# DIMOND CHIROPRACTIC

Date: _________________ PT NUM # ____________

Name: ____________________________________________________________________________________________________

First MI Last

Physical Address__________________________________________________ City, State, Zip:______________________________

Mailing Address__________________________________________________ City, State, Zip:______________________________

Home Phone:_____________________ Work Phone:_______________________ Cell Phone: _____________________________

Sex ___M ___ F Birth date: _________________ Age ____ Driver's License # & State:__________________________________

SSN:________________________________________ **Check one**: __ Married __ Single **# of children**:________

Employer:_____________________________________________________ Occupation:____________________________________

Spouse Name: __________________________________________Spouse Employer: ___________________________________

Emergency Contact:

Name_________________________________________Phone______________________________Relationship_______________

Who can we thank for referring you to our office: ___________________________________________________________________

Reason for consulting this office: ______________________________________________________________________________

Is this injury due to a work or auto accident?_______________________________ Date of Injury: ___________________________

**PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST**

Insurance Company:________________________________________________________ Phone Number____________________

Subscriber:______________________________ Date of Birth: _________________ Relationship to Subscriber: ______________

ID#________________________________________ Group#________________________________

Secondary Insurance Company:_________________________________ Phone Number_____________________

Subscriber:______________________________ Date of Birth: _________________ Relationship to Subscriber: ______________

ID#________________________________________ Group#___________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to me and my dependents. I also authorize Dimond Chiropractic Center to release any information required to process my claims. I also hereby authorize Dr. Shawn Woodmansee and whomever he may designate as assistants to administer care as deemed necessary.

Patient/Guardians Signature________________________________________________

**Privacy Practices**

I have been offered the Notice of Privacy Practices and I have been provided an opportunity to review it if needed.

Patient Name ___________________

_______________________________
Signature

Date of Birth ___________________

Date _________________________

# FINANCIAL POLICY

**PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED**: As a courtesy to our patients, we do allow other payment options within the guidelines of our office policy.

**CASH:** We accept cash, check, Debit, Visa, MasterCard, Discover and American Express. Payment for service is due at the time services are rendered, unless payment arrangements have been approved in advance. Returned checks are subject to a $15.00 service charge.

**GROUP INSURANCE**: Patients are responsible for payment in full at the time of visit, unless our office is able to verify chiropractic benefits. Dimond Chiropractic Center checks your benefits with the insurance companies; understand that the benefits quoted are neither a guarantee of payment nor a guarantee of benefits. They are subject to eligibility, deductible and available benefits are the time services are rendered. As a courtesy to you, we will submit all charges to your insurance company. It is important that you understand that your insurance is an arrangement between you and your insurance company. We do not bill Medicare insurance. You're personally responsible for payment of all charges, whether your insurance company pays or not. Co-pays are due at the time services are rendered, unless payment arrangements have been approved in advance.

**WORKERS' COMPENSATION**: Patients are required to fill out a REPORT OF OCCUPATIONAL INJURY OR ILLNESS with their employer. Once this is completed and verification has been made with the insurer, we will accept assignment.

**ACCIDENT AND PERSONAL INJURY (AUTO):** Patients are responsible for payment in full at the time of each visit unless our office is able to verify the claim number and Medical Payment coverage for the accident/injury. We do not bill third party insurance. If during the course of your treatment here your medical coverage is exhausted, payment arrangements must be made to keep your account current. If an attorney is retained, please let our office know immediately.

*If you have any questions or comments regarding our policy, we will be happy to assist you.*

__________________________________________________________________________

Patient's Signature Date

__________________________________________________________________________

Representative of Dimond Chiropractic Center Date

<u>Dimond Chiropractic Center</u>

Informed Consent for Chiropractic Treatment

Doctors of chiropractic, medical doctors, and physical therapist who use manual therapy are required to advise patients that there are or may be some risks associated with such treatment. In particular, you should note:

A) While rare, some patient have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments;
B) There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with neurological impairment, and may on rare occasion results in serious injury. The possibility of such injuries resulting from cervical spine adjustment is extremely remote;
C) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or spinal treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches, and other similar symptoms. Chiropractic care contributed to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Print Patient Name: ____________________

Patient or Guardian Signature: _________________

Date: ________________

Witness Signature:____________________

Date: _________________

## Patient History

Name_________________________________________________________________ Date______________________________

Have you ever received Chiropractic Care? Yes No
When, where, and for what condition ?

__________________________________________________________________________________________

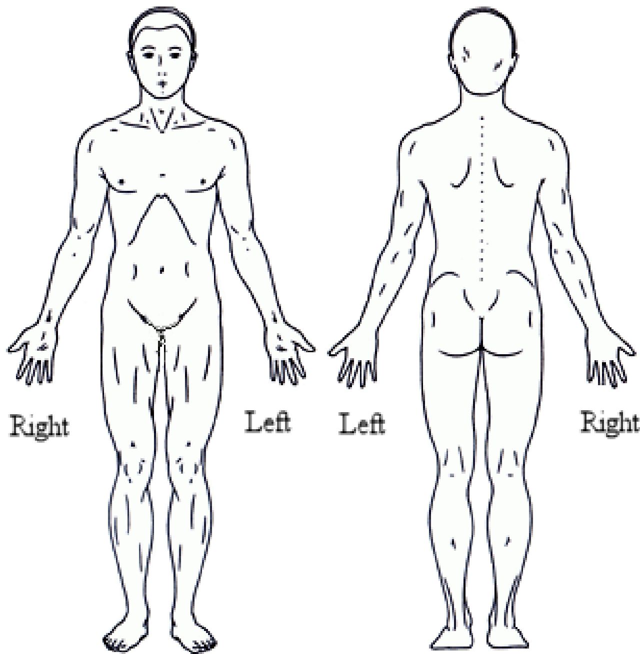
**People visit chiropractors for a variety of reasons and there are different levels of care. Please check the type of care you desire.**

Stage 1 ___ Pain Relief: Just get rid of the pain. Relief is short term
Stage 2 ___ Rehabilitation: Get rid of the pain, but then fix this problem so that it doesn't come back!
Stage 3 ___ Optimal Health: Get rid of the pain, fix the problem, and then put me on a preventive maintenance plan which includes diet, exercise and chiropractic care so that I stay as healthy as possible.
Stage 4 ___ Nutritional Health: I would be interested in spending money on an individualized nutritional program, tailored specifically to my needs.

| Please circle for each of the following: | | Patient Comment If answer is Yes | Chiropractor's Comments |
|---|---|---|---|
| **1. Growth and Development/ Childhood:** | | | |
| Were you breast fed? | Y N | ______________________ | ________________ |
| Health education? | Y N | ______________________ | ________________ |
| Childhood illnesses? | Y N | ______________________ | ________________ |
| Ear infections/ Colic/ Asthma? | Y N | ______________________ | ________________ |
| Attention Deficit? | Y N | ______________________ | ________________ |
| Antibiotics? | Y N | ______________________ | ________________ |
| Drugs, prescription, OTC, recreational? | Y N | ______________________ | ________________ |
| Surgery? | Y N | ______________________ | ________________ |
| Hospitalizations? | Y N | ______________________ | ________________ |
| Sports or other physical activities | Y N | ______________________ | ________________ |
| Injuries during sports? | Y N | ______________________ | ________________ |
| Auto accidents? | Y N | ______________________ | ________________ |
| Did you have other traumas? | Y N | ______________________ | ________________ |
| Did you ever break any bones? | Y N | ______________________ | ________________ |
| **2. Current Health Habits:** | | | |
| Did/do you smoke? | Y N | ______________________ | ________________ |
| Did/do you drink alcohol? | Y N | ______________________ | ________________ |
| Diet, do you eat healthy foods? | Y N | ______________________ | ________________ |
| Have you been in accidents/trauma? | Y N | ______________________ | ________________ |
| Have you had surgery? | Y N | ______________________ | ________________ |
| Drugs, prescription, OTC, recreational? | Y N | ______________________ | ________________ |
| Dental problems? | Y N | ______________________ | ________________ |
| Eye problems? | Y N | ______________________ | ________________ |
| Hearing problems? | Y N | ______________________ | ________________ |
| Exercise regularly? | Y N | ______________________ | ________________ |
| Did/do you have occupational stress? | Y N | ______________________ | ________________ |
| Drive? Daily time spent driving | Y N | ______________________ | ________________ |
| Physical stress? | Y N | ______________________ | ________________ |
| Emotional/Mental stress? | Y N | ______________________ | ________________ |
| Hobbies/Sports injuries? | Y N | ______________________ | ________________ |
| Do you sleep well, hours of sleep? | Y N | ______________________ | ________________ |
| Sleeping posture? O side O stomach O back | | ______________________ | ________________ |

**3. Symptoms and Present State of Health**
Present Complaint/Reason for Seeking Care in this Office:
Major__________________________________________________________________________________
Pain or Problem started on______________________________________________________________
Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other______________________
Does this pain shoot, radiate, or travel in your body? Where?_____________________________________
Are you experiencing numbness or tingling in any area of your body? Where?_____________________________
Since it began, is it: O Same O Better O Worst
What activities aggravate your condition/pain?______________________________________________

What activities lessen your condition/pain?___________________________________________________________________
Is this condition worse during certain times of the day?_______________________________________________________
Is this condition interfering with Work?__________ Sleep?__________Routine?_______Other?______________________
Is this condition progressively getting worse?_______________________________________________________________
Other Doctors seen for this condition_______________________________________________________________________
Any home remedies? ____________________________________________________________________________________
Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Using the symbols below, mark on the pictures where you feel pain.




| | |
|---|---|
| Numbness | = = = |
| Dull Ache | OOO |
| Burning | XXX |
| Sharp/Stabbing | / / / |
| Pins, Needles | + + + |
| Other ______ | ^ ^ ^ |

Please mark any of the following conditions or symptoms that you have now or have experienced:
Other Symptoms:

| | | |
|---|---|---|
| O Headaches | O Pain in Hands or Arms | O Chest Pains |
| O Neck Pain | O Numbness in Hands or Arms | O Heart Attack |
| O Sleeping Problems | O Pain in Legs or Feet | O High Blood Pressure |
| O Low Back Pain | O Numbness in Legs or Feet | O Stroke |
| O Nervousness | O Fatigue | O Cancer |
| O Tension | O Depression | O Painful Urination |
| O Irritability | O Lights Bother Eyes | O Diabetes |
| O Dizziness | O Loss of Memory | O Diarrhea |
| O Pain Between Shoulders | O Shoulder Pain | O Constipation |
| O Neck Stiff | O Sinus | O Stomach Upset |
| O Joint Swelling | O Shortness of Breath | O Heartburn/Reflux |
| O Fever | O Asthma | O Weight Loss |
| O Loss of Balance | O Allergies | O Loss of Smell or Taste |
| O Ringing in Ears | O Cold Hands | O Menstrual Cramps |
| O Jaw/TMJ Problems | O Cold Feet | O Menopause |

Are you under medical care for any condition?_________________________________________________________________
What Medications are you taking?_______________________________________________________How long?_____________
Have you had surgery? Y N What?_____________________________________________________ When?_________________
What side effects have you experienced from the drugs and surgery?______________________________________________
Females Only – Date last Menstrual Period began on________________________________ Are you possibly Pregnant?___________

**Is there a family History of:**

| | Heart Disease | Arthritis | Cancer | Diabetes | Other__________________ |
|---|---|---|---|---|---|
| Father's side | O | O | O | O | O |
| Mother's side | O | O | O | O | O |

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient Signature_________________________________________________________Date___________________________

# Dimond Chiropractic, LLC

Patient Name:______________________________ Date:__________________

Please review the following list of medical problems and mark any that apply to you now or in the past. Please go over the list carefully. Medical problems that do not seem related to your current situation could result in a serious complication if you do not let us know about them.

**Constitutional**
□ Recent weight gain: ____ lbs
□ Recent weight loss: ____ lbs
□ Fever or soaking sweats at night
□ Fatigue
□ Weakness/numbness of arms/legs
□ Headaches > 2 times per week
□ Difficulty walking
□ Loss of consciousness/convulsions

**Eyes**
□ Vision problems not corrected by glasses
□ Glaucoma
□ Eye lens implant
□ Eye prosthesis
□ Contact lenses

**Ear, Nose, Throat**
□ Chronic stuffy nose or nasal polyps
□ Frequent nose bleeds
□ Sinus problems
□ Hay fever allergies
□ Difficulty hearing
□ Ear infections
□ Hearing aids
□ Chronic sore throat or tonsillitis
□ Hoarseness
□ Difficulty swallowing
□ Dentures or partial plates
□ Capped teeth
□ Loose teeth
□ Orthodontic braces

**Cardiovascular**
□ Heart murmur
□ Prolapsed mitral valve
□ Heart peacemaker
□ Irregular heartbeat
□ Palpitations or rapid pulse
□ Fainting spells
□ Chest pain or angina on exertion
□ Chest pain or angina at night
□ Heart attack
□ Congestive heart failure
□ Swelling in feet or ankles
□ Shortness of breath lying flat
□ Shortness of breath at night
□ Blood Clots or pulmonary embolism
□ High blood pressure
□ Low blood pressure

**Respiratory**
□ Asthma or wheezing
□ Bronchitis
□ Emphysema
□ Pneumonia
□ Chronic cough
□ Change in amount of phlegm
□ Change in color of phlegm
□ Coughing up blood
□ Collapsed lung
□ Tuberculosis exposure
□ Blueness of your fingernails

**Gastrointestinal**
□ Kidney stones
□ Kidney infections
□ Kidney failure
□ Dialysis
□ Prostate problems
□ Bladder infections
□ Blood in urine
□ Difficulty urinating
□ Do you lose your urine at times

**Musculoskeletal**
□ Fractures or broken bones
□ Arthritis
□ Difficulty opening mouth wide
□ Scoliosis
□ Spinal column deformity

**Integumentary/Dermatologic**
□ Skin rash or sores
□ Itching
□ Color change, pigmentation, nodules
□ Pressure ulcers

**Neurologic**
□ Seizures or convulsions
□ Epilepsy
□ Stroke
□ Brain aneurysm or hemorrhage
□ Multiple sclerosis
□ Nerve Injury or numbness

**Psychiatric**
□ Depression
□ Anxiety or panic attacks
□ Mental disorder

**Endocrine**
□ Diabetes
□ Insulin use
□ Low blood sugar or hypoglycemia
□ Thyorid problems
□ Steroid use

**Allergic/Immunologic**
□ Herpes exposure
□ AIDS exposure
□ Street drug use

**Hematologic**
□ Abnormal bleeding problems
□ Anemia or low blood count
□ Blood transfusion
□ Hemophilia
□ Sickle cell anemia

**Lymphatic**
□ Swollen glands or masses in axillae, groin
□ Lymphedema

**Others**
□ Sexual problems
□ Muscular dystrophy
□ Myasthenia gravis
□ Malignant hyperthermia
□ Bad reaction to local anesthetic
□ Down Syndrome
□ Cancer or tumor
□ Chemotherapy
□ Radiation Therapy
□ Recent acute illness
□ Recent hospitalization
□ Recent Surgical operation

**For Women Only:**
Are you pregnant? □ Yes □ No
Are your menstrual periods normal?
□ Yes □No
□ Bleeding between periods
□ Bleeding after menopause
Number of pregnancies: _______
Date of last menstrual period: ______
Approx date of last pap smear: ______

Reviewed by: ____________________________ Date:________________________

# 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 clearly describes your current degree of difficulty.
**1**= "I can do it without any difficulty." **2**= "I can do it without much difficulty." **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 all, because of the pain." **NOTE: Only fill in areas that are affected.**

**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 and 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 | | Waking 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 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 | |

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

## Prior Symptom History

| **Prior Similar Symptoms** | **Has your history contributed to your current symptoms?** |
|---|---|
| ___ I have not had prior symptoms similar to my current complaints<br>___ My current complaints DID exist before, but have not been bothering me<br>___ My current complaints ALREADY existed and were worsened | ___ My history HAS contributed to my current symptoms.<br>___ My history HAS NOT contributed to my current symptoms.<br>___ I'm NOT SURE if my history has contributed to my current symptoms |
| My most recent prior symptoms (if applicable) occurred ____ months ago / years ago Or on: Date ______/____/_____ | |
| Write in below any other Prior Symptom History, not covered above: | |

Patients Signature: ________________________________________________ Date:_____________