ABOUT YOU

First Name _____ **Middle Name** _____

Last Name _____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **ZIP Code** _____

Mobile Phone ____-____-_____ **Work Phone** ____-____-_____ **Home Phone** ____-____-_____

Email _____

Date of Birth ____ / ____ / _____ **Gender** ☐ Male ☐ Female

Height _____'_____" **Weight** _____ lbs

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Number of Children _____ **Spouse's Name** _____

EMERGENCY CONTACT INFORMATION.

Name _____

Phone ____-____-_____ **Relation To You** _____

INSURANCE INFORMATION

Do you have Insurance? ☐ Yes ☐ No

Insurance Name _____ **Phone** ____-____-_____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **ZIP Code**_____

ID/Policy Number _____ **Group Number** _____

Insured's Name _____ **Insured's Date of Birth** ____ / ____ / _____

REFERRAL INFORMATION.

Referring Physician _____ **Contact information.** _____

Referring Patient _____

Are you working with an attorney? ☐ Yes ☐ No

How did you hear about us?

☐ Word of mouth ☐ Advertisement ☐ Social media ☐ Direct marketing ☐ Internet

REASON FOR VISIT

What is the date of your scheduled appointment? ____ / ____ / _____

How long have you had this complaint?

- ☐ Less than 5 days (Acute)
- ☐ Between 5-30 days (Sub Acute)
- ☐ More than 30 days (Chronic)

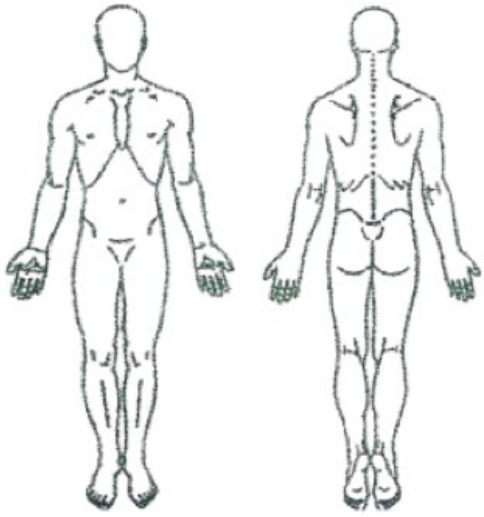
What caused this condition _____

What is the date this condition began? (Skip if due to accident) ____ / ____ / _____

What term(s) describes your discomfort best? _____

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

P - pain
N - numbness
W - weakness
S - shooting
A - Aching



On a scale of 1 to 10, with 10 being the most severe, how do you rate your discomfort?

None ***Unbearable***

0 1 2 3 4 5 6 7 8 9 10

How often do you feel this discomfort? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

How has this complaint changed since the onset? ☐ Worsened ☐ Remained the same ☐ Improved

What activity is most significantly affected by this discomfort? (Explain) _____

_____

What treatment, if any, have you received since the injury? _____

_____

What aggravates this condition? _____

What improves this condition or gives you relief? _____

Have other health care provider(s) performed tests related to this condition? _____

_____

Have you ever had any previous episodes of this condition? _____

_____

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following?

Muscles, Bones or Joints	☐ No ☐ Yes	**Explain:** _____
Nerves, Headaches, Dizziness, or Emotional	☐ No ☐ Yes	**Explain:** _____
Head, Eyes, Ears, Nose or Throat	☐ No ☐ Yes	**Explain:** _____
Heart, Blood Pressure, or Circulation	☐ No ☐ Yes	**Explain:** _____
Shortness of Breath, Coughing, Asthma or Lung Condition	☐ No ☐ Yes	**Explain:** _____
Stomach, Bowels or Digestive Conditions	☐ No ☐ Yes	**Explain:** _____
Genital, Bladder, or Urinary Conditions	☐ No ☐ Yes	**Explain:** _____
Diabetes, Thyroid or Glandular Conditions	☐ No ☐ Yes	**Explain:** _____
Skin or Bleeding Conditions	☐ No ☐ Yes	**Explain:** _____
Do you have any medication allergies?	☐ No ☐ Yes	**Explain:** _____

PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures? ☐ No ☐ Yes **Explain:** _____

Are there any past illnesses or conditions we should be aware of? ☐ No ☐ Yes **Explain:** _____

Do you have a past history of accidents or trauma? ☐ No ☐ Yes **Explain:** _____

Are you presently taking any medication? ☐ No ☐ Yes **Explain:** _____

Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of? ☐ No ☐ Yes **Explain:** _____

WORK SOCIAL HABITS

Current work habits - Choose all that apply.

- ☐ Permanently fully disabled
- ☐ Permanently partially disabled
- ☐ Cannot work due to current condition
- ☐ Full-time (20-40+ hours/week)
- ☐ Part-time (1-19 hours/week)
- ☐ Retired ☐ Student ☐ Homemaker ☐ Unemployed

Personal social habits - Choose all that apply.

- ☐ Smoke or use tobacco products
- ☐ Drink alcohol
- ☐ Drink caffeine
- ☐ Use recreational drugs
- ☐ Other, to be discussed with doctor

Present exercise habits - Choose all that apply.

- ☐ No current exercises
- ☐ Exercises daily
- ☐ Exercises 3+ times per week
- ☐ Cannot return to exercise due to current condition

Diet and nutrition habits - Choose all that apply.

- ☐ Vegan or vegetarian
- ☐ Daily supplements
- ☐ Other

MEN'S HEALTH

Do you have pain or lump in scrotum or testicles?

☐ Yes ☐ No

Do you have an impaired libido (sex drive)?

☐ Yes ☐ No

Do you have discharge from your penis?

☐ Yes ☐ No

Do you have prostate issues?

☐ Yes ☐ No

When was your last prostate exam?

☐ Within the past year ☐ Between 1-4 years
☐ Greater than 5 years ☐ Never had a prostate exam
☐ Prefers not to answer or don't know

When was your most recent PSA (Prostate-Specific Antigen) blood test?

☐ Within the past year ☐ Between 1-4 years
☐ Greater than 5 years ☐ Never had a PSA blood test
☐ Prefers not to answer or don't know

What was your PSA (Prostate-Specific Antigen) level on your latest test?

☐ Normal or low ☐ Moderate
☐ High ☐ Never had a PSA level done
☐ Prefers not to answer or don't know

WOMEN'S HEALTH

Are you pregnant?	☐ Yes ☐ No
Are you nursing?	☐ Yes ☐ No
Are you taking birth control?	☐ Yes ☐ No
Do you experience painful periods?	☐ Yes ☐ No
Do you have irregular cycles?	☐ Yes ☐ No
Do you have breast implants?	☐ Yes ☐ No
Do you perform a regular self-breast examination?	☐ Yes ☐ No
Do you take hormone replacement therapy (HRT)?	☐ Yes ☐ No
Do you take oral contraceptives?	☐ Yes ☐ No
When was your last PAP/pelvic exam?	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a PAP or pelvic exam ☐ Prefers not to answer or don't know
	☐ Within the past year ☐ Between 1-4 years ☐ Greater than 5 years ☐ Never had a mammogram exam ☐ Prefers not to answer or don't know
What was the date of your last menstrual period? (only answer if still menstruating)	☐ Within the past month or currently ☐ Within the past 1-3 months ☐ Greater than 3 months ☐ Postmenopausal ☐ Have not yet begun menstruation ☐ Prefers not to answer or don't know

INFORMED CONSENT TO TREATMENT

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.
Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this clinic. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACTIC CARE

Soreness – Chiropractic manipulations/adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your treating physician in you experience soreness or discomfort.

Soft Tissue Injury – Occasionally chiropractic treatment my aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

Rib Injury – Manual manipulations/adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-manipulation/adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns – Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but if it occurs you should report it to your treating physician, or a staff member of Dr. Tripp Puhl DC, CCSP.

Stroke – Stroke is the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol. 37 No. 2, June, 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical (neck) manipulations.

Other Problems – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your treating physician promptly.

This clinic currently does not provide x-ray services. Should x-rays be necessary, Dr. Puhl will discuss the process for obtaining films. These films will be on file where they may be seen at any time. The treating physician will not be held responsible for any pre-existing medically diagnosed conditions.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be

checked if Dr. Tripp Puhl DC, CCSP extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the Dr. Tripp Puhl DC, CCSP and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment.

I hereby authorize Dr. Tripp Puhl, DC CCSP and staff, to provide and guide treatment deemed necessary to myself. He has explained that there is no guarantee of the effectiveness of the treatment. The risk involved in Chiropractic Manipulations/Adjustments is minimal, but are still a possibility.

If you have any questions concerning this form or the above statements, please ask your treating physician.

Having carefully read the above information, I hereby give my informed consent to have chiropractic treatment administered from my treating physician and staff of Dr. Tripp Puhl DC, CCSP.

Patient Signature: _____ **Date:** ____ / ____ / _____