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

Dimond Chiropractic Center

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: _____

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

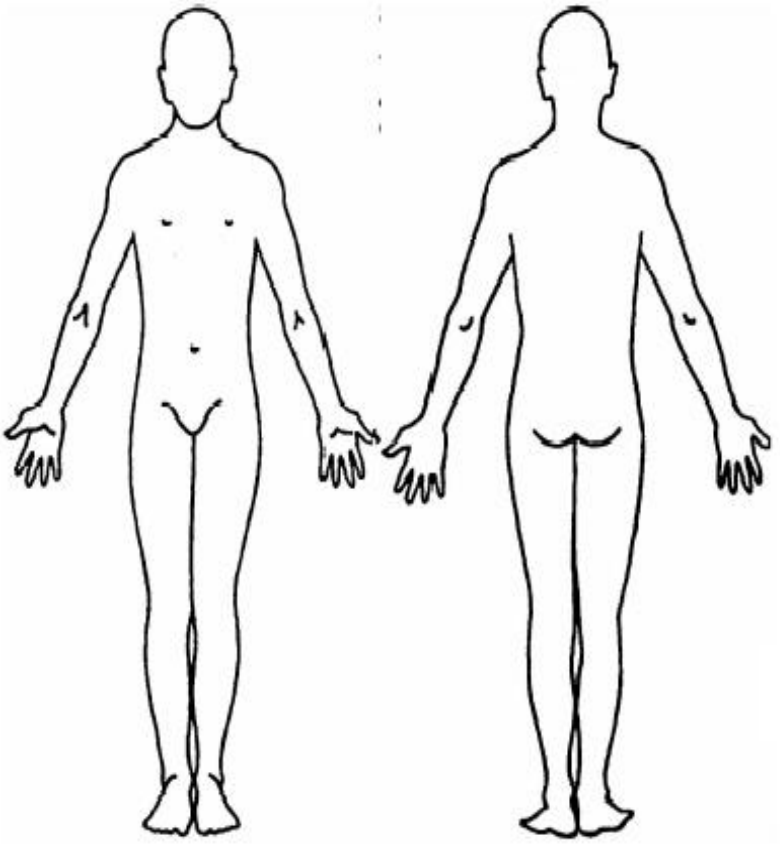
Prior Similar Symptoms	**Has your history contributed to your current symptoms?**
___ I have not had prior symptoms similar to my current complaints ___ My current complaints DID exist before, but have not been bothering me ___ My current complaints ALREADY existed and were worsened	___ My history HAS 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 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:_____

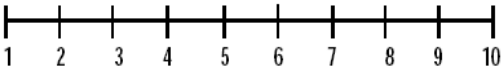
Name:_____ Date: _____

PAIN DIAGRAM

The information you provide on this form will be useful to Dr. Shawn and will help your exam go smoothly . If you are being evaluated for a painful condition, mark the drawings below according to how you feel today. Use the figure labeled “Back” for the pain on the back of your body. If you have any of the symptoms shown in the diagram, indicate where they are by writing in the following letter in the affected area. Please mark the level of pain you experiencing on the 1 to 10 scale. Ten as being the worst and one being no pain



BURNING = B
STABBING = S
PINS & NEEDELS = P
ACHING = A
NUMBNESS = N



WORKER'S COMPENSATION QUESTIONAIRE

Please answer all questions completely

Name_____ **Date**_____

Occupation when injured_____ **Date of injury** _____ **Time of injury** _____ **AM PM**
Employers Name _____ **Employers Phone Number** _____
Employers Address _____**City**_____ **State** _____ **Zip**_____
Employer Insurance Company_____ **Policy #** _____
Mailing Address _____ **City**_____ **State** _____ **Zip**_____
Please Explain in detail how your accident happened:

_____

_____

_____

Did you report the injury to your foreman or employer? Yes ___ No ___
Did he / she (they) recommend care at our clinic? Yes ___ No ___
List the extent of the injuries as you know them:

_____

_____

_____

Did you continue to work after the accident? Yes ___ No ___
Before the injury were you capable of working on an equal basis with others your age? Yes ___ No ___
Have you lost any days of work? Yes ___ No ___ Dates: _____
Since the injury, are your symptoms : ___ Improving ____ Getting worse ___ Same
Did you consult another doctor? ___ Yes ___ No
If so, give doctor's name:_____ **___D.C. ___ M.D. ___ D.O. ___ D.O.S**
Doctor's Diagnosis_____
What treatment's did you receive? _____
How often did you see the doctor? _____
Have you been using home remedies? ___ Yes ___ No If so, what, and were they effective? _____

_____

Have you ever injured this area before? ___ Yes ___ No If so, when? _____
If injured before did you lose time from work? Yes ___ No ___
If you lost time from work with injuries prior to this injury, give name of doctor (s) consulted:

_____

Have you ever been involved in any other type of accident, fall, or had broken bone, etc ? Please give brief description

_____

_____

Do any other diseases or accidents affect your employment? Yes ___ No___ If so, explain :

_____

In your work do you have to favor any part of your body? Yes ___ No ___ If so, explain:

_____

Have you ever had a Worker's Compensation claim before? Yes ___ No ___
Have you been contacted by an insurance adjuster or company representative regarding this claim? Yes ___ No ___
Name of Worker's Compensation Insurance Company: _____
Name of your insurance adjustor: _____

Have you retained an attorney? Yes ___ No ___ Litigation? Yes ___ No ___ Maybe ___
If so, name and address_____