



Name: \_\_\_\_\_

Date Symptoms Began \_\_\_\_\_

What is the current complaint? \_\_\_\_\_

Is the condition due to:  Auto Accident  Work injury  Other Accident  Illness  Unknown

Briefly describe what you think caused your pain: \_\_\_\_\_

Have you had these symptoms before?  No  Yes When? \_\_\_\_\_

Are your symptoms:

- Improving
- About the Same
- Getting Worse
- Comes and goes

List All Surgeries:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List Prescription Drugs:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Chewing Tobacco: Yes or No

Allergies to Medications: \_\_\_\_\_

Smoker: Yes or No Years: \_\_\_\_\_

Stress Level:  Little to None  Minimal  Moderate  Greatly Stressed

Exercise:  No Exercise Program  Light  Moderate  Strenuous

Physical Activity:  Sitting 50% or More  Light Labor  Heavy Labor  Repeated Motions

Do you have **high blood pressure**?  No  Yes **Diabetes?** If YES; Type 1 or Type 2; or NO

**Any chance of pregnancy or currently pregnant?**  No  Yes Due: \_\_\_\_\_

Have you ever been **diagnosed with cancer**?  No  Yes Type: \_\_\_\_\_

Please describe your treatment/diagnosis/etc: \_\_\_\_\_

**Family History of Health Problems:**

Father	_____
Mother	_____
Siblings	_____
Children	_____

Who is your Family Doctor? \_\_\_\_\_

Have you had Chiropractic Before? \_\_\_\_\_ When? \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Name \_\_\_\_\_  
                     First                    Middle                    Last



Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: (M F)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Land Line: \_\_\_\_\_ Cell: \_\_\_\_\_

Your e-mail: \_\_\_\_\_ Marital Status: (M S D W)

Social Security#: \_\_\_\_\_ Driver's License#: \_\_\_\_\_ State: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Occupation/Employer: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone: \_\_\_\_\_

**NOTICE OF PRIVATE PRACTICES (HIPPA):**

In accordance with the Protected Health Information Act (PHI) our office will, without asking your express consent or authorization, use and disclose your PHI for the purposes of:

- Treatment
- Payment
- Health care Options
- Advice of Appointments and Services
- Directory/Sign-In Log
- Court Orders, Subpoenas and Government Investigations
- Advise Family/Friends directed by you to receive information regarding your health or to assist in the payment of your bill.

You have the right to revoke, request special limits or conditions, to receive communication by more confidential means or at alternate locations, to inspect and copy your PHI and to amend your PHI.

Copies of the NPP may be obtained upon request. Our office strives to maintain HIPPA compliance.

I understand by signing the above statement I have been notified of my rights in compliance with HIPPA regulations. I have been advised that I may request a complete copy of these rights available through the HIPPA officer at this location.

**Release of Information:** I authorize the release of any information concerning my health and healthcare services to my insurance companies, prepaid health plan and/or Medicare/Medicaid.

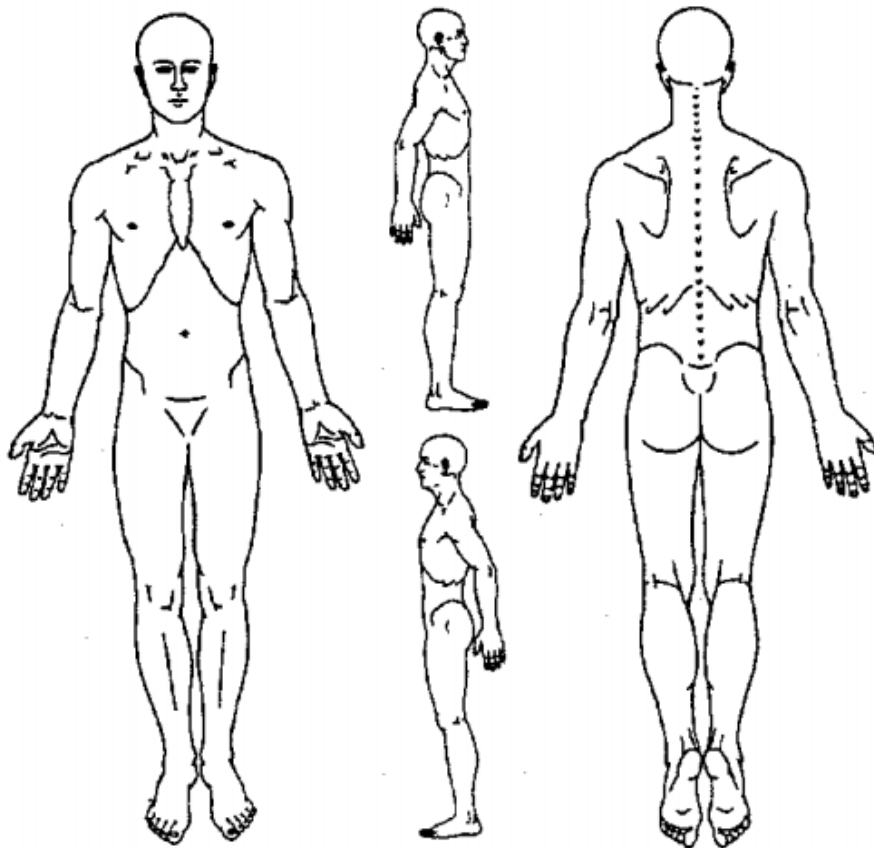
**Payment Agreement:** I understand there is no guarantee that my insurance company(ies) or prepaid health plan will cover or pay for all my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Consent to Treat a Minor:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please indicate your pain on the diagram below:



**Symptom key**

- ===== Aching
- dddd Stiffening
- ^^^^ Tightness
- cccc Cramping
- xxxx Burning
- //// Stabbing
- 000 Numbness
- tttt Tingling
- ssss Sensitive
- pppp Other

<i>Office Use Only</i>	
Height	
Weight	
Temp	
BP	/
Pulse	

Pain Level (circle): Pain Free 1 2 3 4 5 6 7 8 9 10 Worst

How long have you had this pain? \_\_\_\_ Years \_\_\_\_ Months \_\_\_\_ Weeks \_\_\_\_ Days

First Episode of this Pain: Yes / No

How did it Happen?: \_\_\_\_\_

What makes it **Better?** Nothing Ice Heat Medication Rest  
Chiropractic Massage Sleep Movement Other: \_\_\_\_\_

What makes it **Worse?** Lifting Bending Twisting Sitting Standing  
Walking Working Moving Other: \_\_\_\_\_

Does the Pain Travel? \_\_\_\_\_ Where? \_\_\_\_\_

Any other symptoms today?: Dizziness Nausea Vomiting Headache  
Vision Changes Trouble Breathing Trouble Swallowing  
Change in bathroom habits Other \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Review of Systems (In the last 5 years have you had?)****Musculoskeletal** No Musculoskeletal Complaints Osteoporosis       Back problems       Arthritis       Hip disorders       Scoliosis Knee injuries       Foot/ankle pain       Gout       Fractures       Poor posture Cramping       Shoulder problems       Neck pain       Elbow/wrist pain Swelling, redness deformity of joint(s)       Implants, plates, pins or screws Joint or muscle pains/stiffness       OTHER**Neurological** No Neurological Complaints Anxiety and/or panic       Pins and needles       Depression       Numbness Memory issues       Loss of smell or taste       Sleeping issues       Headache Temporary loss of vision       Weak muscles       Difficulty concentrating Dizziness       Epilepsy or seizures       Stroke       OTHER**Head, Eyes, Ears, Nose and Throat** No Complaints Migraines       Dental problems       Eye or vision problems Gum problems       Eyeglasses or contact lenses       TMJ problems Eye surgery       Sore throat       Cataracts Postnasal drip       Glaucoma       Swollen lymph nodes Nose congestion or sinus trouble       Ear or hearing problems       OTHER**Cardiovascular** No cardiovascular complaints Chest pain or tightness       Rheumatic fever       Palpitations       Heart murmur Leg pain upon walking       Swollen legs or feet       Blood clots       Excessive bruising High blood pressure       Varicose veins       Heart attack       Low blood pressure High cholesterol or triglycerides       Coronary artery disease       OTHER



### **Respiratory**

- No respiratory complaints       Persistent cough       Blood in sputum  
 Wheezing     Pneumonia       Shortness of breath       Snoring issues     COVID-19  
 Asthma     Apnea       Emphysema       Tuberculosis       Hay fever     OTHER

### **Gastrointestinal**

- No Complaints       Abdominal pain     Black or bloody stool     Heartburn  
 Nausea or vomiting     Bloating     Hemorrhoids       Colitis       Severe diarrhea  
 Food sensitivities     Ulcer       Constipation       Jaundice     Pancreatitis  
 Difficulty swallowing     Irritable Bowel Syndrome     Liver disease     Gastric reflux  
 Crohn's disease     Gallbladder problems     Colon cancer/colon polyps     Change in bowel habits  
 OTHER

### **Genitourinary**

- No genitourinary complaints     Painful or frequent urination     Sexual dysfunction  
 Blood in urine     Incontinence       Kidney stones       Urinary infections     OTHER

### **Endocrine**

- No endocrine complaints     Feeling hot or cold all the time     Hyperparathyroidism  
 Thyroid problems     Testosterone deficiency     Diabetes       Cushing's syndrome  
 Increase urination     Steroid treatments       Excessive thirst     Hyperthyroidism  
 OTHER

### **Dermatological and Bleeding**

- No skin or bleeding complaints     Skin trouble or rashes     Skin cancer       Flushing  
 Easy bruising     Skin pigmentation issues       Change in hair or nails     Eczema  
 Blood in stool     Excessive acne     Gum bleeding       Psoriasis     OTHER

**Informed Consent**



Dear Patient:

While Chiropractic seeks to render the best and safest care, please understand that examination and treatment of any kind has limitations and risks. With respect to Chiropractic, these may include:

Stroke (CVA): current research indicates that this is a rare complication that can occur in spite of pre-treatment screening. To prevent problems, it is vitally important that you inform us of ANY and ALL history of stroke, ultrasound testing of arteries and results, and of ANY medical condition or changes of health status.

Inflammation/Bruises: these are more common side effects of manipulation and may involve pain, soreness, stiffness, or skin discoloration. Symptoms are usually self-resolving, but can necessitate referral to your medical provider for medications to alleviate the symptoms.

Fracture: this complication can occur when bone is weakened by osteoporosis, cancer, chemotherapy, or other conditions.

Skin irritation: due to taping, hot pack use and/or ultrasound and electrical muscle stimulation pads, these are usually self-resolving.

I, undersigned, have been fully informed by my Chiropractic Physician that there is no such thing as a perfect test or procedure in health care, or Chiropractic. I have been informed of all potential treatment complications, alternative treatments, and consequences of no treatment. I hereby grant Lisa N. Braden, D.C. to examine and treat me as necessary now and into the indefinite future.

---

Patient (Print Name)

Date

Witness Signature

Date

---

Patient Signature

Payment is due when the service is rendered.

Dr. Lisa N. Braden, D.C. is committed to the success of your chiropractic treatment and better health. Your clear understanding of our financial policy is important to our professional relationship. Blue Ribbon Chiropractic is not currently in network with any insurance plans and we do not bill to Medicare/Medicaid/TriCare. Our office currently accepts Personal Checks, VISA, MasterCard, and FSA/HSA, as well as Cash payment.

Cancellation Policy:

**A 24-hour notice is required for cancelled appointments. An office visit charge of \$45 will be applied to your account if any appointment is “no showed”. If rescheduled prior to 24-hours of appointment, no charge will be applied to your account.**

We understand that things come up and emergencies happen. However, because we block 20-30 minutes in the appointment schedule for you to meet with the doctor, this causes others with health care needs seeking treatment unable to come in when our schedule is full. As a courtesy, text message reminders are sent to remind you of your upcoming appointment. Due to the variation of cell phone plans the lack of delivery of a text reminder does not exclude you from paying the \$45 fee if an appointment is missed.

I understand the above terms:

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Wittness: \_\_\_\_\_