



Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Initial \_\_\_\_\_

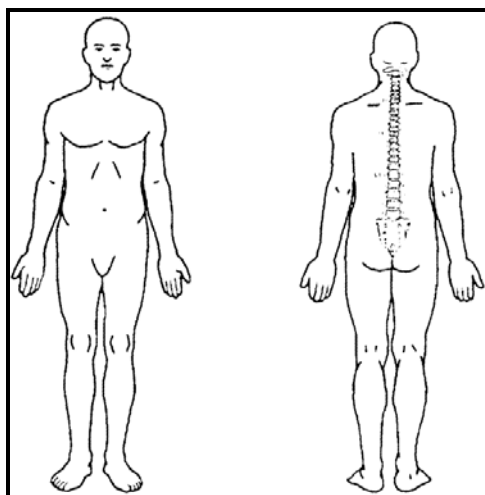
## Major Complaint Information

What is your major complaint(s)? \_\_\_\_\_

When did this symptom(s) begin? \_\_\_\_\_

If this is an injury, describe what happened? \_\_\_\_\_

Using the symbols provided in the Pain Index box, mark the areas of the illustrations below where you are experiencing pain, followed by a number from 1 to 10 indicating the extent of the pain. (1 being minor, 10 being severe)



## Pain Index

<b>D</b>	Dull Nagging Ache
<b>B</b>	Burning
<b>S</b>	Sharp / Stabbing
<b>N</b>	Numbness / Tingling

For example: if you are experiencing moderately severe burning pain in back of your neck, you should note a "B8" on the neck of the illustration

Have you experienced these symptoms before?  Yes  No When? \_\_\_\_\_

What aggravates this condition? \_\_\_\_\_

What decreases the symptoms / pain? \_\_\_\_\_

Have you seen another doctor for this condition?  Yes  No Doctor's Name: \_\_\_\_\_

Date consulted: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Does this condition interfere with your sleep?  Yes  No If so, how many times do you wake up in pain per night? \_\_\_\_\_In what position do you sleep?  Back  Side  StomachDo you sleep with a pillow?  Yes  No How many? \_\_\_\_\_Does heat affect the pain?  Yes  No If so, how? \_\_\_\_\_Does cold affect the pain?  Yes  No If so, how? \_\_\_\_\_Do you wear a heel lift?  Yes  No If so, which side  Right  LeftDoes it cause pain to cough, grunt, or sneeze?  Yes  No If so, where? \_\_\_\_\_

Check those activities below during which you experience difficulty or pain:

- Lying on back
- Lying on side
- Turning over in bed
- Lying flat on stomach
- Getting in/out of car
- Dressing Self
- Sexual Activity
- Pushing
- Pulling
- Reaching
- Kneeling
- Stooping
- Sitting
- Bending forward
- Bending backward
- Walking
- Standing for long periods
- Sneezing
- Coughing
- Other \_\_\_\_\_

**FILL OUT THE NEXT THREE SECTIONS AS THEY APPLY TO YOU**

Lower Back Pain

- Does pain radiate into the leg?  Yes  No Where: \_\_\_\_\_ Does pain radiate to the abdomen?  Yes  No
- Do you ever have impairment of bowel or urinary function?  Yes  No Explain: \_\_\_\_\_
- Do you have numbness or tingling into the legs?  Yes  No Explain: \_\_\_\_\_

Neck Pain

- If you have a neck injury, does it affect: (Check all that apply)  Hearing  Vision  Balance  Cause ringing in ears
- Do you hear grating sounds?  Yes  No Do you feel pressure behind your eyes?  Yes  No
- Does pain radiate into the arm?  Yes  No Where: \_\_\_\_\_
- Do you have difficulty lifting or turning your head:  Yes  No If so, in which direction  Right  Left  Up  Down

Headaches

- Do you get headaches?  Yes  No Frequency \_\_\_\_\_ Do you have a family history of headaches?  Yes  No
- Do you experience the following along with your headaches: Pain or cracking in your jaw?  Yes  No
- Abnormal blood pressure?  Yes  No  High  Low Nausea, Vomiting, or Visual disturbances?  Yes  No
- When was your last eye exam by a doctor?  1-6 months  6-12 months  1-2 years  over 2 years Results \_\_\_\_\_

If female, are you pregnant?  Yes  No  Not Sure If not sure, date of your last menstrual period: \_\_\_\_\_

List of all medications you are taking now, including over the counter medication. \_\_\_\_\_

Are you allergic to any medications?  Yes  No  Not Sure Please list: \_\_\_\_\_

Have you ever had any surgeries or hospitalizations?  Yes  No Please list:

Type of Hospitalization/Surgery:	Date:	Type of Hospitalization/Surgery:	Date:
_____	_____	_____	_____
_____	_____	_____	_____

Have you been x-rayed in the last 12 months?  Yes  No When?: \_\_\_\_\_

Have you ever been seen by a chiropractor before?  Yes  No Please list:

Name of Chiropractor:	Dates:	Name of Chiropractor	Dates:
_____	_____	_____	_____

Do you have a family physician?  Yes  No Name of physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

### Additional Complaints

Please check all additional complaints that you have at this time:

- |  |   |  |   |  |
|--|---|--|---|--|
| <input type="checkbox"/> Loss of Concentration   | <input type="checkbox"/> Neck Pain/Stiffness        | <input type="checkbox"/> Shortness of Breath     | <input type="checkbox"/> Cold Hands             | <input type="checkbox"/> Arthritis           |
| <input type="checkbox"/> Eyes Sensitive to light | <input type="checkbox"/> Upper Back Pain/ Stiffness | <input type="checkbox"/> Irritable               | <input type="checkbox"/> Cold Feet              | <input type="checkbox"/> HIV (Aids)          |
| <input type="checkbox"/> Memory Loss             | <input type="checkbox"/> Mid Back Pain/ Stiffness   | <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Jaw Pain               | <input type="checkbox"/> Other (Please List) |
| <input type="checkbox"/> Heavy Feeling of Head   | <input type="checkbox"/> Right/ Left Shoulder Pain  | <input type="checkbox"/> Depression              | <input type="checkbox"/> Hypertension _____     |  |
| <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Right/ Left Arm Pain       | <input type="checkbox"/> Insomnia                | <input type="checkbox"/> Diabetes _____         |  |
| <input type="checkbox"/> Ringing in Ears         | <input type="checkbox"/> Low Back Pain/ Stiffness   | <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Convulsions            |  |
| <input type="checkbox"/> Loss of Balance         | <input type="checkbox"/> Pins & Needles Arms/ Legs  | <input type="checkbox"/> Excess Perspiration     | <input type="checkbox"/> Allergies (list) _____ | (location) _____                             |
| <input type="checkbox"/> Loss of Smell           | <input type="checkbox"/> Right/ Left Leg Pain       | <input type="checkbox"/> Digestive Trouble _____ | <input type="checkbox"/> Numbness _____         |  |
| <input type="checkbox"/> Loss of Taste           | <input type="checkbox"/> Vision Problems            | <input type="checkbox"/> Nausea _____            | <input type="checkbox"/> Swelling _____         |  |
| <input type="checkbox"/> Pain Behind Eyes        | <input type="checkbox"/> Sinus Trouble              | <input type="checkbox"/> Vomiting _____          | <input type="checkbox"/> Cuts _____             |  |
| <input type="checkbox"/> Fainting                | <input type="checkbox"/> Nervousness                | <input type="checkbox"/> Diarrhea                | <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Bruising _____      |
| <input type="checkbox"/> Palpation               | <input type="checkbox"/> Chest Pain                 | <input type="checkbox"/> Constipation            | <input type="checkbox"/> Heart Disease          |  |

Do you have, or have you ever had, any diseases or medical problems not listed?  Yes  No If so, please list: \_\_\_\_\_

Have you ever had?  Motor Vehicle Injury  Sports Injury  Work Injury  Slip and Fall Injury

If yes, please explain: \_\_\_\_\_

Any additional information you would like the doctor to know about before beginning care at Great River Spine & Sport: \_\_\_\_\_

### Personal Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_

Mobile Phone: (    ) \_\_\_\_\_ Email: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F

Occupation: \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Work Address: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

Marital Status:  S  M  D  W Spouse's Name: \_\_\_\_\_ # of Children: \_\_\_\_\_

Please check one:  Smoker  Non-smoker  Tobacco user

How were you referred to Great River Spine & Sport? \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_

Address: \_\_\_\_\_

### Insurance Information

Insurance Company: \_\_\_\_\_

Phone #: \_\_\_\_\_ Address: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Birth Date: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

**IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS****Personal Injury**

Date of Accident: \_\_\_\_\_ Hour \_\_\_\_\_ AM \_\_\_\_\_ PM \_\_\_\_\_ Location \_\_\_\_\_  
 How did the accident occur? \_\_\_\_\_ Auto Collision \_\_\_\_\_ On-the-job-injury \_\_\_\_\_ Other: \_\_\_\_\_  
 Please describe the accident: \_\_\_\_\_  
 If work related, did you report the injury to your foreman or employer?  Yes  No  
 If work related, name and phone number of foreman or authorized person: \_\_\_\_\_  
 If auto accident were you  Driver  Passenger  Pedestrian  
 If auto collision, were you struck from  Behind  Right Side  Left Side  Front  Auto was parked  
 If auto accident, did your car strike the other(s) involved?  Yes  No  
 Or did the other car strike yours?  Yes  No  Undetermined Did your vehicle's airbags deploy?  Yes  No  
 Were you wearing a seat belt?  Yes  No Did anybody strike any objects in the car?  Yes  No  
 List Object(s) struck: \_\_\_\_\_ Lost work time  Yes  No If yes, date you returned to work \_\_\_\_\_  
 Do you have an attorney who has advised you in this case?  Yes  No Attorney Name: \_\_\_\_\_  
 Attorney's Address: \_\_\_\_\_

**Authorization & Assignment**

I authorize Great River Spine & Sport to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you. Great River Spine & Sport has an outside billing source.

I, the undersigned do hereby appoint Great River Spine & Sport authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand that Great River Spine & Sport uses an outside billing source to bill my insurance company.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. 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 me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Date: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_

**Informed Consent**

I hereby authorize physicians at Great River Spine & Sport to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Great River Spine & Sport responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

**Specific Risk Possibilities Associated with Chiropractic Care:**

**Soreness**— Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

**Soft Tissue Injury**— Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft-tissue injury.

**Rib Injury**— Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

**Physical Therapy Burns**— Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

**Stroke**— Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

**Other Problems**— There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

I you have any question concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Date: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_