Carradine Chiropractic Center, Inc.
8286 South Avenue, Building B. Boardman, OH 44512
(330) 758.4446

Patient Name: _____ Date: _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **Carradine Chiropractic Center, Inc.** I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Consent to Evaluate and Treat a Minor:

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

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device,
i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

First Name_____ Last Name_____ Date_____
Address _____City_____ State_____ Zip _____
Phone # _____ Driver Lic. # _____
Email Address _____
** New Federal regulations require us to email you your health information. By providing my email address, I authorize my doctor to contract me regarding my health records.
Gender ☐ Male ☐ Female Date of Birth_____ Age_____ SS# _____
Employment Status: ☐ Employed ☐ Student ☐ Retired ☐ Unemployed **Occupation** _____
Employer _____ Number of Children_____
Marital Status: ☐ S ☐ M ☐ D ☐ W Spouse's Name _____
Spouse's Occupation _____ Spouse's Employer _____
Race: (Check one) ☐ White ☐ Black/African American ☐ Hispanic ☐ Other _____ Multi-Racial: ☐ Yes ☐ No
Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former Smoker ☐ Never been a smoker ☐ Chew tobacco ☐ Packs/day <1, 1 , 2 , 3 , 4+
What is your chief complaint? _____
How were you refereed to our office? _____

List/Check all complaints/conditions you have had or currently have:

General: None☐
☐ Allergy_____
☐ Headaches/Migraines
☐ Loss of Sleep
☐ Anxiety/Panic/Depression
☐ Loss of Energy
☐ Cancer Type:_____
☐ Other_____

Musculoskeletal & Neurological: None☐
☐ Neck Pain/Stiffness
☐ Back Pain/Stiffness
☐ Bulging/Herniated Discs/Degeneration
☐ Arthritis/Join Inflammation
☐ MS/RA/SLE (Autoimmune)
☐ Fibromyalgia
☐ Other _____

Genito-Urinary: None☐
☐ Kidney Infections/Stones
☐ Frequent Urination
☐ Other_____

Gastrointestinal: None☐
☐ Reflux/Indigestion
☐ Constipation
☐ Irritable Bowel
☐ Other_____

Cardiovascular/Respiratory: None☐
☐ **Do you have a pacemaker? YES NO**
☐ High Cholesterol
☐ Blood Pressure HIGH/LOW
☐ Muscle Cramps
☐ Shortness of Breath
☐ Other_____

Women-OB/GYN: None☐
☐ **Are you pregnant? YES NO**
☐ PMS/Painful Menstrual Cycle
☐ Hot Flashes/Menopausal Issues
☐ Irregular Menses
☐ Other_____

Hormonal, Blood & Skin: None☐
☐ Diabetes _____Type 1 _____Type 2
☐ Thyroid Issues
☐ HIV/AIDS
☐ Hepatitis Type:_____
☐ Easy Bruising
☐ Skin Problems:_____
☐ Other_____

Ears/Eyes/Nose/Throat: None☐
☐ Cataracts/Macular Degeneration
☐ Ringing In Ears
☐ Sinus Infections/Blockages
☐ Other_____

Social History: None☐
☐ Alcohol NOT consumed
☐ Alcohol/day <1, 1 , 2 , 3 , 4+
☐ Caffeine NOT consumed
☐ Caffeine / Day <1, 1 , 2 , 3 , 4+
☐ Exercise__freq___occas___none
☐ _____

Family History: None☐
*Please list family member with condition on line
☐ Arthritis_____
☐ Cancer_____
☐ Diabetes_____
☐ Heart Problems_____
☐ Other:_____

List all surgeries:
_____
_____
_____
_____
_____
_____
_____

List all recreational activities:
_____
_____

List all current medications and dosages: (Prescription/OTC/Nutritional)_____
_____
List all past illnesses or accidents: _____
Have you had any X-rays/MRI/CAT Scan within the last year? (If yes, what facility?) _____
_____
List all physicians seen for this condition: _____
What are your goals for care in our office?
☐ I Just want some relief of my immediate pain.
☐ I would like to correct the underlying problem so it doesn't return.
☐ I am Interested in being healthiest and learning to stay that way

I clearly understand and agree that all services rendered to me are charged to me and that I am personally responsible for payment. If filing a claim through any third party and the claim or treatment is not allowed. I agree that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fee for professional service rendered to me will be immediately due and payable.

Patient or Parent/Guardian Signature _____Date _____

Please list your area of complaint & indicate which side of the body the pain is located on:

1._____Right/Left/Both
2._____Right/Left/Both
3._____Right/Left/Both
4._____Right/Left/Both
5. _____Right/Left/Both
6._____Right/Left/Both

How long have you had this condition? _____

What caused your painful Symptoms to begin? _____

Is this condition (Only Check One) ☐ Better or ☐ Worse (In the) ☐ morning ☐ Mid-day ☐ end of the day ☐ night

Does the pain travel anywhere? ☐ Yes ☐ No If yes, Where? _____

DO NOT WRITE BELOW - FOR OFFICE USE ONLY:

NOTES:

_____

_____

Symptoms that explain how the pain feels:

_____Aching	_____Heavy	_____ "Pops"	_____Stinging
_____Annoying	_____Jabbing	_____Pressure	_____Squeezing
_____Burning	_____ "Just Hurts"	_____Pulling	_____Tender
_____Buzzing	_____ "Kink"	_____Radiating	_____Tense
_____ "Catches"	_____Knots	_____Sharp	_____Throbbing
_____Cramping	_____Nagging	_____Sharp with movement	_____Tightness
_____Deep	_____Nasty	_____Shooting	_____Tingling
_____Dull	_____Nauseating	_____Shoots to front	_____Tiredness
_____Electric Shock	_____Numbness	_____Sore	_____ Twinges
_____Grabbing	_____Ouchy	_____Spasm	_____Weakness
_____Grinding	_____Pinching	_____Stabbing	_____
_____Gnawing	_____Pinprick	_____Stiffness	_____

Factors that increase symptoms:

_____Activity	_____Getting up from sitting	_____Making the bed	_____Stooping
_____Baking	_____Golfing	_____Movement	_____Strain w/bowel movement
_____Bending	_____Grocery shopping	_____Raising the arm	_____Stress
_____Carrying	_____Household chores	_____Raking leaves	_____Stretching
_____Changing positions	_____Laughing	_____Reaching	_____Talking on the phone
_____Child or pet care	_____Lifting	_____Reading	_____Touching the area
_____Chewing	_____Lights	_____Repetitive motions	_____Traveling
_____Cleaning	_____Looking down	_____ Rotating head to left	_____Twisting
_____Computer use	_____Looking over shoulder	_____Rotating head to right	_____Vacuuming
_____Cooking	_____Looking up	_____Running	_____Vibration
_____Coughing	_____Lying down	_____Shoveling snow	_____Walking
_____Driving	_____Lying on side	_____Sitting in poor posture	_____Washing dishes
_____Exercise	_____Mopping	_____Squeezing	_____Working
_____Getting in/out car	_____Pulling	_____Squatting	_____Yardwork
_____Getting out of bed	_____Pushing	_____Stair stepping	_____
_____Getting up from laying	_____Quick movement	_____Standing	_____

Factors that Relieve symptoms:

_____Chiro adjustment	_____Knees bent up	_____Nothing	_____Stretching
_____Bending	_____Leaning for support	_____ Pain relief gel	_____Turning on other side
_____Bending forward	_____Lying down	_____Physical therapy	_____Walking
_____Elevating leg	_____Massage	_____Propping feet up	_____
_____Exercise	_____Medication (OTC)	_____Rest	_____
_____Heat packs	_____Medication(prescription)	_____Standing	_____
_____Hot shower/bath	_____Movement	_____Sitting	_____
_____Ice/cold packs	_____No movement	_____Sitting with pillows	_____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient: _____
Employer:_____
Claim/Group #_____
SS#/ID#_____

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

Carradine Chiropractic Center, Inc.
8286 South Avenue, Bldg. B
Boardman, Ohio 44512

If my current policy prohibits direct payment to doctor, then I hearby also instruct and direct you to make the check out to me and mail it as follows:

c/o **Carradine Chiropractic Center, Inc.**
8286 South Avenue, Bldg. B
Boardman, Ohio 44512

the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignees, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any Insurance Company, adjusted, or attorney involved in this case.

_____ _____
Signature of Policyholder or Claimant if other than Policyholder — Date

_____ _____
Witness — Date