Full Name:_____ Age: _____ Birthdate: _____ Today's date:_____

Address:_____ City: _____ State:_____ Zip: _____

Cell Phone#: _____ Email:_____ Soc. Sec. No.: _____

Opt-In for Text Reminders for appointments? Y N Home phone#(optional):_____

Place of Employment: _____ Occupation:_____ Years on job: _____

Gender: M F FEMALES: Are/could possibly be pregnant? Y N Marital Status: S M W D

Primary Health Ins. _____ Secondary Health Ins. _____

Prim Member ID _____Group _____Sec Member ID _____Group _____

Referrals: Our Clinic is primarily referral based. We would like to know who to thank for sending you to us.

Existing Patient_____ Ad Internet Phone Book Other _____

Primary complaint:_____Started When?_____

How?_____

Other complaint:_____Started When?_____

How?_____

AUTHORIZATION TO BILL INSURANCE

I give permission to Elkins Family Chiropractic, Inc. To file for insurance benefits to pay for the care that I received. I understand that Elkins Family Chiropractic will send my medical information to my insurance company, I must pay my share of the cost, I must pay for the cost of care I received my insurance company does not pay or I do not have insurance. Furthermore, I understand I have the right to Refuse any treatment or procedure, I have the right to discuss all medical treatments with my provider, and I have the right to ask about cost before I intrigued.

Signature :_____ Date:_____

Notice Of Privacy Practice

HIPAA Privacy Policy: I understand and have been provided with a *HIPAA Notice of Privacy Practices* that provides a more complete description of information uses and disclosures of protected health information. I understand that I have the following rights and privileges: The right to review the notice prior to signing this consent, The right to object to the use of my health information for directory purposes and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Signature :_____ Date:_____

CONSENT TO TREATMENT OF MINORS

I hereby request and authorize Elkins Family Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion. As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Parent/Guardian(sign): _____ Minor's Name _____

Informed consent documentation

Patient Name:_____

To the Patient: 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 used by doctors 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.

The risks inherent in chiropractic adjustment. As with any health care procedure, there are certain complications which may arise doing chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costove1tebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor 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 the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during exanimation and X-ray. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options. Other treatment options for your condition may include:

1.Self-administered, over-the-counter analgesics and rest 2. Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers 3. Hospitalization 4. Surgery If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

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.

Analysis / Examination / Treatment As a part of the analysis, exanimation, and treatment, you are consenting to the any and all of the following procedures **that are not checked**: ___ manual spinal manipulative therapy ____Instrument assisted spinal manip___ palpation ___ vital signs ___ range of motion testing ___ 0rthopedic testing ___ basic neurological testing ____ muscle strength testing ____ postural analysis testing ____ ultrasound ____EMS ____ radiographic studies _____ Other (please explain)

By Signing below, I have read and had the opportunity to discuss the risk and benefits of chiropractic care and consent to treatment by John Elkins, DC or Amy Elkins DC

Doctor: _____

Signature: _____ Date: _____

Date: _____ John C. Elkins, DC Amy R. Elkins, DC

DR. AMY R. ELKINS **CASE HISTORY** **DR. JOHN C. ELKINS**

I. Past History:

1. **Surgeries:** (Check all that apply and put the date in the space provided) Patient:_____

☐ Appendectomy_____ ☐ Bunion _____ ☐ Cardiac bypass_____

☐ Cardiac valve _____ ☐ Cataracts (Rt/ Lt) _____ ☐ C-Section _____ ☐ Cosmetic/plastic_____

☐ Carpel Tunnel _____ ☐ Ear tubes(Rt/ Lt) _____ ☐ Gall bladder _____ ☐ Gastric bypass_____

☐ Hysterectomy _____ ☐ Knee Replace(Rt/Lt)_____ ☐ AAA repair _____

Other: _____

_____

2. **Medications**: Current: _____

_____

Current medication Allergies: (Check all that apply and describe the reaction)

☐ Amoxicillin _____ ☐ Cipro _____ ☐ Codeine _____ ☐ NSAIDS _____

☐ Demerol _____ ☐ Erythromyocin _____ ☐ Iodine _____ ☐ Morphine_____

☐ Penicillins_____ ☐ Sulfa _____ ☐ Ultram_____ ☐ Other_____

3. **Illnesses:** Please list any major illness you have been previously diagnosed with and the date (i.e. hypertension, diabetes, cancer, stroke, epilepsy, heart disease, MS, depression, asthma, osteoporosis, liver disease, rheumatoid, etc)

_____

_____

_____

4. **Accidents:** *Please check any major traumas and list the approximate date they happened.*

☐ Slip / fall_____ ☐ Automobile _____ ☐ Boating _____ ☐ Work Injury_____

Has any injury resulted in fractures, permanent injury or disability hospitalization? Y / N *Which injury?* _____

II Family History

	High Blood Pressure	Heart Disease	Cancer	Diabetes	Stroke	Kidney	Scoliosis	Hereditary Arthritis	Thyroid	Hereditary Disorder	Other _____
Mother:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Siblings:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Children:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

III **Work History** *Hours/week* *Please check all that apply to your current job.*

☐ Full Time ☐ 20-40 ☐ mostly sitting ☐ mostly standing ☐ mostly walking

☐ Part Time ☐ 40-50 ☐ light labor ☐ moderate labor ☐ heavy labor ☐ sedentary

☐ Home Maker ☐ 50-60 ☐ computer ☐ repetitive ☐ telephone ☐ difficult

☐ Unemployed ☐ 60-70 ☐ enjoyable ☐ relaxed ☐ stressful

☐ Student Current Employer:_____

IV **Social History**

Exercise

☐ Several time/week ☐ Aerobic

☐ Every other day ☐ Weights

☐ Once a week ☐ Stretching

☐ Almost nothing ☐ Walking

☐ Sports?_____

Alcohol use

☐ Never

☐ Social

☐ Light

☐ Moderate

☐ Heavy

Smoking

☐ Never

☐ Light

☐ Moderate

☐ Heavy

☐ Former

Diet

☐ Controlled ☐ 1-2 ☐ Balanced

☐ Not controlled ☐ 2-3 ☐ Low Carb

☐ Restricted ☐ 4+ ☐ High protein

☐ Unrestricted ☐ Low fat

☐ Low-Cholesterol

Initial / Date	Initial / Date	Initial / Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you follow a diet plan (Jenny Craig,Vegan Vegan, Diabetic)_____

Energy Drinks _____ per day

Patient Name:_____ Date:_____

Musculoskeletal

Osteoporosis	Y	N
Arthritis	Y	N
Scoliosis	Y	N
Neck pain	Y	N
Back problems	Y	N
Hip disorders	Y	N
Knee injuries issues	Y	N
Foot/ankle pain	Y	N
Shoulder problems	Y	N
Elbow/wrist pain	Y	N
TMJ	Y	N
Poor posture	Y	N

Nervous System

Anxiety	Y	N
Depression	Y	N
Memory issues	Y	N
Sleeping issues	Y	N
Headache	Y	N
Dizziness	Y	N
Pins and needles	Y	N
Numbness	Y	N
Loss of smell/taste	Y	N
Weakness	Y	N
Tremors	Y	N
Loss of Coordination	Y	N

Head and Neck Symptoms

Change in head size	Y	N
Blurred/double vision	Y	N
Earache	Y	N
Hearing loss	Y	N
Ringing in the ears	Y	N
Hoarseness	Y	N
Sore throat	Y	N
Chronic ear infections	Y	N
Difficulty swallowing	Y	N
Sinus Infection	Y	N

Cardiovascular Symptoms

Chest pain	Y	N	Low Blood Pressure	Y	N
Palpitations	Y	N	High cholesterol	Y	N
Dizziness	Y	N	Excessive bruising	Y	N
Trouble breathing	Y	N	Leg Swelling	Y	N
High Blood Pressure	Y	N	Jaw/Arm Pain	Y	N

Respiratory Symptoms

Cough	Y	N	Emphysema	Y	N
Shortness of	Y	N	Hay fever	Y	N
breath			Pneumonia	Y	N
Asthma	Y	N	Wheezing	Y	N
Sleep Apnea	Y	N	Coughing blood	Y	N

Gastrointestinal Symptoms

Nausea	Y	N	Food Sensitivities	Y	N
Vomiting	Y	N	Alt. Bowel Habits	Y	N
Stomach Pain	Y	N	Constipation	Y	N
Heartburn	Y	N	Diarrhea	Y	N
Ulcer	Y	N	Blood in Stool	Y	N

Genitourinary Symptoms

Trouble Urinating	Y	N	Painful urination	Y	N
Urgency	Y	N	Lump in groin	Y	N
Urinary Frequency	Y	N	Chronic urinary	Y	N
Incontinence	Y	N	infections		
Blood in the Urine	Y	N			

Endocrine Symptoms

Diabetes	Y	N	Increase in size	Y	N
Heat or Cold	Y	N	Of hands/feet		
Intolerance			Sudden weight	Y	N
Hyperthyroidism	Y	N	changes		
Hypothyroidism	Y	N	Constant Thirst	Y	N
Pancreatic probs	Y	N	Purple Streaks	Y	N

Skin, Hair and Nails Symptoms

New Rashes	Y	N	Eczema	Y	N
Easily Bruised	Y	N	Psoriasis	Y	N
Bleeding gums	Y	N	Skin Cancer	Y	N
Increased/Decrease	Y	N	Excessive hair loss	Y	N
pigmentation			Skin Lesions	Y	N
Excessive acne	Y	N			

Doctor's Comments: _____

_____

Initial / Date _____/_____ _____/_____ _____/_____ _____/_____

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____