Patient information

Date:________________

Name:____

Address:______________________________________

City:________________ State:________ Zip:________

SS#:________________ Sex ○ Male ○ Female

Date of birth:________________ Age:________

○ Married ○Single ○Widowed
○ Separated ○Divorced ○ Minor

Employer:______________________________
Occupation:____________________________

Spouse or parent's name:____________________

Whom may we thank for refering you to our office?

____

Insurance information

Work or Auto related?________________________

Policy Holder's Name________________________

Relationship to self:________________________

Insurance Company:__________________________

Is patient covered by additional insurance? YES / NO

Person responsable for Account if other tan self?
Name:______________________________

Address:____________________ Phone:__________

Accident information

Is condition due to an accident? ○Yes ○No Date________

Type of accident: ○Auto ○Work

To whom have you made a report of your accident

○Auto insurance ○Employer ○Worker's Comp

Claim number (if appliable) ____________________

Attorneys Name:______________________________

Phone number

Home Phone: (____)____________________________

Work Phone: (____)____________________________

Cell phone: (____)____________________________

Cell pone carrier ____________________________

Email Adress:________________________________

In case of emergency, please contact:

Name:________________ Relationship__________

Phone number: (____)________________

Pain diagram

Please complete the following "pain diagram" using letters to indicate your areas of complaint.

P. Pain
T. Tingling
N. Numbness
B. Burning
S. Stiffness

FRONT BACK

Explain:____

____

____

____

____

Health History

Name: Todays's date: Date of onset:

Please select ALL choices that apply to the patient

☐ Abdominal pain	☐ Colitis	☐ Headache	☐ Irritable colon	☐ Osteosporosis	☐ Sinus trouble
☐ Allergies	☐ Colon Cancer	☐ Heart Attacks	☐ Kidney disease	☐ Painful Urination	☐ Spinal Disc Disorder
☐ Angina	☐ Convulsions	☐ Heart Disease	☐ Kidney Stone	☐ Peptic Ulcer	☐ STD's
☐ Anorexia	☐ Diabetes	☐ Hepatitis A	☐ Kyphosis	☐ PMS	☐ Stomach Ulcer
☐ Aortic Aneurism	☐ Dislocated Joint	☐ Irr. Menstrual	☐ Leg Pin	☐ Polio	☐ Stomach cancer
☐ Asthma	☐ Dizzines	☐ High BP	☐ Lordosis	☐ Prostate Cancer	☐ Thyroid disorder
☐ Blood Disorder	☐ Duodenum Ulcer	☐ Hip Pain	☐ Low BP	☐ Prostate Problems	☐ Traumatic Arthritis
☐ Bone Cancer	☐ Emphysema	☐ HIV/AIDS	☐ Low Back Pain	☐ Rapid Heart Rate	☐ Tuberculosis
☐ Brain Cancer	☐ Epilepsy	☐ Hypertension	☐ Lung Cancer	☐ Rectum Cancer	☐ Ulcer
☐ Breast Cancer	☐ Esophageal Cancer	☐ Hyperthyroid	☐ Lung Disease	☐ Rheumatoid arthritis	☐ Upper Back Pain
☐ Breast soreness	☐ Fainting	☐ Hypotension	☐ Migraine	☐ Rheumatic fever	☐ Vaginal Discharge
☐ Bulemia	☐ Gouty Arthritis	☐ Hypothyroid	☐ Multiple sclerosis	☐ Scoliosis	☐ ______________
☐ Cancer	☐ Juvenile Diabetes	☐ Irregular Bowel	☐ Neck Pain	☐ Shoulder Pain	☐ ______________
☐ Chest Pain	☐ Hay Fever	☐ Hepatitis B	☐ Osteoarthritis	☐ Sickle cell anemia	☐ ______________

Select ALL choices that apply to the patients FAMILY (please DO NOT include relations by marriage)

☐ Abdominal pain	☐ Colitis	☐ Headache	☐ Irritable colon	☐ Osteosporosis	☐ Sinus trouble
☐ Allergies	☐ Colon Cancer	☐ Heart Attacks	☐ Kidney disease	☐ Painful Urination	☐ Spinal Disc Disorder
☐ Angina	☐ Convulsions	☐ Heart Disease	☐ Kidney Stone	☐ Peptic Ulcer	☐ STD's
☐ Anorexia	☐ Diabetes	☐ Hepatitis A	☐ Kyphosis	☐ PMS	☐ Stomach Ulcer
☐ Aortic Aneurism	☐ Dislocated Joint	☐ Irr. Menstrual	☐ Leg Pin	☐ Polio	☐ Stomach cancer
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☐ Breast Cancer	☐ Esophageal Cancer	☐ Hyperthyroid	☐ Lung Disease	☐ Rheumatoid arthritis	☐ Upper Back Pain
☐ Breast soreness	☐ Fainting	☐ Hypotension	☐ Migraine	☐ Rheumatic fever	☐ Vaginal Discharge
☐ Bulemia	☐ Gouty Arthritis	☐ Hypothyroid	☐ Multiple sclerosis	☐ Scoliosis	☐ ______________
☐ Cancer	☐ Juvenile Diabetes	☐ Irregular Bowel	☐ Neck Pain	☐ Shoulder Pain	☐ ______________
☐ Chest Pain	☐ Hay Fever	☐ Hepatitis B	☐ Osteoarthritis	☐ Sickle cell anemia	☐ ______________

SMOKING: ☐ I smoke everyday ☐ I smoke on the weekends ☐ I used to smoke ☐ Never smoked

MEDICATIONS: (Please list a ll medications and dosage)____

____

____

ALLERGIES:____

____

PAST HOSPITALIZATIONS AND/OR SURGERIES:____

____

Who is/was your most recent general physician?______________________________

Physicians phone number:____________________________________

History of pregnancy: ____

Previous treatment and diagnosis for current condition: ☐ No ☐Yes

Explain:____
____
____

I understand that the information I have provided above is current and complete to the best of my knowledge

____
Signature Date

CURRENT / CHIEF COMPLAINT

What is your current complaint? (why are you seeking treatment?)

____
____
____
____

How severe is this problem?	How Frequent?	On a 1-10 scale, how would you rate your pain? (10=most painful, 1=least painful)	Improvement (%)
☐ Mild ☐ Mild to moderate ☐ Moderate ☐ Moderatly severe ☐ Severe	☐ Constant ☐ Occasional ☐ Intermitent ☐ Frequent	1– 2– 3– 4– 5– 6– 7– 8– 9– 10	10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

When was the onset of this problem ?

☐Gradual ☐About a day ago ☐About a month ago
☐Insidious ☐Several days ago ☐Several months ago
☐Sudden ☐About a week ago ☐Several years ago
☐Several weeks ago ☐About a year ago

Select each choice that applies to you.

Movement
☐Cramps ☐Spasm
☐Inflexibility ☐Stiffness
☐Restricted Movement

Sensation
☐Crawling ☐Pins and Needles
☐Dead ☐Prickly
☐Numb ☐Tigling

Select the type of pain that best describes your complaint.

☐Achy ☐ Burning ☐ Dull ☐ Excruciating ☐ Numb ache ☐ Pounding
☐ Pulsating ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Stinging ☐ Throbing

AT WHAT TIME OF THE DAY DOES IT FEEL BETTER? ☐It is never better
☐Usually better in the morning ☐Usually better during the day ☐Usually better at night

AT WHAT TIME OF THE DAY DOES IT FEEL WORST?
☐Usually worst in the morning ☐Usually worst during the day ☐Usually worst at night

I understand that the information I have provided above is current and complete to the best of my knowledge.
Signature____________________ **Date**______________

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concern itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

____

Print Name　　　　Signature　　　　Date

Consent to evaluate and adjust a minor child

I, __________________ being the parent or legal guardian of __________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle: ________________________

____

Signature　　　　Date

Patient Name:_________________________________ File:______________

Standard Waiver of Liability:

I understand that I am financially responsible for any charges incurred at this office, for those patients using insurance, this would include co-pays, deductibles, and charges denied or not covered by my insurance company.

I realize my care may be subject to pre-authorization by my insurance company, and I accept any responsibility for charges which may not be approved. My insurance company will review any/all documentation submitted by Cordero Family Chiropractic for review for medical necessity, however, final determination is based upon my insurance company's medical guidelines. Insurance policy limitations are per individual insurance policy plans, as are co-payments, co-insurance, deductibles, referrals, etc.

I understand this office agrees to notify me as soon as possible whether my care is approved or denied by my insurance company. I further understand my initial visit may be denied and this may be beyond the office ability to notify me prior to rendering acute care, while waiting for insurance coverage approval. These charges will be my responsibility if denied by my insurance company.

NOTE: our office does not bill secondary insurance carriers.

I understand this office will require payment from me for any services not covered by my health insurance plan. Any payment due beyond 30 days is subject to late fees, interest at 1.5% per month and collection agency fees. I agree to pay all collection costs associated with collecting said debt, including, but not limited to attorney fees of 25% (twenty-five percent), together with the cost and disbursement of the action.

Assignment of Benefits:

I hereby authorize my insurance benefits to be paid directly to Dr. Francisco Colon and/or Dr. Sebastian Colon.

I have read this document and understand my obligations for payments for care in the absence of insurance coverage.

____

Signature (Patient, Parent/guardian of patient) Date

Release of Medical Records:

I give my permission for Dr. Colon to request medical information for other medical facilities that may help the doctor to accurately assess and treat my current condition.

____

Signature (patient, or Parent/guardian of patient) Date