PREFERREDCARE
MEDICAL CENTER • LTD

# PATIENT INFORMATION
(Please Print)

| | | | |
|---|---|---|---|
| Last Name: | First Name: | | MI: |
| Preferred Name: (if different) | Birthdate: | Sex: M F | SSN: |
| Permanent Address: (street #, city, state, zip) | | | |
| Home Phone: [ ] Preferred | | Cell Phone: [ ] Preferred | |
| Work Phone: | Email: | Employer Name: | |
| Are you transferring care from your previous provider? [ ] Y [ ] N | | Employer Address: | |
| Primary Care Provider (PCP): | | PCP Office/Phone: | |
| Emergency Contact: | | Responsible Party if under 18yrs | |
| Emergency Contact Phone: | | Responsible Party Phone: | |
| Relationship to Patient: | | Relationship: | |

# GENERAL INFORMATION

| | | |
|---|---|---|
| **Ethnicity:**<br>[ ] Hispanic/Latino<br>[ ] Non-Hispanic/Latino<br>[ ] Other _____ | **Race:**<br>[ ] Asian [ ] American Indian/Alaska Native<br>[ ] Black/African American [ ] Pacific Islander<br>[ ] White/Caucasian [ ] Hispanic [ ] Other _____ | **Primary Language:**<br>[ ] English<br>[ ] Spanish<br>[ ] Other _____ |
| OK to leave messages **at home**?: [ ] YES [ ] NO | OK to leave messages **on cell?**:[ ] YES [ ] NO | |
| OK to leave messages **at work**: [ ] YES [ ] NO | OK to contact by **email?**: [ ] Yes [ ] NO | |
| Pharmacy:<br>(Name and Address) | Pharmacy Phone #: | |
| What is your occupation: | Work Activity:<br>[ ] Sitting [ ] Standing [ ] Light Labor [ ] Heavy Labor | |
| How did you hear about our office:<br>[ ] Newspaper [ ] Brochure [ ] Internet [ ] Friend/Family: Name _____ [ ] Other_____ | | |

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# MEDICAL, FAMILY, AND SOCIAL HISTORY

| Patient's Full Name: | Date of Birth: | Today's Date: |
|---|---|---|

**Medication Allergies**

| Medication | Reaction |
|---|---|
| | |
| | |

**Current Medications**
Include vitamins and OTC.
(Use back if needed)

| Name | Dose (mg, ml...) | Route (oral, topical...) | Frequency (times/day) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Surgical History**
Please list all surgeries you have had.

| Type of Surgery | Date of Surgery |
|---|---|
| | |
| | |
| | |

**Medical History**
Have you ever been diagnosed with any of the following:

- ☐ Abnormal Heart Rhythm
- ☐ AID/HIV
- ☐ Allergies/Hay Fever
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder/Blood Clot
- ☐ Breast Lump
- ☐ Cancer: Type _____
- ☐ Car Accident
- ☐ Chicken Pox
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Fainting/Dizziness/Vertigo
- ☐ Fractures
- ☐ Frequent Infections
- ☐ Gallbladder Disease
- ☐ Glaucoma
- ☐ Goiter/Thyroid Disease
- ☐ Headache/Migraine
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Menstrual Dysfunction
- ☐ Measles
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Nervousness/Anxiety
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Sexually Transmitted Disease
- ☐ Sleep Disorder
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Whooping Cough

**Social History**

Tobacco Use: [ ] Yes [ ] Not currently [ ] Never
Caffeine: Amount/day _____
Drug Use: [ ] Yes [ ] Never [ ] Not currently
Exercise: How long/how often _____
Alcohol Use: [ ] No [ ] Yes: Type _____ How Much? _____ How Often? _____

**Family History**

| | Father | Mother | Child | Sibling | Grandfather Paternal (P), Maternal (M) | Grandmother Paternal (P), Maternal (M) | Other (Please Specify) |
|---|---|---|---|---|---|---|---|
| Heart Disease | | | | | | | |
| High Blood Pressure | | | | | | | |
| Stroke | | | | | | | |
| Diabetes | | | | | | | |
| Seizure | | | | | | | |
| Headaches | | | | | | | |
| Cancer | | | | | | | |
| Other (Specify) | | | | | | | |

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# Review of Systems

| **Patient's Full Name:** | **Date of Birth:** | **Today's Date:** |
|---|---|---|

Form Completed By: [ ] Patient [ ] Parent/Guardian/Other: Name _____ Relation _____

What is your main complaint or reason for visit? _____

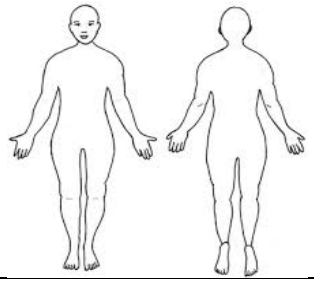
When did this start? _____

Are symptoms [ ] Constant or [ ] Intermittent?

Are symptoms getting Progressively Worse? [ ] Yes [ ] No

Rate your pain: 1-10 (10 is the worst pain you have ever had): _____

Please mark an X on the diagram at the location of your symptoms.



Quality: [ ] sharp [ ] dull [ ] ache [ ] burning [ ] tinging [ ] throbbing

Does your pain radiate? [ ] YES [ ] NO

Are your symptoms related to an injury? [ ] YES [ ] NO

Symptoms related to work/auto accident? [ ] YES [ ] NO

Have you used anything to relieve your symptoms? [ ] YES [ ] NO
If yes, what have you tried? _____

Did this help? [ ] YES [ ] NO [ ] Temporarily

Indicate what activities make symptoms worse:
[ ] Sitting [ ] Standing [ ] Walking [ ] Bending [ ] Lying Down

Symptoms interfere with:
[ ] Work [ ] Sleep [ ] Daily Routine [ ] Recreation

PLEASE MARK THE BELOW SYMPTOMS THAT YOU ARE **CURRENTLY** EXPERIENCING

### CONSTITUIONAL

Fever [ ] Yes [ ] No
Chills/Sweats [ ] Yes [ ] No
Fatigue [ ] Yes [ ] No
Weight gain/loss [ ] Yes [ ] No
Difficulty Sleeping [ ] Yes [ ] No

### CHILDREN-BABIES ONLY

Decreased Activity [ ] Yes [ ] No
Inconsolable/Fussy [ ] Yes [ ] No
Increased Crying [ ] Yes [ ] No
Drinking/Eating Less [ ] Yes [ ] No
Pulling at Ears [ ] Yes [ ] No
Diaper Rash [ ] Yes [ ] No
Attends Daycare [ ] Yes [ ] No

### EYES

Eye Pain [ ] Yes [ ] No
Sensitivity to Light [ ] Yes [ ] No
Redness [ ] Yes [ ] No
Vision Changes [ ] Yes [ ] No

### EARS-NOSE-THROAT-MOUTH

Sore Throat [ ] Yes [ ] No
Nasal Congestion [ ] Yes [ ] No
Runny Nose [ ] Yes [ ] No
Ear Pain/Ache [ ] Yes [ ] No
Foreign Body in Nose [ ] Yes [ ] No
Tooth Pain [ ] Yes [ ] No

### RESPIRATORY

Cough [ ] Yes [ ] No
*With sputum? [ ] With Blood? [ ]
Shortness of Breath [ ] Yes [ ] No
Wheezing [ ] Yes [ ] No
Pain with cough/breath [ ] Yes [ ] No

### CARDIOVASCULAR

Chest Pain [ ] Yes [ ] No
Palpitations [ ] Yes [ ] No
Heart Racing [ ] Yes [ ] No
Leg Swelling [ ] Yes [ ] No
Difficulty Breathing [ ] Yes [ ] No

### SKIN-HAIR-NAILS

Rash [ ] Yes [ ] No
Skin Redness [ ] Yes [ ] No
Cold Feet/Hands [ ] Yes [ ] No
Itching [ ] Yes [ ] No
Cut, bumps, bruise [ ] Yes [ ] No
Finger or Toe Problem [ ] Yes [ ] No

### GENITOURINARY/GYN

Pain/Pressure/Discomfort with Urination [ ] Yes [ ] No
Blood in Urine [ ] Yes [ ] No
Kidney Pain [ ] Yes [ ] No
Vaginal Discharge [ ] Yes [ ] No
Penile Discharge [ ] Yes [ ] No
Female Only:
Pregnant [ ] Yes [ ] No
Breast Feeding [ ] Yes [ ] No
Method of Birth Control: _____
Last Menstrual Period: _____

### NEUROLOGICAL

Headache [ ] Yes [ ] No
Dizziness [ ] Yes [ ] No
Loss of Consciousness [ ] Yes [ ] No
Numbness/Tingling [ ] Yes [ ] No
Seizure [ ] Yes [ ] No
Weakness [ ] Yes [ ] No

### GASTROINTESTINAL

Abdominal Pain [ ] Yes [ ] No
Indigestion/Reflux [ ] Yes [ ] No
Nausea [ ] Yes [ ] No
Vomiting [ ] Yes [ ] No
Diarrhea [ ] Yes [ ] No
Constipation [ ] Yes [ ] No
Black/Bloody Stool [ ] Yes [ ] No
Hemorrhoid [ ] Yes [ ] No
Rectal Problem [ ] Yes [ ] No

### MUSCULOSKELETAL

Back Pain [ ] Yes [ ] No
Neck Pain [ ] Yes [ ] No
Muscle Ache [ ] Yes [ ] No
Bone Pain [ ] Yes [ ] No
Joint Pain [ ] Yes [ ] No
Joint Swelling [ ] Yes [ ] No
Extremity Swelling/Pain [ ] Yes [ ] No

### HEMATOLOGY-ENDOCRINE

Easy Bruising [ ] Yes [ ] No
Prolonged Bleeding [ ] Yes [ ] No
Swollen Glands [ ] Yes [ ] No
Excessive Thirst [ ] Yes [ ] No
Excessive Hunger [ ] Yes [ ] No

### PSYCHOLOGIC

Sadness [ ] Yes [ ] No
Depression [ ] Yes [ ] No
Anxiety/Nervousness [ ] Yes [ ] No
Irritability [ ] Yes [ ] No
Mood Swings [ ] Yes [ ] No

### OTHER

Please Specify:

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# Patient Consent Form

## NOTICE OF PRIVACY POLICY HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) ACKNOWLEDGEMENT

By signing below, you consent to the use of your Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. You consent that Preferred Care Medical Center, LTD. (PCMC) can use and disclose medical information to treat you and to seek payment from third parties for this treatment. You also consent to disclosure of PHI to insurers and providers outside of PCMC, when necessary, so that these insurers and/or providers may treat you, seek payment for that treatment, and so that they can perform their health care operations. You may refuse all or part of this consent. If you refuse the use of your medical information for use of payment from your insurance company, you will be responsible for your bills. This consent will be valid for the entire duration of treatment by PCMC unless you request that consent be revoked.

Initials: _____

## FINANCIAL RESPONSIBILITY

By signing below, you agree to pay PCMC accounts on yourself and/or your dependent(s) for the services rendered when they are presented to you. If you have medical insurance on yourself and/or your dependent(s), you authorize those benefits to be paid directly to PCMC. **All co-payments to will be paid to the receptionist prior to your appointment.** My signature states that I understand that I am responsible for any balance that the insurance company does not cover.

Initials: _____

## INSURANCE RELEASE OF INFORMATION

By signing below, you authorizePCMC to release any medical information that may be necessary for processing your insurance claim to your insurance company. You further assign any benefits payable on your behalf to PCMC. You are financially responsible for any balance not covered by your insurance carrier.

Initials: _____

## PERMISSION TO COMMUNICATE WITH YOUR PRIMARY CARE PHYSICIAN AND/OR ANY OTHER CARE PROVIDERS

My signature below authorizes PCMC to release confidential information in my healthcare records to my primary care provider (PCP) or other healthcare provider. This information includes, but is not limited to, progress notes, history & physical, radiology, lab, medication consultation reports, and ECG. I authorize history of illness and diagnostic/therapeutic information, including any dependency, HIV, AIDS, and/or other communicable diseases.

Initials: _____

**Release Private Health Information to:**

PCP:_____ Phone: _____ Fax: _____
Employer: _____ Phone: _____ Fax: _____
Patient: _____ Phone: _____ Fax: _____
Guardian: _____ Phone: _____ Fax: _____

## CONSENT FOR MEDICAL CARE

By signing below, you grant permission to the physicians, nurse practitioners, and employees of PCMC to do such procedures as may be necessary to diagnose, treat, and care for the needs of medical or mental health conditions, and/or the routine care of yourself or your dependent.

**Patient Signature** (or person authorized to sign for patient) _____

**Relationship to Patient**_____[ ] self **Date** _____

**Authorized Staff Signature**_____ **Date**_____

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# CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me ( or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether sig\natories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes , dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment.

Name of Patient:_____

Signature of Patient/or Guardian:_____

Doctor of Chiropractic Name:_____

Signature of Doctor of Chiropractic:_____

Date:_____

Office Use Only: Reviewed by _____ Date _____ Pain/Chiro