PERSONAL INFORMATION
PLEASE PRINT

SCOTT CHIROPRACTIC & WELLNESS

First Name: _____ M.I.: ____ Last Name: _____ Preferred Name: _____

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

Birthdate: _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female SSN: _____/_____/_____

Primary Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

By providing my email address and cell phone number, I authorize my doctor to contact me via email/text with the email address and phone number provided.

Occupation: _____ Employer: _____

Status: (Check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Seperated

Race: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ I choose not to specify

Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Japanese ☐ Chinese ☐ German ☐ Other: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Family Physician Name: _____ City: _____ Phone: _____

How were you referred to Scott Chiropractic and Wellness? ☐ Patient: _____ ☐ Physician: _____

☐ Internet ☐ Sign ☐ Other: _____

ASSIGNMENT/ AUTHORIZATION/ RELEASE

☐ **Health Insurance:**

I certify that I, and/or my dependents, have insurance and assign directly to Scott Chiropractic and Wellness all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that “copays” are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider’s office may use my health care information and may disclose such information to the insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

☐ **Private Pay/ Cash:**

By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered.

☐ **Yes. I authorize Scott Chiropractic to store my credit card information on file, to use for payment for services rendered.**

☐ **No. I do not authorize Scott Chiropractic to store my credit card information on file.**

Name of person responsible for this account: _____

X _____ Date: _____

Signature of Patient, Parent or Legal Guardian (if minor)

Patient Name: _____

Date: _____

SCOTT CHIROPRACTIC & WELLNESS

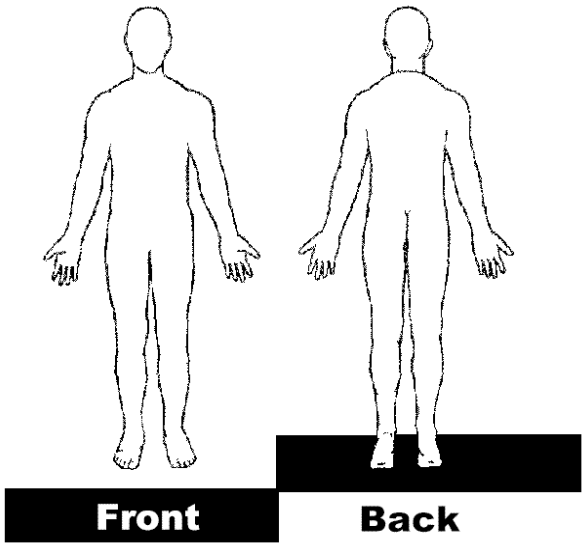
What is the reason for your visit today?

- ☐ **Headache**
- ☐ **Neck Pain**
- ☐ **Mid-Back Pain**
- ☐ **Low Back Pain**
- ☐ **OTHER:** _____

What caused this complaint(s)?: _____

When did this complaint begin?: ____/____/_____ Is it getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes & Goes

Have you had this or similar complaint in the past?: ☐ **Yes** ☐ **No** **If "Yes", when?:** _____



What does your complaint(s) feel like? Circle all that apply:

Sharp/ Dull/ Sore/ Stiff/ Tight/ Aching/ Spasms/ Throbbing/ Other:

_____

Please circle or make an "X" on the body diagram to the left

where you have pain or other symptoms.

Area for doctor's notes

On the scale below, please circle the severity of your main complaint right now:

No Pain — Moderate Pain — Worst Possible Pain

0	1	2	3	4	5	6	7	8	9	10

What area(s) does the pain radiate, shoot, or travel to? (if applicable):

_____

What aggravates this complaint? Circle all that apply: **Sitting/ Standing/ Walking/ Getting up from seat/ Walking stairs/ Inactivity/ Sleeping/ Physical Activity/ Exercise/ Movement/ Bending Forward/ Bending Backward/ Twisting/ Reaching/ Lifting Desk Work/ Sneezing/ Everything/ Unknown/ Other:**

_____

What relieves this complaint? Circle all that apply: **Sitting/ Standing/ Walking/ Resting/ Exercise/ Movement/ Stretching/ Massage/ Chiropractic/ Heat/ Ice/ Laying down/ Medication/ Nothing/ Unknown/ Other:** _____

How often do you experience your symptoms? ☐ 25% of the day ☐ 50% of the day ☐ 75% of the day ☐ 100% of the day

Timing of complaint: Check appropriate box: ☐ Morning ☐ As day progresses ☐ Afternoon ☐ Evening ☐ While sleeping ☐ During activities ☐ After activities ☐ Symptoms are constant and do not change ☐ Other: _____

With time are your symptoms: ☐ Improving ☐ Worsening ☐ Not changing

Have you seen other Doctors for this complaint? ☐ Yes ☐ No If "Yes", Please provide the following information:

Doctor's Name: _____ **Date consulted**: _____ **Diagnosis**: _____

Is this condition interfering with your: (Circle all that apply) Sleep/ Getting in or out of bed or chair/ Personal care/ Travel/ Work/ Recreation/ Lifting/ Walking/ Standing/ Daily routine/ Social activities/ Exercise/ Other: _____

Is your complaint interfering with your daily activities? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

X: _____ DATE: _____

Signature of Patient, Parent or Legal Guardian (if minor)

Patient Name: _____ **Date:** _____

HEALTH HISTORY

Please check **ALL** of the health conditions below that apply to you currently or in the past.

☐	Osteoarthritis / Degenerative Joint Disease	☐	Whiplash Injury Date of injury: _____	☐	Cancer Type: _____
☐	Asthma	☐	Headaches	☐	Anemia
☐	Diabetes ☐ Type I ☐ Type II Was your blood/lab work test for hemoglobin A1c > 9.0 %? ☐ Yes ☐ No ☐ Not Sure	☐	Pregnant # of weeks: _____ Due Date: _____ OB Doctor/Midwife: _____	☐	Diabetes (Check One) ☐ Type I ☐ Type II
☐	Anemia	☐	Migraines	☐	Heart problems / Stroke
☐	Cancer / Tumor	☐	Osteoporosis / Osteopenia	☐	High Blood Pressure
☐	Rheumatoid Arthritis	☐	Epilepsy / Seizures	☐	Genetic Disorders
☐	Depression / Anxiety	☐	Fibromyalgia / Chronic Fatigue	☐	Rheumatoid Arthritis
☐	Disc Herniation	☐	Genetic Disorders		
☐	High Blood Pressure / Hypertension	☐	Heart Disease / Stroke		

Family History
Mark **ALL** conditions that run in your family (Father, Mother, Sister, Brother)

PREVIOUS SURGERIES (LIST & DATE)

_____

SOCIAL HISTORY:

Height _____**ft** _____ **in.** **Weight** _____**lbs**

Do you exercise? ☐ Yes ☐ No **Times per week?:** _____ **Intensity:** ☐ Light ☐ Moderate ☐ Strenuous **Type:** _____

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former Smoker ☐ Never been a smoker **How many Years?:** _____

Do you drink alcohol? ☐ Yes ☐ No **How many drinks per week?:** _____ **How many years?:** _____

Do you drink caffeine? ☐ Yes ☐ No **How many drinks per day?:** _____ **What type?:** ☐ Coffee ☐ Tea ☐ Soft Drinks ☐ Energy Drinks

Do you take pain killers? ☐ Yes ☐ No How often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely What Type? ☐ Aspirin ☐ Ibuprofen ☐ Tylenol

☐ Other: _____

What do your work duties include? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Other: _____

Please describe your overall health right now? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

What is your stress level?: ☐ Mild ☐ Moderate ☐ High

Have you seen a CHIROPRACTOR in the PAST? ☐ Yes ☐ No

List current prescription medications. If there are NO current medications, CHECK HERE ⬭

Name of Prescription Medication	Dosage

SCOTT CHIROPRACTIC & WELLNESS

INFORMED CONSENT CHIROPRACTIC

I hereby request and consent to the performance of chiropractic examinations, adjustments, and any other associated procedures on me by Scott Chiropractic and Wellness. I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, strokes, and muscle spasms for a short period of time. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures.

I have had an opportunity to discuss the nature, purpose, and risks of chiropractic care and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed. I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present conditions) and for any future condition(s) for which I seek treatment.

Patient Name: _____ Date:_____

Signature of Patient: _____

INFORMED CONSENT MASSAGE THERAPY

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand and agree to abide by the therapist policies and will not hold Scott Chiropractic and Wellness or the therapist responsible for any personal injury or loss of property. I hereby give my consent to that treatment.

Patient Name: _____ Date:_____

Signature of Patient: _____

HIPAA

The undersigned does hereby acknowledge that he/she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations. The practice reserves the right to change the privacy policy as allowed by law. The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family?

YES / NO If **YES**, please name the members allowed:

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

CANCELLATION / NO SHOW POLICY

Our goal is to provide quality chiropractic/massage care in a timely manner. In order to do so we have implemented an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of chiropractic/massage care.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If it is necessary to cancel your scheduled appointment, we require that you call one working day in advance. Appointments are high in demand, and your early cancellation will give another person the possibility to have access to timely chiropractic/massage care.

To cancel an appointment, please call our office at (972) 540-5445. You may also cancel via email within 24 hours working day after office hours at **scottchiropracticandwellness@gmail.com** or through our patient portal.

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. If you are running late, please notify the office. **If a patient is 15 minutes past their scheduled time, we may have to reschedule your appointment.**

CANCELLATION / NO SHOW FEES FOR MISSED APPOINTMENTS:

ADJUSTMENT: $25 **MASSAGE: $50** **DRY NEEDLING: $50**

Patient Name: _____ **Date: _____**

Patient Signature: _____