FAMILY CHIROPRACTIC CLINIC OF SAGINAW

70 North Frost Dr
Saginaw, MI 48603
(989) 792-1718

Last Name:_____ First Name: _____ M.I.:_____ DOB:_____

Address: _____ Primary Phone: _____ (Home/Cell/Work)

City: _____ Zip:_____ Secondary Phone: _____ (Home/Cell/Work)

SS#:_____ Sex: Male Female Email: _____

Race: American Indian or Alaskan Native / Asian / Black or African American / White or Caucasian / Native Hawaiian or Pacific Islander / Decline to Specify

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Declined to Specify Preferred Language: _____

Relationship Status: Married Single Widowed Partnered Other

How did you hear about our office? _____

Employment Status

Employment Status: Employed Student Retired Other: _____ Occupation: _____

Employer/School: _____ Phone: _____

Address: _____ City: _____ Zip:_____

Emergency Contact

Name: _____ Relationship: _____ Phone:_____

Insurance Information

Primary Insurance: _____ Policy#:_____ Group#:_____

Subscriber Name: _____ Relationship: _____ Subscriber DOB: _____

Secondary Insurance: _____ Policy#: _____ Group#: _____

Subscriber Name: _____ Relationship: _____ Subscriber DOB: _____

Accident Information

Are you here today because of an accident? _____ Date of accident: _____ Type of accident? Auto Work Home Other

To whom did you report your accident to? Auto Insurance Employer Worker Comp Other:_____

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with the policies listed above and assign directly to Collier Chiropractic Bay City all insurance benefits, if any, otherwise payable to me for services rendered. It is my responsibility to know my insurance coverage. I understand that I am financially responsible for all charges whether or not paid by an insurance. I authorize the use of my signature on all insurance submissions. Family Chiropractic Clinic of Saginaw may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for related services.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative

Please Print Name of Patient, Parent, guardian, or Personal Representative

_____ _____

Date

Relationship to Patient

MEDICAL HISTORY

Patient Name: _____ DOB: _____

Reason for visit TODAY: _____

How would you describe your pain? DULL ACHE SHARP SHOOTING THROBBING NUMBNESS BURNING TINGLING

Does your pain travel or shoot anywhere? YES NO If yes, where? _____

How long have you had this pain? _____ How did it start? _____

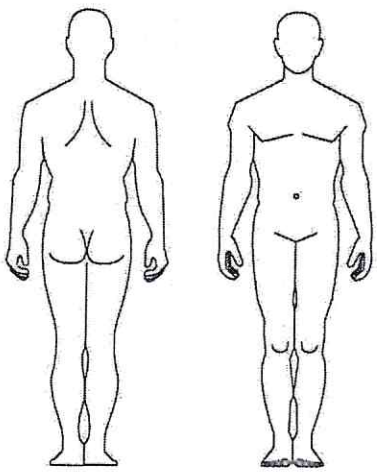
What aggravates your condition? _____ What helps your condition? _____

How often do you have this pain? _____ Is the pain constant or come and go? _____

Is this condition interfering with: WORK SLEEP DAILY ROUTINE OTHER: _____

Have you seen any other provider for this condition? YES NO If yes, who? _____

Any diagnostic testing done (X-ray, MRI, CT Scan, UltraSound)? _____ If yes, when? _____



Mark an X in the areas you have pain.

Circle ALL that apply:

AIDS/HIV	Hepatitis	Prosthesis
Allergy Shots	Hernia	Psychiatric Care
Anemia	Herniated Disc	Rheumatoid Arthritis
Arthritis	Migraines	Stroke
Asthma	Mono	Thyroid Problems
Bleeding Disorder	Multiple Sclerosis	Tumors, Growths
Cancer	Mumps	Other: _____
Diabetes	Osteoporosis	_____
Emphysema	Pacemaker	_____
Epilepsy	Parkinson's Disease	_____
Fractures	Pinched Nerve	_____
Goiter	Pneumonia	_____
Heart Disease	Polio	_____

Circle ALL that apply:

Exercise
- None
- Moderate
- Daily
- Heavy

Work Activity
- Sitting
- Standing
- Light Labor
- Heavy Labor

Habits
- Smoking – Packs/Day: _____
- Alcohol – Drinks/Week: _____
- Coffee/Caffeine – Cups/Day: _____
- High Stress Level – Reason: _____

Family
- Are you Pregnant? _____

Injuries/Surgeries (Falls, Head Injuries, Broken Bones, Dislocations, Surgeries):

_____

_____

_____

Medications: _____

_____

_____

Allergies: _____

Patient's Name _____ **DOB:**_____

INFORMED CONSENT

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- palpation/range of motion/orthopedic/neurological/postural testing
- spinal manipulative therapy
- physiotherapy/massage therapy/decompression therapy

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization / Surgery

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

NOTICE OF PRIVACY PRACTICES

I understand the "Notice of Privacy Practices for Protected Health Information" describing how my medical information may be used and disclosed, and how I can get access to this information. (A copy of this document can be sent to you at any time.)

MINOR CONSENT

I hereby authorize Family Chiropractic Clinic, together with whomever my treating doctor may designate as an appropriate individual(s) to administer chiropractic care, including X-rays, and appropriate adjunctive services as my treating chiropractor deems is necessary to my child. I acknowledge that I have legal authority to provide such written consent on behalf of such child/ward.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE

Signature of Patient OR
Parent/Legal Guardian (If signing for a minor): _____ **Date:** _____

Printed Name of Patient OR
Parent/Legal Guardian (If signing for a minor): _____ **Witness:** _____