

PAIN RELIEF CENTER NEW PATIENT FORM

Case #: _____

Welcome to our office! In order to help you, we need to gather information about you and your condition(s). Please complete these forms to completion. Please print neatly. And please sign and date each page at the bottom (in the designated areas). Thank you.

SECTION 1: ABOUT YOU

Patient's Name: _____		Today's Date: _____	
Date of Birth: _____	Age: _____	Sex: _____	Social Security Number: _____ / _____ / _____
Drivers License #: _____		Primary Care Physician: _____	
Who May We Thank For Referring You? _____			
Home Address: _____			
Home phone #: _____		Work phone #: _____	
Cell phone #: _____		E-mail address: _____	
Occupation: _____		Employer: _____	
Marital Status: Married / Divorced / Single / Widowed			
Spouse's Name: _____		Spouse's Occupation: _____	
How many children do you have? _____			
In event of emergency who should we contact? _____			
Relationship: _____		Phone #: _____	

SECTION 2: INSURANCE INFORMATION

Name of Insured: _____		Date of Birth of Insured: _____	
Patient's Relationship To Insured: _____		Insured's Employer: _____	
Primary Insurance: _____	Policy #: _____	Group #: _____	
Secondary Insurance: _____	Policy #: _____	Group #: _____	

PATIENT SIGNATURE _____ DATE _____

SECTION 3: DESCRIPTION OF HEALTH CONCERN

Our ability to draw effective conclusions about your present state of health and how to improve it depends significantly on your ability to respond thoughtfully and accurately to the questions posted in the written questionnaire as well as by the doctor during your consultation. The doctor will review this questionnaire with you during your initial consultation. Information contained in this questionnaire and obtained during your initial visit consultation are held in strict confidentiality.

Please carefully consider each question. Your thoughtful consideration will enhance the doctor's efficiency and will provide for a more effective use of your consultation time. There are usually a few questions that do not apply to you or for which you will not know the answers. If so, leave these blank for the time being and proceed from there. If you need more room for a particular question, please use the back or additional sheets. Thank you for your time.

Please check the **primary reason for seeking care from our practice and Dr. Group**

- I'd like to resolve a chronic (on-going) health condition/concern. Specifically, (*name your concern here*):
- I'd like to take care of a recent health concern; specifically it is:
- I'm seeking a knowledgeable and supportive health practitioner to manage all of my health concerns including:
- Other – please describe the nature of your health concern(s):

If this involves a specific health condition, please describe it in detail. List the very first time that you noticed the condition and describe carefully any factors that you suspect may have played a role in its onset and perpetuation. Please describe what makes it feel better and what makes it feel worse (aggravates the problem). Please list every detail possible and give the doctor the opportunity to distinguish what may or may not be relevant to your case.

SECTION 4: LOCATION OF SYMPTOMS

Please indicate any areas of discomfort or pain on the body chart below. Mark the areas where you feel the described sensations using the following symbols. Please include all affected areas and mark areas of radiation (traveling pain).

Pain = PPP

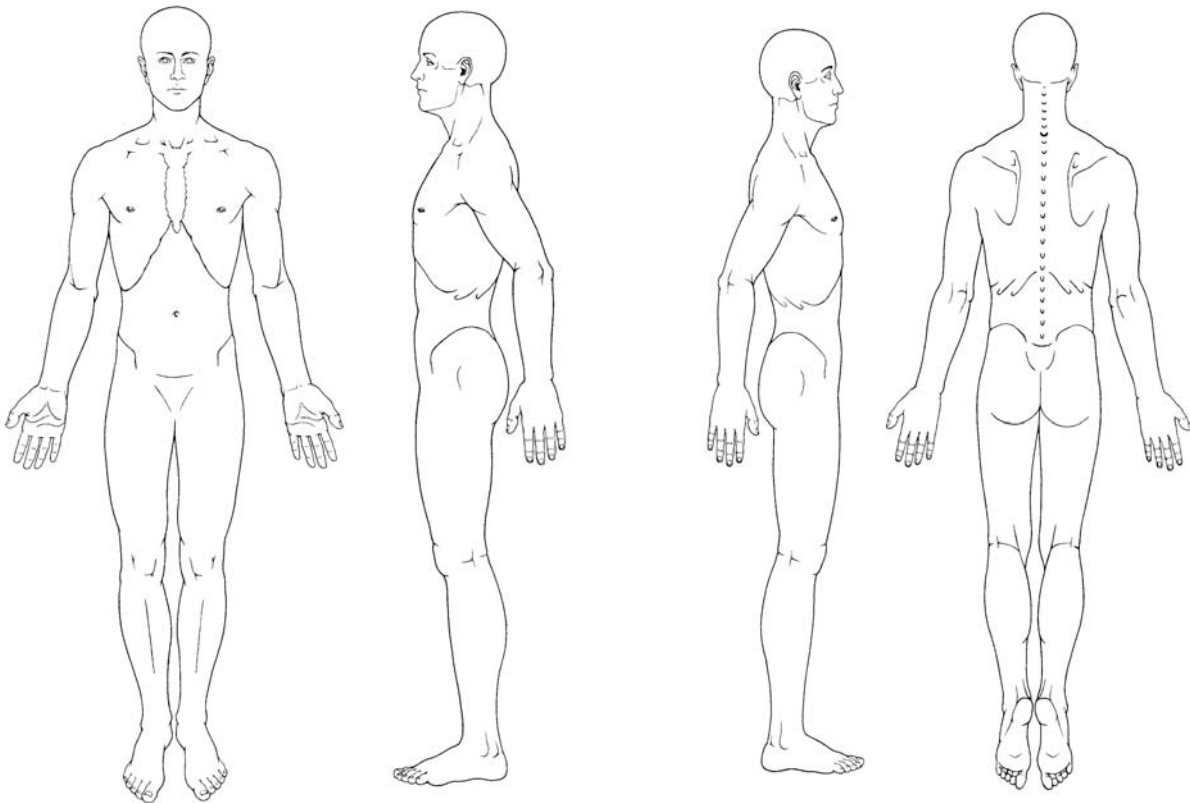
Numbness = NNN

Burning = BBB

Tingling = TTT

Cramping = CCC

Radiating Pain = / / / / / / / /



SECTION 5: QUALITY OF PAIN & SYMPTOMS

How would you describe the quality of the pain (at rest)?

Dull/achy Sharp/stabbing Burning Throbbing Electrical Boring

How would you describe the quality of the pain (during motion)?

Dull/achy Sharp/stabbing Burning Throbbing Electrical Boring

PATIENT SIGNATURE _____ DATE _____

SECTION 6: SEVERITY OF PAIN & SYMPTOMS

Please **CIRCLE** on the lines below to indicate the intensity of your pain:

1. Right now: No Pain 0__1__2__3__4__5__6__7__8__9__10 Worst Possible Pain
2. Average: No Pain 0__1__2__3__4__5__6__7__8__9__10 Worst Possible Pain
3. At Worst: No Pain 0__1__2__3__4__5__6__7__8__9__10 Worst Possible Pain

SECTION 7: TIMING & FREQUENCY OF SYMPTOMS

How frequently do you experience these symptoms?

- | | |
|---|--|
| <input type="checkbox"/> 100% of the time | <input type="checkbox"/> 50% of the time |
| <input type="checkbox"/> 90% of the time | <input type="checkbox"/> 40% of the time |
| <input type="checkbox"/> 80% of the time | <input type="checkbox"/> 30% of the time |
| <input type="checkbox"/> 70% of the time | <input type="checkbox"/> 20% of the time |
| <input type="checkbox"/> 60% of the time | <input type="checkbox"/> 10% of the time |

SECTION 8: PRIOR TREATMENTS & THERAPIES

What have you already tried to resolve your problem(s)?

- Over The Counter Drugs
- Prescription Strength Drugs
- Physical Therapy
- Surgery
- Chiropractic
- Massage Therapy
- Acupuncture
- Nutritional Supplements
- Other _____

What were the results of these treatments? _____

PATIENT SIGNATURE _____ DATE _____

SECTION 9: MEDICAL HISTORY

Check any of the symptoms you have noticed (= previously, = now)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Low Back Pain or Stiffness | <input type="checkbox"/> <input type="checkbox"/> Auto Accidents | <input type="checkbox"/> <input type="checkbox"/> Vision / Eye Problems | <input type="checkbox"/> <input type="checkbox"/> Sports Injuries |
| <input type="checkbox"/> <input type="checkbox"/> Mid Back Pain or Stiffness | <input type="checkbox"/> <input type="checkbox"/> H / L Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Ear Problems | <input type="checkbox"/> <input type="checkbox"/> Frequent Colds / Flus |
| <input type="checkbox"/> <input type="checkbox"/> Upper Back Pain or Stiffness | <input type="checkbox"/> <input type="checkbox"/> Work Injuries | <input type="checkbox"/> <input type="checkbox"/> Nose / Sinus Problems | <input type="checkbox"/> <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> <input type="checkbox"/> Neck Pain / Stiffness | <input type="checkbox"/> <input type="checkbox"/> Other Accidents / Falls | <input type="checkbox"/> <input type="checkbox"/> Throat Problems | <input type="checkbox"/> <input type="checkbox"/> Female Problems / PMS |
| <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> <input type="checkbox"/> Fractured Bones | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> <input type="checkbox"/> Migraine | <input type="checkbox"/> <input type="checkbox"/> Sore Achy Muscles | <input type="checkbox"/> <input type="checkbox"/> Allergies | <input type="checkbox"/> <input type="checkbox"/> Impotence |
| <input type="checkbox"/> <input type="checkbox"/> Pain radiating down arm(s) | <input type="checkbox"/> <input type="checkbox"/> Tiredness / Fatigue | <input type="checkbox"/> <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> <input type="checkbox"/> Pain w/ coughing |
| <input type="checkbox"/> <input type="checkbox"/> Numbness / Tingling Arm(s) | <input type="checkbox"/> <input type="checkbox"/> Dizziness | <input type="checkbox"/> <input type="checkbox"/> Heart Problems | <input type="checkbox"/> <input type="checkbox"/> Pain w/ sneezing |
| <input type="checkbox"/> <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> <input type="checkbox"/> Fainting | <input type="checkbox"/> <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> <input type="checkbox"/> Pain at stools |
| <input type="checkbox"/> <input type="checkbox"/> Shoulder Pain / Stiffness | <input type="checkbox"/> <input type="checkbox"/> Stress | <input type="checkbox"/> <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> <input type="checkbox"/> Elbow Pain / Stiffness | <input type="checkbox"/> <input type="checkbox"/> Tension | <input type="checkbox"/> <input type="checkbox"/> Intestine Problems | <input type="checkbox"/> <input type="checkbox"/> Cancer |
| <input type="checkbox"/> <input type="checkbox"/> Wrist / Hand Pain or Stiffness | <input type="checkbox"/> <input type="checkbox"/> Nervousness | <input type="checkbox"/> <input type="checkbox"/> Colorectal Problems | <input type="checkbox"/> <input type="checkbox"/> Restricts Exercise |
| <input type="checkbox"/> <input type="checkbox"/> Hip Pain or Stiffness | <input type="checkbox"/> <input type="checkbox"/> Irritability | <input type="checkbox"/> <input type="checkbox"/> Liver / Gall Bladder | <input type="checkbox"/> <input type="checkbox"/> Unable to Work |
| <input type="checkbox"/> <input type="checkbox"/> Pain radiating down leg(s) | <input type="checkbox"/> <input type="checkbox"/> Anxiety | <input type="checkbox"/> <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> <input type="checkbox"/> Poor Diet |
| <input type="checkbox"/> <input type="checkbox"/> Knee Pain or Stiffness | <input type="checkbox"/> <input type="checkbox"/> Concentration | <input type="checkbox"/> <input type="checkbox"/> Diabetes / Hypoglycemia | <input type="checkbox"/> <input type="checkbox"/> Inadequate Water Intake |
| <input type="checkbox"/> <input type="checkbox"/> Ankle/Foot Pain or Stiffness | <input type="checkbox"/> <input type="checkbox"/> Mood Disorders | <input type="checkbox"/> <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> <input type="checkbox"/> Inadequate Exercise |
| <input type="checkbox"/> <input type="checkbox"/> Trouble Walking | <input type="checkbox"/> <input type="checkbox"/> Depression | <input type="checkbox"/> <input type="checkbox"/> Skin Problems | <input type="checkbox"/> <input type="checkbox"/> No Energy |
| <input type="checkbox"/> <input type="checkbox"/> Restricts Daily Activity | <input type="checkbox"/> <input type="checkbox"/> Memory Loss | <input type="checkbox"/> <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> <input type="checkbox"/> Other _____ |

Please list all hospitalizations and surgeries (with dates): _____

Please list all known allergies: _____

Please list all traumas (sports injuries, automobile accidents, slips & falls): _____

Do you have any implants, surgical hardware, pacemakers or metallic sutures? Yes / No

[Females Only]

Are you pregnant? Yes / No Date of the start of your last menstrual cycle: _____

Have you ever been diagnosed with: Cancer Diabetes Cardiovascular Disease
 Auto-Immune Disease Endocrine Problems Gastrointestinal Problems
 Skin Problems Vision Problems Blood Clotting Disorders Emotional Problems
 Neurological Problems Liver Problems Kidney Problems Urinary Problems

PATIENT SIGNATURE _____ DATE _____

SECTION 9: MEDICAL HISTORY (continued)

Have you experienced any unintentional weight loss? Yes / No

Please list all medications you're taking: _____

Please list all dietary supplements you're taking: _____

How many glasses of water (per day) do you drink? _____

How many times per week do you exercise? _____

Do you have at least one bowel movement every day? Yes / No

Please mark an "X" on the line below to indicate your average energy levels:

No Energy (Always Tired) _____ Constant High Energy

Please mark an "X" on the line below to indicate your average stress levels:

Way Over Stressed _____ No Stress At All

Please mark an "X" on the line below to grade how you'd rate the quality of your diet:

Poor _____ Perfect (nothing but health foods)

Please mark an "X" on the line below to grade your sleeping habits:

Inadequate Restful Sleep _____ Abundant Restful Sleep

SECTION 10: SOCIAL HISTORY

Do you smoke? Yes / No If yes, how many packs per week? _____

Do you drink alcohol? Yes / No If yes, how many drinks per day? _____ X per week _____

Do use recreational drugs? _____

What are your favorite pastimes? _____

Do you have any hobbies and if yes, what are they? _____

Average number of hours per day watching TV: _____

Average number of hours per day on the internet: _____

Number of minutes per day you spend exercising: _____

How has your current condition(s) affected your ability to engage in your favorite pastimes? _____

SECTION 11: FAMILY HEALTH HISTORY

Use the following key: **M** = Mother, **F** = Father, **B** = Brother, **S** = Sister, **GM** = Grandmother
GF: Grandfather, **A** = Aunt, **U** = Uncle, **C** = Cousin

Allergies	_____	Digestion Problems	_____
Alzheimer's	_____	Genetic Disorders	_____
Asthma	_____	Heart Disease	_____
Auto-Immune Disease	_____	Gluten Sensitivity	_____
Cancer	_____	Muscular Dystrophy	_____
Celiac Disease	_____	Osteoarthritis	_____
Crohn's Disease	_____	Parkinson's	_____
Depression	_____	Thyroid Disorders	_____
Diabetes	_____	Weight Problems	_____

PATIENT SIGNATURE _____ DATE _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of chiropractic treatment:

The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", and you may feel movement of the joint. **This is simply a release of gas from the joint.** Various other therapy procedures, such as hot or cold packs, electric muscle stimulation, ultrasound, cold laser or spinal decompression may also be used.

Possible Risks - As with any health care procedure, complications are possible following a chiropractic manipulation or therapy procedure. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring : The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of Cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to therapy procedures is also considered "rare". If Dr. Group decides that Spinal Decompression is recommended he will explain these potential risks in a separate consent form.

Other treatment options which could be considered - may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated : Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult. In the case of moderate to severe disc injuries, delaying conservative care can result in nerve damage and may potentiate the need for invasive procedures such as spinal surgery.

Unusual risks - I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment and therapy procedures. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

PATIENT SIGNATURE _____ DATE _____

Authorization For The Use Of Protected Health Information

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization.
2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information: **Jonathan N. Group, R.D., D.C.**
3. I authorize the following persons (or class of persons) to receive my protected health information:
Jonathan N. Group, R.D., D.C.
4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
6. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. §164.524).
7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Pain Relief Center Chiropractic, nor will it affect my eligibility for benefits.
8. I DO or DO NOT (circle) authorize Dr. Group or an authorized employee of Pain Relief Center to leave a voice mail message regarding important information related to my care.

I certified that I have received a copy of the authorization:

PATIENT SIGNATURE _____ DATE _____