent urination
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Irregular cycles		<input type="checkbox"/> Painful urination
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Boils	<input type="checkbox"/> Hot flashes		<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Sensitive skin	<input type="checkbox"/> Cramps		<input type="checkbox"/> Kidney infections
<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Hives	<input type="checkbox"/> Vaginal discharge	Other Information: List	<input type="checkbox"/> Bed wetting
<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Eczema	<input type="checkbox"/> Currently pregnant		<input type="checkbox"/> Incontinence
<input type="checkbox"/> Stroke		<input type="checkbox"/> Breast implants		<input type="checkbox"/> Prostate trouble
<input type="checkbox"/> Heart attack	Respiratory	Date of last PAP:		<input type="checkbox"/> Bladder infections
	<input type="checkbox"/> Cough			
	<input type="checkbox"/> Short of breath			

Do you suffer from any condition other than that for which you are consulting us?

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty. **NOTE: Only fill in the areas that are affected.**

- 1 = "I can do it without much difficulty."
 2 = "I can do it without much difficulty, despite some pain."
 3 = "I manage to do it by myself, despite marked pain."
 4 = "I manage to do it, despite the pain, but only if I have help."
 5 = "I cannot do it at all, because of the pain."

Difficulties with Self Care and Personal Hygiene Activities

Bathing Drying hair Brushing teeth Putting on shoes Preparing meals Taking out trash
 Showering Combing hair Making bed Tying shoes Eating Doing laundry
 Washing hair Washing face Putting on shirt Putting on pants Cleaning dishes Going to toilet

Difficulties with Physical Activities

Standing Walking Kneeling Bending back Twisting left Leaning back
 Sitting Stooping Reaching Bending left Twisting right Leaning left
 Reclining Squatting Bending forward Bending right Leaning forward Leaning right
 Standing for long periods Sitting for long periods Walking for long periods Kneeling for long periods

Difficulties with Functional Activities

Carrying small objects Lifting weights off floor Pushing things while seated Exercising upper body
 Carrying large objects Lifting weights off table Pushing things while standing Exercising lower body
 Carrying brief case Climbing stairs Pulling things while seated Exercising arms
 Carrying large purse Climbing inclines Pulling things while standing Exercising legs

Difficulties with Social and Recreational Activities

Bowling Jogging Swimming Ice Skating Competitive Sports Dating
 Golfing Dancing Skiing Roller Skating Hobbies Dining out

Difficulties with Traveling

Driving a motor vehicle Riding as a passenger in a motor vehicle Riding as a passenger on a train
 Driving for long periods of time Riding as a passenger on an airplane Riding as a passenger for long periods

Use the following 1 to 5 scale to describe the difficulties below:

- 1 = "This area is not affected by my condition."
 2 = "This area is slightly affected by my condition."
 3 = "My condition moderately restricts my ability."
 4 = "My condition seriously limits my ability in this area."
 5 = "My condition prevents me from using this ability."

Difficulties with Different Forms of Communication

Concentrating Hearing Listening Speaking Reading Writing Using a keyboard

Difficulties with the Senses

Seeing Hearing Touch Taste Smell

Difficulties with Hand Functions

Grasping Holding Pinching Percussive movements Sensory discrimination

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep Bowel control/function Bladder Control/Function

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms

- I have NOT had prior symptoms similar to my current complaints.
 My current complaints DID exist before, but have not been bothering me.
 My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Current Symptoms?

- My history HAS contributed to my current symptoms.
 My history HAS NOT contributed to my current symptoms.
 I'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms (if applicable) occurred _____ months ago OR _____ years ago OR on Date: ____/____/____

Write in below any other Prior Symptom History, not covered above:

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Health Insurance/Payment Information

I understand & agree that health & accident insurance policies are an arrangement between my insurance company & myself – not between my insurance company & this office. 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 to me will be immediately due and payable. I understand that an interest charge at the highest allowable annual rate permitted by law will appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including but not limited to, all court costs and attorney fees. **Initial:** _____

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HIPAA RELEASE

I understand that some of my health information may be used and/or disclosed by Dr. J. Scott Verner, D.C. to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures, I can request a copy of the privacy notice entitled, "Our Privacy Practices," and that disclosures of my health information for any other reason must be agreed upon by me in writing,. I further understand that I can also revoke this consent in writing, but only to the extent that the Office has not taken action in reliance thereon. I understand that over time the Offices privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the revised notice, I can request a copy from the Office. **Initial:** _____

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The Nature of Chiropractic Treatment: Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. Chiropractors commonly use their hands or a mechanical device in order to restore mobility and function of joints that are not moving or functioning optimally. For many patients certain therapies or exercises may also be used to maximize healing and pain relief.

Possible Risks: The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or other treatment, if he/she is aware that such care may cause problems. It is the patient's responsibility to inform the doctor of any known pathological defects, illnesses, or deformities which would not otherwise come to the attention of the doctor. The most common adverse effects are minor and temporary and include stiffness or soreness after the first few days of treatment (similar to starting a new exercise regimen or having braces put on your teeth). Other rare but potential complications include muscular strain, fractures of bone, injury to intervertebral discs, nerves or spinal cord, or stroke/cerebrovascular injury (estimated to be less than 1 in 2 million to 5.8 million cervical adjustments). Complications from therapies used in addition to your adjustment are rare, but may cause skin irritation, burns, soreness, or other minor complications.

Risk of remaining untreated: Delay of treatment often results in further deterioration of the condition and may lead to chronic pain and disability, or spine injury.

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction before initialing. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent for the doctor to examine me and treat my condition as he or she deems appropriate through the use of chiropractic health care and I give authority for these procedures to be performed. Initial: _____

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I have read, understood, and agree to the foregoing. The information, which I have provided, is true & complete to the best of my knowledge.

Patient's Signature; _____ **Date:** ____/____/____

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CONSENT TO TREATMENT OF A MINOR (The minor is the patient listed on first page of this document)

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor ("the minor"), and hereby authorize **Dr. J. Scott Verner, D.C.** to administer treatment as he so deems necessary to the minor from this day forward unless I revoke my consent in writing. In the event that the minor has received treatment at this practice previous to the date of this consent form, I hereby authorize such treatment in addition to the treatment mentioned above. I further authorize the minor to complete and sign any documents at **Dr. J. Scott Verner, D.C.'s office**, which are customarily completed and signed by patients as a condition to treatment, and such signature shall serve as my own. In no event shall my signature to any other such document have any effect on this consent form.

Name of Custodial Parent/Legal Guardian (please print & spell clearly): _____
Relationship to the minor: Custodial Parent ___ Adoptive Parent with custody ___ Other (please specify): _____
Guardian by Law ___ Date guardianship commenced ____/____/____
SS# Of Parent/Guardian ____-____-____ Date of Birth of Parent/Guardian ____/____/____
Address of Parent/Guardian _____
Home phone: (____)____-____ Work phone: (____)____-____

Signature: _____ **Date:** ____/____/____