Genesis Chiropractic Wellness & Rehabilitation Center

Is this visit due to an auto or workman's comp accident? ☐NO ☐YES

(If yes, please inform the front desk of this if you haven't already.)

Name: ____**Date:**______/_______/_______

Address: ____

City: _____________________________ **State:** _______________ **Zip:** __________________________________

Home Phone: ___________________**Work Phone**: __________________ **Cell Phone**: _____________________

Would you like text reminders? No/Yes **Who is your cell phone carrier?**__________________________

Email Address: ____ Occupation: ________________________

Date of Birth: ___________________ **Gender**: ☐ Male ☐ Female **Social Security #**: _______-______-______

Race: ☐ American Indian ☐ Asian ☐Black or African American ☐ Native Islander ☐White ☐ Decline

Ethnicity: ☐Hispanic/Latino ☐ Non-Hispanic/Latino☐ Decline **Preferred Language**:______________________

Are you Pregnant? ☐ Yes ☐ No **Number of Children**: ______ **Marital Status**: _________________________

Primary Care Physician Name:___________________ **Clinic Name/Location**:_____________________________

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

Have you had x-rays, MRI, or CT scans completed? (if yes) When/Where/Area of body:____________________

____

Do you consume caffeine? No/Yes < 3 Drinks/day 3-6 Drinks/day >6 Drinks/day

Do you consume alcohol? No/Yes Casual Drinker Moderate Drinker Heavy Drinker

Do you smoke? No/Yes Current Smoke (Since :_______) Former Smoker (Quit when______)

Do you use drugs? No/Yes Recreational (___________) Addiction Former Addict

Do you exercise? No/Yes Daily Weekly Walks Runs Swims

List ALL **Allergies (Medications/Food/Environmental)** :____

____

List ALL **Surgeries (DATES INCLUDED):**____

____

List ALL **Medical History** conditions:____

____

____

List ALL **Medications/Vitamins** you are taking (**DATE STARTED as well as dosage**) **If you have a medication list, please provide that instead.**____

____

____

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Print Name:_________________________ Date:______________

Family Health History: Please write down any/all medical histories below that apply to the following family members.

Father: ____ **Mother**: ___________________________________

Brothers: ____ **Sisters**: __________________________________

Son:____ **Daughter**:_________________________________

Circle any activities of daily living that are currently affected due to your pain/discomfort

Dressing, Grooming, Walking, Sitting, Standing, Sitting to Standing, In/out of bed, Transfers, Lifting, Climbing Stairs, Housework, Driving, Sleep, Childcare,

Exercises Affected? (list exercise activities)____________________________ Other:__________________________

List/Circle all Medical History conditions please read through the full list as it is important to your care and circle NONE if nothing applies.

Constitutional Systems	Unexplained weight loss, night sweats, fatigue, appetite, fever, itch/rash, recent trauma, lumps/bumps/masses, unexplained falls	**NONE**
Eyes	Visual changes, headaches, eye pain, double vision, blind spots,	**NONE**
Ears, Nose, Mouth, and Throat (ENT)	Runny nose, frequent nose bleeds, sinus pain, stuffy ears, ear pain, ringing in ears, gingival bleeding, toothache, sore throat, pain with swallowing	**NONE**
Cardiovascular	Chest pain, shortness of breath, trouble exercising, palpitations, fainting, loss of consciousness, calf pain when walking, high blood pressure, high cholesterol	**NONE**
Respiratory	Coughing, coughing blood, wheeze, shortness of breath	**NONE**
Gastrointestinal	Abdominal pain, difficulty swallowing, indigestion, bloating, cramping, nausea/vomiting, diarrhea/constipation, vomiting blood, abnormal stool	**NONE**
Genitourinary	Incontinence, blood in urine, frequent urination, trouble urinating, menopause	**NONE**
Musculoskeletal	Pain, stiffness, joint swelling, decreased range of motion, arthritis	**NONE**
Skin/Breast	Itching, rashes, wounds, tumors, eczema, excessive dryness, Breast: pain, soreness, lumps, or discharge	**NONE**
Neurological	Any changes in: sight, smelling, hearing, or taste. Seizures, pins and needles, numbness, weakness, poor balance, speech problems, problems with bowel/bladder control	**NONE**
Psychiatric	Depression, problems sleeping, anxiety, trouble concentrating, lack of energy, mood swings, change in personality	**NONE**
Endocrine	**Hyperthyroid**: prefer cold weather, mood swings, sweaty, diarrhea, weight loss. **Hypothyroid**: prefer hot weather, slow, tired, depressed, thin hair, constipation, dry skin **Diabetes:** Frequent urination, increased appetite, increased thirst, dizziness, sweating, headache	**NONE**
Hematological / Lymphatic	Anemia, bruising easily, family history of blood issues, history of blood transfusion	**NONE**

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Print Name:_________________________ Date:______________

For the following, please only fill out/circle what applies.

NECK PAIN **Date Started**:_______	**Rate Pain** 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) **Which side?** Left/Center/Right	**How did pain start?** **Have you had similar pain before? (When?)** **Do you have radiating pain? (Where?)**
Is the pain… →	Constant 100-75% of time / Frequently 75-50% of time / Intermittent 50-25% of time / Occasional 25-0% of time	
Is the pain… →	Sharp / Shooting / Stabbing / Achy / Dull / Throbbing / Tingling / Numb / Burning / Tight	
What time of day does your pain feel BEST →	Morning / As the day progresses / Afternoon / Evening / During the night / Stays consistent	
What time of day does your pain feel WORSE →	Morning / As the day progresses / Afternoon / Evening / During the night / Stays consistent	
What makes the pain feel better? →	Resting / Stretching / Ice / Medication / Chiropractic Care / Other:	
What makes the pain feel worse? →	Working / Standing / Twisting / Movement / Walking / Other:	

UPPER/MID BACK PAIN **Date Started**:_______	**Rate Pain** 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) **Side** Left/Center/Right	**How did pain start?** **Have you had similar pain before? (When?)** **Do you have radiating pain? (Where?)**
Is the pain… →	Constant 100-75% of time / Frequently 75-50% of time / Intermittent 50-25% of time / Occasional 25-0% of time	
Is the pain… →	Sharp / Shooting / Stabbing / Achy / Dull / Throbbing / Tingling / Numb / Burning / Tight	
What time of day does your pain feel BEST →	Morning / As the day progresses / Afternoon / Evening / During the night / Stays consistent	
What time of day does your pain feel WORSE →	Morning / As the day progresses / Afternoon / Evening / During the night / Stays consistent	
What makes the pain feel better? →	Resting / Stretching / Ice / Medication / Chiropractic Care / Other:	
What makes the pain feel worse? →	Working / Standing / Twisting / Movement / Walking / Other:	

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Print Name:_________________________ Date:______________

LOW BACK PAIN **Date Started**:_______	**Rate Pain** 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) **Side** Left/Center/Right	**How did pain start?** **Have you had similar pain before? (When?)** **Do you have radiating pain? (Where?)**
Is the pain… →	Constant 100-75% of time · Frequently 75-50% of time · Intermittent 50-25% of time · Occasional 25-0% of time	
Is the pain… →	Sharp · Shooting · Stabbing · Achy · Dull · Throbbing · Tingling · Numb · Burning · Tight	
What time of day does your pain feel BEST →	Morning · As the day progresses · Afternoon · Evening · During the night · Stays consistent	
What time of day does your pain feel WORSE →	Morning · As the day progresses · Afternoon · Evening · During the night · Stays consistent	
What makes the pain feel better? →	Resting · Stretching · Ice · Medication · Chiropractic Care · Other:	
What makes the pain feel worse? →	Working · Standing · Twisting · Movement · Walking · Other:	

OTHER: _________________ **Date Started**:_______	**Rate Pain** 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) **Side** Left/Center/Right	**How did pain start?** **Have you had similar pain before? (When?)** **Do you have radiating pain? (Where?)**
Is the pain… →	Constant 100-75% of time · Frequently 75-50% of time · Intermittent 50-25% of time · Occasional 25-0% of time	
Is the pain… →	Sharp · Shooting · Stabbing · Achy · Dull · Throbbing · Tingling · Numb · Burning · Tight	
What time of day does your pain feel BEST →	Morning · As the day progresses · Afternoon · Evening · During the night · Stays consistent	
What time of day does your pain feel WORSE →	Morning · As the day progresses · Afternoon · Evening · During the night · Stays consistent	
What makes the pain feel better? →	Resting · Stretching · Ice · Medication · Chiropractic Care · Other:	
What makes the pain feel worse? →	Working · Standing · Twisting · Movement · Walking · Other:	

Genesis Chiropractic Wellness & Rehabilitation Center

HIPPA – ACKNOWLEDGEMENT OF RECEIPT
Notice of Privacy Practices

Printed **Patient** Name: ______________________________

Patient Birth Date: _________________________________

We at Genesis Chiropractic Wellness and Rehabilitation Center are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPPA Compliance Officer in person or by our main phone number. If you would like a copy of the Notice, **please ask.**

I hereby acknowledge that I have reviewed the HIPPA notice of Privacy Practice document.

____ __________________
Signature of patient **OR** patient's representative/parent Date

____
Printed name of patient **OR** patient's representative/parent

____
Relationship to patient

Consent to X-ray and Verification of Non-Pregnancy

I herby state that to the best of my knowledge I am not pregnant and am not actively trying to become pregnant. I also state that pregnancy is neither suspected nor confirmed at this time. I release Genesis Chiropractic Clinic Inc from any liability and authorize them to complete and radiology examination deemed necessary.

____
Patient (Parent or Guardian) Signature

____
Date

Genesis Chiropractic Wellness & Rehabilitation Center

INFORMED CONSENT

The Nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop” similar to the noise produced when a knuckle is “cracked,” and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or traction may also be used.
Possible Risks: As with any health care procedures, complications are possible following a chiropractic manipulation. Complications could conceivably include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.
Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as “rare” to “extremely rare”, statistically less often than complications from taking a single aspirin tablet..
Other treatment options which could be considered may include the following:
1. *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.
2. *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
3. *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
4. *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.
Unusual Risks: I have had the following unusual risks of my case explained to me:

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. 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 to treatment.

______________________________________ ____________________
Print Date

______________________________________ ____________________
Sign Date

****Consent to evaluate and adjust a minor child:** I, ______________________________ being the parent or legal guardian of _____________________________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

FEES AND PAYMENTS

Payment in full is due at the time services are rendered. We urge patients to be familiar with their chiropractic insurance benefits prior to appointment. Our office staff calls and verifies your insurance benefits if you need to be informed. Co pays and deductibles are due at time of service or your appointment may be rescheduled. If payment arrangements need to be made, please speak with our office staff to make payment arrangements. Billing your insurance company does not ensure payment, in cases of partial payment OR denial (unless stated otherwise by your insurance carrier) you are responsible for the remaining balance. You are responsible to inform our office of any changes to your insurance policy prior to your visit at our facility, not doing so can result in timely filing, in which the unpaid claim will become your responsibility

WELLNESS/MAINTENANCE CARE

Most insurance companies do not pay for maintenance care. Maintenance care is deemed **medically unnecessary** through insurance companies. Some verbiage your insurance company might use to describe medically unnecessary treatment is as follows:

- Treatment for a chronic condition if there is no reasonable expectation of improvement.
- Treatment to prevent a relapse or exacerbation of a condition (maintenance)
- Treatment dates over a 2-4 weeks interval
- Long term treatment for the same or similar condition

This notice is to inform you of possible non-covered services that you may be responsible for payment.

Any services deemed not medically necessary or unpaid by your insurance, will be discounted to our cash fees.

Upon signing this notice, I am declaring that I fully understand what has been described above and agree to pay all uncovered services. I fully understand that my insurance company will no longer be billed for treatment received and I cannot appeal to see if my insurance will pay for said treatment.

______________________________ ______________

Print Name Date

______________________________ ______________

Signature Date

Genesis Chiropractic Wellness & Rehabilitation Center

AUTHORIZED CONSENT FORM

I, ______________________________ authorize the following people to accompany and discuss any and all chiropractic treatment at Genesis Chiropractic Wellness and Rehabilitation Center, INC. This includes any information pertaining to medical treatment, diagnosis, prognosis, and calling and scheduling/canceling appointments.

1. _____________________________________ Relationship to Patient ________________
   Phone #____________________________

2. _____________________________________ Relationship to Patient ________________
   Phone #____________________________

____ __________________

*Signature *Date

Communication Method Disclosure and Consent

Genesis Chiropractic Clinic Inc communicates with its patient population in a variety of ways. We use information the patient or the patient's representative/parent provides, including landline phone, cell phone, text messaging, email, fax and U.S. mail.

By providing your **cell phone** number during the registration process, you

1. Consent and agree to receive telephone calls, text messages and other communications. These calls may be in regard to services received at Genesis Chiropractic Clinic Inc and your financial obligations related to those services. I understand this consent applies to all current and future medical service accounts for which I am the Guarantor.
2. Understand you may be charged for such calls, messages, or other communications by your wireless carrier.
3. I understand it is my responsibility to inform **Genesis Chiropractic Clinic Inc** if I choose to withdraw this permission. I can withdraw this consent at any time by contacting **Genesis Chiropractic Clinic Inc.**

I have read, fully understand, and agree to the above:

____ __________________

Print Patient OR Patient Representative/Parent Name Date

____ __________________

Sign Patient OR Patient Representative/Parent Name Date