Redenius
Chiropractic | Physical Therapy

Welcome To Our Office!

Today's Date ____/____/____

Patient Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr.

Name _____ **Preferred Name**_____
First *Middle* *Last*

Address_____

City_____ **State**_____ **Zip Code**_____

Home Phone_____ **Work Phone**_____ **Mobile Phone**_____

Email Address_____

Preferred Contact Method ❑ Home Phone ❑ Work Phone ❑ Mobile Phone

Date of Birth ____/____/____ **Age**_____ **Gender** ❑ Male ❑ Female

Marital Status ❑ Single ❑ Married ❑ Other **Spouse's Name**_____

Emergency Contact_____ **Phone #**_____ **Relationship**_____

Financial Responsibility_____

Referred to our office by_____

Employment Status ❑ Employed ❑ Full-Time Student ❑ Part-Time Student ❑ Retired ❑ Other

Occupation _____ **Employer** _____

Health Information

Do you currently take any medications? ❑ Yes ❑ No

	Medication Name	*Frequency*	*Dosage*	*For What Condition?*
1				
2				
3				
4				
5				

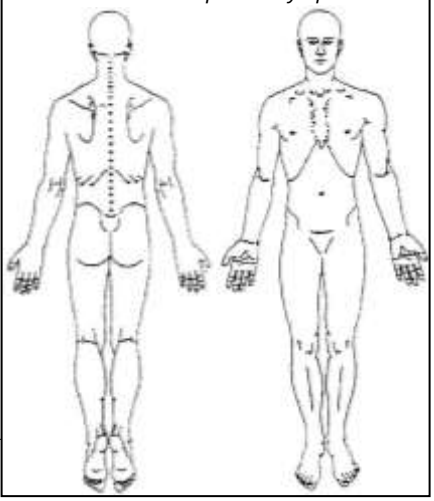
Are you allergic to any medications? ❑ Yes ❑ No

If yes, please list known allergies to medications:_____

Current Problem

Reason for this visit?_____

Mark location of pain or symptoms:



What level of intensity would you rate your pain?
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Please CIRCLE all that apply:

-Dull -Sharp -Throbbing -Burning -Deep -Aching

-Tingling -Stabbing -Cramping - Numbness -Radiating -Stiffness

What is the frequency of your symptoms?
❑ Constant ❑ Frequent ❑ Occasional ❑ Intermittent

What makes your symptoms worse?_____

What makes your symptoms better?_____

When did the symptoms start?_____

How did you injure yourself?_____

Have you ever experienced this before? ❑ Yes ❑ No _____

How does this affect your personal life? (hobbies, sports, etc…)_____

How does this affect your job? (missed days, inability to lift, stand, sit, etc…)_____

What home remedies have you tried?_____

Have you been to another doctor for this problem? ❑ Yes ❑ No_____

Have you ever been to a Chiropractor before? ❑ Yes ❑ No_____

Does this affect any of the following tasks? *SELECT the answers that apply to you.*

Bathing/Showering	Hobbies	Playing Sports
Bending Forward	Walking	Preparing Meals
Driving	Eating	Standing
Brushing Teeth	Kneeling	Putting on Pants
Bending to the side Left/Right	Getting In/Out of Bed	Stair Stepping
Twisting	Leaning Back	Putting on Shirt
Cleaning	Going to the Bathroom	Sitting
Carrying Objects	House Work	Putting on Shoes

Past Health History

Have you ever…

Yes	No	
❑	❑	Been Knocked Unconscious?_____
❑	❑	Been in a car accident?_____
❑	❑	Been treated for a spine problem/nerve disorder?_____
❑	❑	Had any significant falls, slips, or injuries?_____
❑	❑	Fractured/broken a bone?_____
❑	❑	Had surgery?_____
❑	❑	Been hospitalized for other than surgery?_____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker
If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker # Packs per day____

Do you consume alcohol? ❑ Yes ❑ No # Drinks per week_____

Do you consume caffeine? ❑ Coffee ❑ Soda ❑ Tea ❑ Energy Drinks # Drinks per day_____

Do you exercise? ❑ No ❑ Infrequent ❑ Occasional ❑ Regular ❑ Avoid due to pain

Please mark any you currently have or have had previously:

❑ AIDS	❑ Cramps	❑ Kidney Infection	❑ Sciatica
❑ Alcoholism	❑ Depression	❑ Kidney Stone	❑ Shortness of Breath
❑ Allergies	❑ Diabetes	❑ Loss of Memory	❑ Sinus Infection
❑ Anemia	❑ Digestions Problems	❑ Loss of Balance	❑ Sleep Problems/Insomnia
❑ Arteriosclerosis	❑ Dizziness	❑ Loss of Smell	❑ Spinal Curvatures
❑ Arthritis	❑ Excessive Menstruation	❑ Loss of Taste	❑ Stroke
❑ Asthma	❑ Eye Pain/Difficulties	❑ Migraine Headache	❑ Swelling in Ankles
❑ Back Pain	❑ Fatigue	❑ Neck Pain or Stiffness	❑ Swollen Joints
❑ Breast Lump	❑ Frequent Urination	❑ Nervousness	❑ Thyroid Condition
❑ Bronchitis	❑ Headache	❑ Nosebleeds	❑ Tuberculosis
❑ Bruise Easily	❑ Hemorrhoids	❑ Pacemaker	❑ Ulcers
❑ Cancer	❑ High Blood Pressure	❑ Polio	❑ Varicose Veins
❑ Chest Pain/Conditions	❑ Hot Flashes	❑ Poor Posture	❑ _____
❑ Cold Extremities	❑ Irregular Heart Beat	❑ Prostate Issues	❑ _____
❑ Constipation	❑ Irregular Cycle	❑ Ringing in Ears	❑

Is there a family history of? *(Include Relationship)*

❑ Heart Disease_____
❑ Cancer_____
❑ Stroke_____
❑ Arthritis_____
❑ Diabetes_____
❑ High Blood Pressure_____
❑ Other_____

Women Only
Are you pregnant? ❑ Yes ❑ No ❑ Maybe
Number of Weeks_____
Estimated Due Date_____

The information that I have provided above is accurate to the best of my knowledge and will be used to determine appropriate chiropractic care. _____
Patient Signature

Notice of Privacy Practices

Our practice is dedicated to maintain the privacy of your health information according to the guidelines set forth by federal and state laws. These laws also require us to provide you with notice of privacy practices, and to inform you of your rights and our obligations concerning your health information. The undersigned hereby acknowledge that I have received, reviewed, and understand and agree to the notice of Privacy Practices of Redenius Chiropractic, which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by Redenius Chiropractic.

Patient's Initials_____

Patient's Rights and Responsibilities

Health care involves a partnership between patients, families, and health care providers, each of whom have certain rights and responsibilities. When you are well-informed, participate in treatment decisions, and communicate openly with your doctor and other health professionals, you help make your care as effective as possible. This clinic encourages respect for the personal preferences and values of each individual. The undersigned hereby acknowledges that I have received, reviewed, and understand my rights and responsibilities.

Patient's Initials_____

Statement of Informed Consent

Chiropractic adjustments & Physical Therapy are performed in our office by a skilled doctor of chiropractic who has successfully completed advanced educational requirements, national board examinations and state board licensure. As with any healthcare procedure, there are some inherent risks that exist. Whenever possible this risk is minimized to its lowest level. The undersigned hereby consents to evaluation to provide the safest chiropractic care available. The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and that any/ all treatment have risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from the doctor.

Patient's Initials_____

Assignment of Benefits

Assignment of benefits authorizes Redenius Chiropractic & Physical Therapy to file charges directly to your insurance company, saving you time and effort of filing claims yourself. The undersigned hereby authorizes Redenius Chiropractic to submit my insurance claims to my insurance company. By having my signature of file, I need not sign each claim submitted by this office. I understand that I may withdraw my signature at any time. I understand that I may ultimately be responsible for all charges for which my insurance does not pay. I also understand that as the patient I am responsible for paying the copay/coinsurance/deductible at each time of service.

Patient's Initials_____

Patient Signature_____ Date_____

Patient Acknowledgement & Receipt of Notice of Privacy Practices Pursuant to HIPAA & Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of Redenius Chiropractic & Physical Therapy Notice of Privacy Practices Pursuant to HIPAA & has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law & Federal Law.

By _____ Date _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State Law:

By _____ Date _____
Signature of Parent/ Guardian

Pregnancy Waiver For Films

I hereby acknowledge that Dr. Jeff Redenius or any other provider of Redenius Chiropractic & Physical Therapy has informed me prior to having Radiographic Films of the advisability of risk & the probable consequences of receiving such procedures during pregnancy. I have stated on my own volition that I am not pregnant at this time & do hereby release & hold harmless from any legal action or responsibility caused by the use of this procedure.

By _____ Date _____
Signature of Patient or Authorized Representative

If Patient is Under the age of 18

I the parent/guardian allow my child that is a minor under the age of 18 to be seen at Redenius Chiropractic & Physical Therapy PLC for care. Without my supervision.

By_____ Date_____
Signature of Parent/Guardian

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Redenius Chiropractic & Physical Therapy

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Sign only after you understand and agree to the above.

Printed name of Patient _____ Date_____

*Signature of Patient*_____ *Date*_____

Signature of Representative _____ *Date*_____

(If patient is a minor or is handicapped)

Note: The patient needs to sign this form **before** treatment actually begins.