

## ABOUT YOU

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

Last Name \_\_\_\_\_

Street Address \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mobile Phone \_\_\_\_-\_\_\_\_-\_\_\_\_ Work Phone \_\_\_\_-\_\_\_\_-\_\_\_\_ Home Phone \_\_\_\_-\_\_\_\_-\_\_\_\_

Email Address \_\_\_\_\_

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 \_\_\_\_\_

ID/Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## REFERRAL INFORMATION

Referring Physician \_\_\_\_\_ Contact Info \_\_\_\_\_

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 terms describe your discomfort best? (aching, burning, tingling, etc.)

\_\_\_\_\_

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 would you rate your current level of discomfort?

None 0 1 2 3 4 5 6 7 8 9 10 Unbearable

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 have you received for this condition up to now?

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

**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:** \_\_\_\_\_

**Allergies or Sensitivities**  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 there any past illnesses or conditions we should be aware of?  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 AND SOCIAL HABITS

Current work habits: select 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: select all that apply

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

Present exercise habits: select all that apply

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

Diet and nutrition habits: select all that apply

- Vegan or vegetarian
- Daily supplements
- Other

## ADULT MEN'S HEALTH

**Do you have pain or a lump in your scrotum or testicles?**  Yes  No

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**Do you have an impaired libido (sex drive)?**  Yes  No

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**Do you have discharge from your penis?**  Yes  No

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**Do you have prostate issues?**  Yes  No

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**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

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**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

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**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

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## ADULT 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?  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

When was your last mammogram?  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 may 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.

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Patient Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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