

Simply In Demand Chiropractic

-Introduction Patient Case History-

Full Name: _____ **Preferred Name:** _____ **Today's Date:** _____

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

Cell: _____ **Home:** _____ **Work:** _____

Email: _____

Gender: ☐ Female ☐ Male **Date of Birth:** _____ **Social Security #:** _____

Preferred Method of Contact: ☐ Text ☐ Email **Call -** ☐ Cell ☐ Home ☐ Work **Other:** _____

Referred by: _____

Relation: ☐ Family ☐ Friend ☐ Co-worker ☐ Doctor ☐ Other: _____

Race & Ethnicity: (Choose up to 2)

- ☐ African American / Black
- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ White
- ☐ Decline

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Other: _____
- ☐ Decline

Emergency Contact Information

Name: _____ **Primary Care Doctor:** _____

Home: _____ **Mobile:** _____ **Doctor's Phone:** _____

Relationship: ☐ Child ☐ Parent ☐ Spouse ☐ Other: _____

Financial Information

Is today's visit the result of an accident?

☐ No ☐ Auto ☐ Work ☐ Other: _____

Where would you like statements sent?

☐ Self ☐ Other (Details below)

Will we be working with insurance? ☐ No ☐ Yes

Name: _____ **Phone:** _____

Primary: _____ **ID#:** _____

Address: _____

Secondary: _____ **ID#:** _____

Email: _____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature: _____ **Date:** _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

History Of Present Illness

Major Complaint: _____

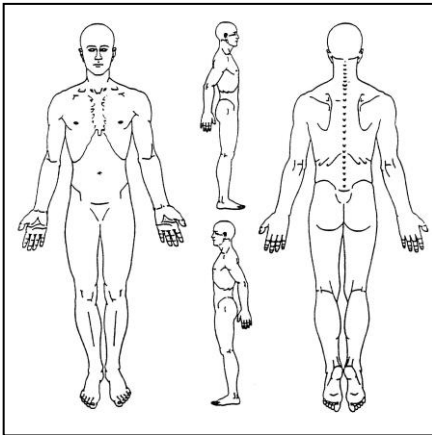
Secondary Complaints: _____

When did it start? (month/year) _____ What happened? _____

Which daily activities are being affected by this condition? _____

Major Complaint

Location of Symptoms and Radiation



P – Pain / N – Numb / S – Spasm
T – Tender / H - Hypoesthesia

Grade Intensity/Severity:

- ☐ Non (0/10)
- ☐ Mild (1-2/10)
- ☐ Mild-Moderate (2-4/10)
- ☐ Moderate (4-6/10)
- ☐ Moderate-Severe (6-8/10)
- ☐ Severe (8-10/10)

Frequency:

- ☐ Off & On
- ☐ Constant

Quality:

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy
- ☐ Dull
- ☐ Stiff & Sore
- ☐ Other: _____

Does it radiate?

- ☐ No ☐ Yes (Please indicate on drawing)

Improves with:

- ☐ Ice
- ☐ Heat
- ☐ Movement
- ☐ Stretching
- ☐ OTC Medications
- ☐ Other: _____

Worsens with:

- ☐ Sitting
- ☐ Standing/Walking
- ☐ Lying Down/Sleeping
- ☐ Overuse/Lifting
- ☐ Other: _____

Previous Treatment:

- ☐ None
- ☐ Chiropractor _____
- ☐ Medical Doctor _____
- ☐ Physical Therapy _____
- ☐ ER/Urgent Care _____
- ☐ Orthopedic _____
- ☐ Other: _____

Previous Diagnostic Testing:

- ☐ None
- ☐ Xrays
- ☐ MRI
- ☐ CT
- ☐ Other: _____

Women: Are you pregnant?

- ☐ No Last period: _____
- ☐ Yes Due Date: _____

Present Illness Comments:

Prescription Medications & Supplements:

If YES (List – name, dosage, frequency)

Allergies to Medications (please list)

☐ No known allergies

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Name: _____

Patient or Guardian Signature: _____ Date: _____

Past, Family and Social History

Have you ever had any of the following? (Please select all that apply and use the comments to elaborate)

Illnesses:

- ☐ Asthma
- ☐ Autoimmune Disorder: _____
- ☐ Blood Clots
- ☐ Cancer: _____
- ☐ CVA/TIA (stroke)
- ☐ Diabetes
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Other: _____
- _____
- _____

Hospitalizations: (non-surgical with date)

Surgeries: (type & date)

- ☐ Cancer _____
- ☐ Orthopedic
- Shoulder – R/L _____
- Elbow/Forearm – R/L _____
- Wrist/Hand – R/L _____
- Hip – R/L _____
- Knee – R/L _____
- Ankle/Foot – R/L _____
- ☐ Spinal Surgery
- Neck: _____
- Back: _____
- ☐ Other: _____
- _____
- _____
- _____

Medical History Comments:

Injuries:

- ☐ Back Injury
- ☐ Broken Bones:
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Falls
- ☐ Other: _____

Family History (Please mark X to all that apply and use comments to elaborate)

☐ Unknown ☐ Unremarkable

	Mother	Father	Sibling 1	Sibling 2	Sibling 3	Child 1	Child 2	Child 3
Gender	F	M						
Age at death (if deceased)								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

Family History Comments:

Social and Occupational History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other **Number of children:** _____

Employed: ☐ No ☐ Yes – Occupation: _____ **Student?** ☐ Full Time ☐ Part Time

Highest Level of Education: ☐ High School ☐ College Grad ☐ Post Grad ☐ Other: _____

Smoking/Tobacco Use: If current smoker, amount = _____ ☐ Every Day ☐ Some Days ☐ Former ☐ Never

Alcohol Use: ☐ Every Day ☐ Weekly ☐ Occasionally ☐ None

Caffeine Use: ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drinks ☐ None

Exercise: ☐ Daily ☐ 3-4xs/week ☐ 2-3xs/week ☐ Rarely ☐ Never

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Name: _____

Patient or Guardian Signature: _____ Date: _____

☐ Fever

☐ Fatigue

☐ Other: _____

☐ Difficulty Breathing

☐ Cough

☐ Other: _____

☐ Joint Pain/Stiffness/Swelling

☐ Muscle Pain/Stiffness/Spasms

☐ Broken Bones: _____

☐ Other: _____

☐ Eye Pain

☐ Blurred or Double

☐ Sensitivity to Light

☐ Other: _____

☐ Dizziness or Lightheaded

☐ Convulsions or Seizures

☐ Tremors

☐ Other: _____

☐ Frequent or Recurrent Headaches

☐ Ear – Ache/Ringing/Drainage

☐ Hearing Loss

☐ Sensitivity to Loud Noises

☐ Sinus Problems

☐ Sore Throat

☐ Other: _____

☐ Nervousness/Anxiety

☐ Depression

☐ Sleep Problems

☐ Memory Loss or Confusion

☐ Other:

☐ Infertility

☐ Recent Weight Change

☐ Eating Disorder

☐ Other: _____

☐ Frequent or Painful Urination

☐ Blood in Urine

☐ Incontinence or Bed Wetting

☐ Painful or Irregular Periods

☐ Other: _____

☐ Excessive Thirst or Urination

☐ Cold Extremities

☐ Swollen Glands

☐ Other:

- ☐ Loss of Appetite
- ☐ Blood in Stool or Black Stool
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____

☐ Rash or Itching

☐ Change in Skin, Hair or Nails

☐ Non-healing Sores or Lesions

☐ Change of Appearance of a Mole

☐ Breast Pain, Lump or Discharge

☐ Other:

☐ Chest Pains/Tightness

☐ Rapid or Heartbeat Changes

☐ Swelling of Hands, Feet or Ankles

☐ Other: _____

☐ Food Allergies

☐ Environmental Allergies

☐ Other: _____

Patient or Guardian Name: _____

Patient or Guardian Signature: _____ Date: _____



chiropractic • acupuncture • animal adjusting
physical medicine modalities & therapeutic procedures

Dr. Kelli J. Meier, D.C.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including acupuncture with or without needles as well as various modes of physical medicine modalities & therapeutic procedures, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here Dr. Kelli J. Meier, D.C. and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Kelli J. Meier, D.C. and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

To be completed by the patient's representative, if necessary,
(e.g.: if the patient is a minor or is physically or mentally incapacitated)

Print Patient's Name

Date

Print Patient's Name

Date

Signature of Patient

Print Name of Representative

Signature of Representative

This form should be maintained in the patient's health record.
43610 N. Acadia Ct, New River, AZ 85087

Simply In Demand Chiropractic, LLC

Pinnacle C.O.P. Manual-1.0

Revised 01.01.2015

Patient Name: _____ **D.O.B.** _____ **Date:** _____

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation and examination on the above.

AUTHORIZATION FOR X-RAY WITH RELEASE: By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to be paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliged to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGEMENT: By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

Signature of Patient:

Signature of Parent or Guardian:

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected our ability to manage everyday activities.

For each item below, **please circle the number which most closely describes your condition right now.**

Pain Intensity	<div>0</div> No Pain	<div>1</div> Mild Pain	<div>2</div> Moderate Pain	<div>3</div> Severe Pain	<div>4</div> Worst Possible Pain
Sleeping	<div>0</div> Perfect sleep	<div>1</div> Mildly disturbed sleep	<div>2</div> Moderately disturbed sleep	<div>3</div> Greatly disturbed sleep	<div>4</div> Totally disturbed sleep
Personal Care (washing, dressing, etc.)	<div>0</div> No pain; no restrictions	<div>1</div> Mild pain; no restrictions	<div>2</div> Moderate pain; need to go slowly	<div>3</div> Moderate pain; need some assistance	<div>4</div> Severe pain; need 100% assistance
Travel (driving, etc.)	<div>0</div> No pain on long trips	<div>1</div> Mild pain on long trips	<div>2</div> Moderate pain on long trips	<div>3</div> Moderate pain on short trips	<div>4</div> Severe pain on short trips
Work	<div>0</div> Can do usual work plus unlimited extra work	<div>1</div> Can do usual work; no extra work	<div>2</div> Can do 50% of usual work	<div>3</div> Can do 25% of usual work	<div>4</div> Cannot work
Recreation	<div>0</div> Can do all activities	<div>1</div> Can do most activities	<div>2</div> Can do some activities	<div>3</div> Can do a few activities	<div>4</div> Cannot do any activities
Frequency of Pain	<div>0</div> No pain	<div>1</div> Occasional pain; 25% of the day	<div>2</div> Intermittent pain; 50% of the day	<div>3</div> Frequent pain; 75% of the day	<div>4</div> Constant pain; 100% of the day
Lifting	<div>0</div> No pain with heavy weight	<div>1</div> Increased pain with heavy weight	<div>2</div> Increased pain with moderate weight	<div>3</div> Increased pain with light weight	<div>4</div> Increased pain with any weight
Walking	<div>0</div> No pain; any distance	<div>1</div> Increased pain after 1 mile	<div>2</div> Increased pain after ½ mile	<div>3</div> Increased pain after ¼ mile	<div>4</div> Increased pain with all walking
Standing	<div>0</div> No pain after several hours	<div>1</div> Increased pain after several hours	<div>2</div> Increased pain after 1 hour	<div>3</div> Increased pain after ½ hour	<div>4</div> Increased pain with any standing

Name _____

Signature _____

Date _____

ID/SS# _____

Plan ID _____

Total Score _____