# **PROVANCE** CHIROPRACTIC
## SPORTS, FAMILY & REHABILIATION CLINIC

### PATIENT INTRODUCTION FORM

Name________________________________ Name Called____________ Date of Birth______________ Age_______

Address______________________________________ City__________________ State______ Zip__________

Home Phone________________________ Work____________________ Cell______________________

Email________________________________________________

Married_____ Single_____ Divorced_____ Widowed____ Social Security Number______________________

Employed_______ Employed by____________________________________ Full Time Student__________

Have You Had Previous Chiropractic Care?__________ Where?________________________________

Who Referred You?_____________________________ Relationship___________________________

Sports You Participate In?____________________________

WOMEN ONLY Are You Pregnant?__________ Date of Last Menstrual Cycle______________________

Name of Wife or Husband______________________ Ages of Children__________________________

Spouse's Employer______________________________ Spouse's Business Phone___________________

Nearest Relative Not Living with You______________________________

Relative's Address________________________________________ Phone Number___________________

Who is Responsible for Your Bill? Self___ Spouse___ Parent ___ Employer____ Insurance_____ Other_______

How will Payment be Made?

_____Cash ______Check _______Credit Card

______Health Insurance ______Worker's Comp _______Auto Insurance Policy

Insured Name:____________________________________

Insured Date of Birth:____________________________

Is your current condition related to current or previous employment? Yes____ No____

Is your current condition related to an auto accident? Yes____ No_____

Is your current condition related to another type of accident? Yes_____ No______

**Patient's or Authorized Person's Signature:** I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorized card.

Signed____________________________________________________ Date________________________

**Insured or Authorized Person's Signature:** I authorize payment of medical benefits to Provance Chiropractic for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing.

Signed__________________________________________________ Date_________________________

**If you are paying cash**: I understand that payments are due when services are rendered unless other specific arrangements are made in advance.

**If you are filing insurance**: I understand that whatever amounts are not collected from insurance claims, I personally owe the clinic the remaining balance.

Signature_______________________________________________ Date__________________________

**Name**____________________

Please describe the principle health problems for which you came to this office:

1. ________________________________________
2. ________________________________________
3. ________________________________________

Date of each problem:______________________________

Have you ever had these problems/symptoms before?_______ If yes, please explain____________________

________________________________________

List any other doctors you have seen for this problem____________________

List diagnosis(es) and type of treatment(s)____________________

Your condition after these treatments (circle one): same better worse

Dates of Disability: From ___________ to ____________: Hospitalized From _____________to ____________

Does your injury interfere with your normal living and work? Yes_____ No______ In what way?_______________

________________________________________

Have you lost any days of work? Yes____ No____ Dates:____________________

Has a physician treated you for any health condition in the last year? Yes_____ No______

If Yes, explain:______________________________

________________________________________

Are you presently taking any medication? List name and dosage:____________________

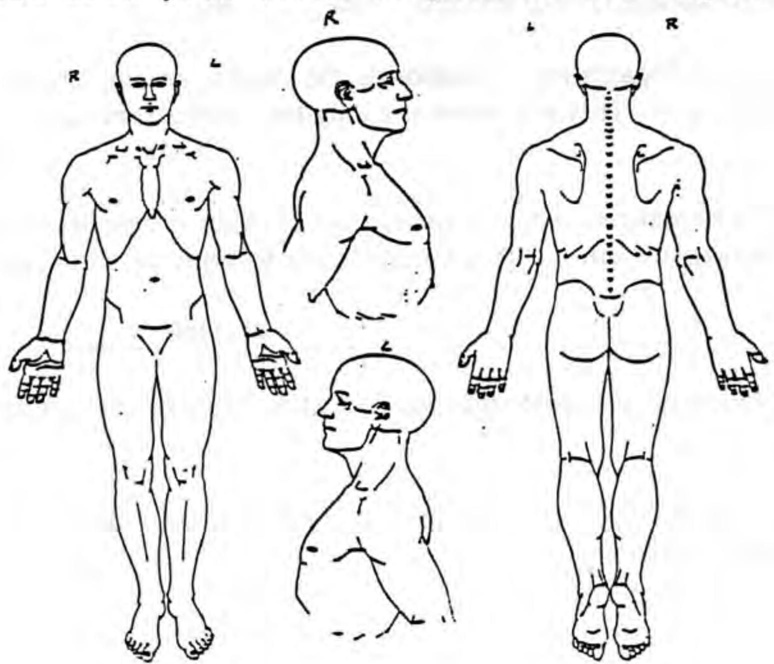
________________________________________

## PAST HISTORY

List the approximate dates of any operations, unusual diseases, serious illnesses or accidents you have had (include any broken bones)____________________

________________________________________

Please mark your areas of pain in the figure below:



# PROVANCE CHIROPRACTIC
# SPORTS, FAMILY, AND REHAB CLINIC

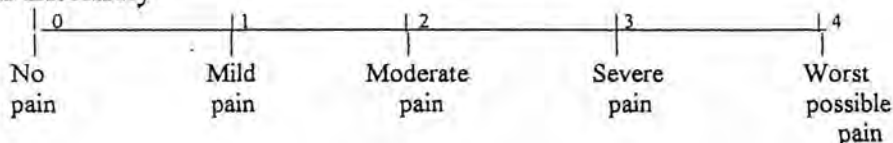
**Name**________________________

## FUNCTIONAL RATING INDEX

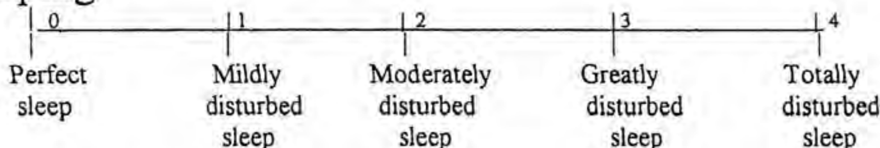
FOR USE WITH NECK AND /OR BACK PROBLEMS ONLY.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

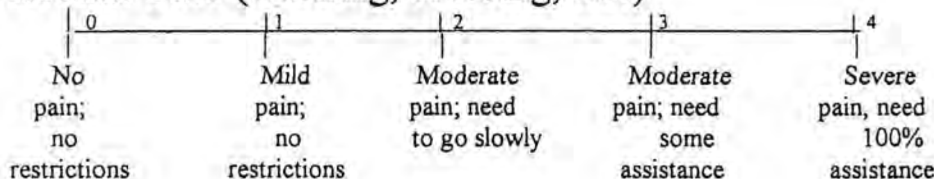
1. Pain Intensity



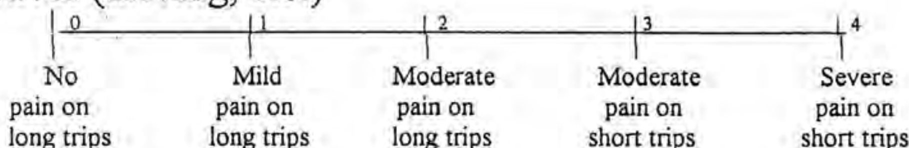

2. Sleeping



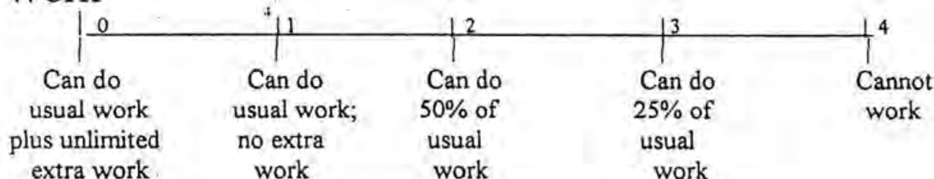

3. Personal Care (washing, dressing, etc.)



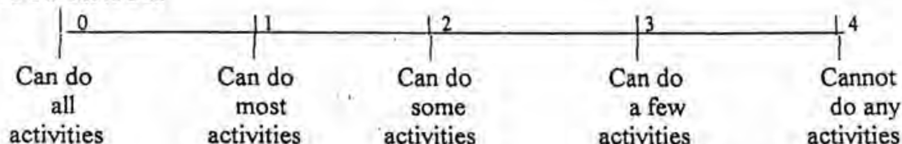

4. Travel (driving, etc.)



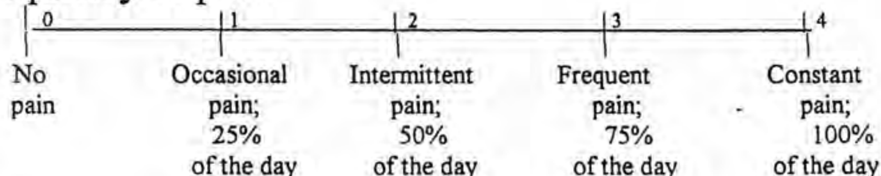

5. Work



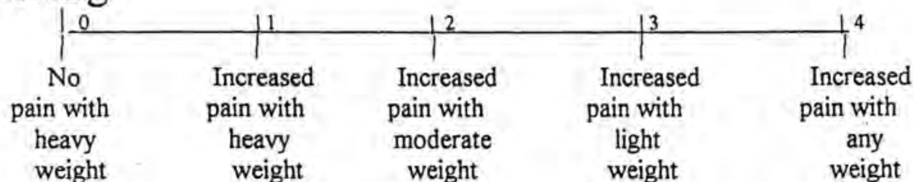
## 6. Recreation



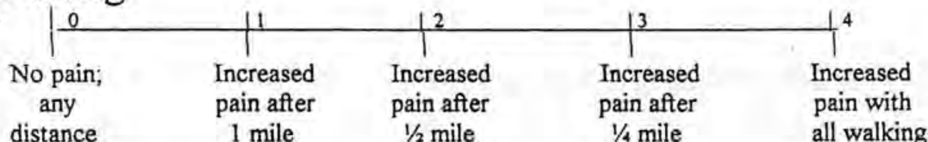

## 7. Frequency of pain



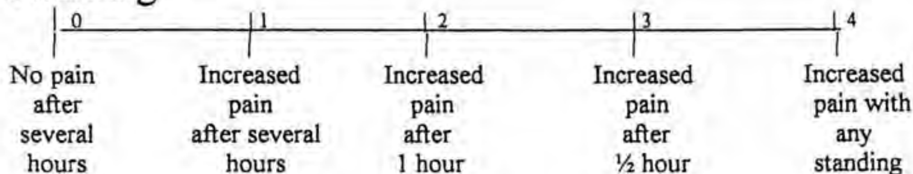

## 8. Lifting




## 9. Walking




## 10. Standing




Patient's Signature ____________________ Date ____________

Functional Rating Index · Feise and Menke
©1999 Institute of Evidence-Based Chiropractic
Spine · Volume 26 · Number 1 · 2001

## Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone at work or home and you are not available, a message will be left on your answering machine or with whoever answers your phone. By signing this form, you are giving Provance Chiropractic Clinic authorization to contact you with reminder calls, reminder cards, dismissal letters, and any other correspondence to your home or office. This authorization will also allow our office to display names of patients who have referred new patients to our office on our referral board.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (R164.524).

This notice is effective as of _______________. This authorization will expire six years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

| | |
|---|---|
| ______________________________ | ______________________________ |
| Patient name printed | Date |
| ______________________________ | ______________________________ |
| Patient Signature | Authorized provider representative |
| ______________________________ | ______________________________ |
| Personal representative (printed) | Personal representative (signature) |

______________________________________________________________________

Description of personal representative's authority to act for the patient.

**Your right to complain**

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

Secretary for Health and Human Services
200 Independence Ave. , SW
Washington, DC 20201

**To contact us**

If you would like further information about our privacy policies and practices please contact:

Provance Chiropractic **(Name or office)**
2007 Clearview Pkwy **(Address)**
Metairie, La. 70001
(504)456-9296 **(Phone)**

This notice is effective as of ____________________. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

| | |
|---|---|
| ______________________ Patient name printed | ______________________ Date |
| ______________________ Patient Signature | ______________________ Authorized Provider Representative |
| ______________________ Personal representative printed | ______________________ Personal representative signature |

______________________________________________
Description of personal representative's authority to act for the patient.



Copyright © 2001 Wisconsin Chiropractic Association. All rights reserved

PROVANCE Chiropractic
Sports, Family & Rehab Clinic, Inc.

Patient Name____________
Date____________

## CONFIDENTIAL HEALTH HISTORY

The items below may relate to your condition. In the space in front of each item (√) if you have this problem.

### GENERAL
_____ Fever
_____ Chills
_____ Night Sweats
_____ Loss of Sleep
_____ Fatigue
_____ Nervousness
_____ Weight Loss or Gain
_____ Allergies
_____ Bleeding Problem
_____ Anemia
_____ Diabetes
_____ Cancer
_____ Thyroid Disease/ Goiter
_____ Alcoholism
_____ Drug Abuse
_____ Any surgeries
_____ Any Medications
_____ Any Supplements/Vitamin

### EYE EAR NOSE THROAT
_____ Poor Vision
_____ Pain in Eyes
_____ Deafness/Difficulty Hearing
_____ Nose Bleeds
_____ Nose Problems
_____ Sinus Trouble
_____ Dental Problems
_____ Hoarseness
_____ Tonsillectomy

### GASTROINTESTINAL
_____ Poor Appetite/Digestion
_____ Difficulty Swallowing
_____ Belching or Gas
_____ Frequent Nausea
_____ Vomiting
_____ Vomiting Blood
_____ Pain over Abdomen
_____ Ulcer
_____ Black or Bloody Stools
_____ Liver Problems
_____ Gall Bladder Problems
_____ Jaundice
_____ Hernia
_____ Diarrhea
_____ Constipation
_____ Hemorrhoids
_____ Appendicitis

### MEN ONLY
_____ Testicular Swelling/Pain
_____ Prostate Problems

### RESPIRATORY
_____ Difficulty Breathing
_____ Chronic Cough
_____ Spitting Phlegm
_____ Spitting Blood
_____ Wheezing/Asthma
_____ Pneumonia
_____ Tuberculosis

### CARDIOVASCULAR
_____ Irregular Heartbeat
_____ High Blood Pressure
_____ Pain over Heart
_____ Ankle Swelling
_____ Varicose Veins
_____ Rheumatic Fever
_____ Stroke

### GENITOUINARY
_____ Frequent urinating
_____ Painful Urination
_____ Blood in Urine
_____ Kidney Disease
_____ Inability to control urination
_____ Difficulty Starting Urine Flow
_____ Get up _____ times per night to urinate
_____ Breast Lump or Pain
_____ Venereal Infection
_____ Sexual Difficulties

### WOMEN ONLY
_____ Painful Periods
_____ Excessive Flow
_____ Vaginal burning or itching
_____ Hot Flashes
_____ Date Last Period Began
_____ Date of Last Pap Test

### Skin
_____ Itching
_____ Burning Easily
_____ Change in Mole(s)
_____ Skin Cancer

### NEUROLOGIC
_____ Weakness
_____ Twitching
_____ Tremors
_____ Headache
_____ Fainting
_____ Dizziness
_____ Convulsions
_____ Epilepsy
_____ Numbness/tingling
_____ Arm/Leg Pain
_____ Mental Disorder

### MUSCULOSKELETAL
_____ Neck Stiffness/Pain
_____ Pain Between Shoulders
_____ Low Back Pain
_____ Swollen Joints
_____ Painful Joints
_____ Muscle Aches/Soreness
_____ Spinal curvature
_____ Arthritis
_____ Any Fractures

### HABITS
_____ Smoking _____Packs per day
_____ Drinking
_____ Recreational Drug Use

### EXERCISE
_____ None
_____ 1-2 times per week
_____ 3-5 times per week
_____ 6-7 times per week

### FAMILY HISTORY
_____ Diabetes
_____ Thyroid Disease
_____ Tuberculosis
_____ Kidney Disease
_____ High Blood Pressure
_____ Heart Disease
_____ Cancer
_____ Muscle, bone or Nerve Disease

# PROVANCE CHIROPRACTIC
# SPORTS, FAMILY AND REHAB CLINIC

## *Informed Consent For Chiropractic Treatment*

**TO THE PATIENT:** You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and 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 on the facts then known, is in my best interest. I further acknowledge that no guarantees or or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and al my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition(s) for which I seek treatment.

---

To be completed by the patient:

____________________________
print name

____________________________
signature of patient

____________________________
date signed

To be completed by patient's representative, if necessary, e.g., if the patient is a minor or physically or legally incapacitated:

____________________________
print name of patient

____________________________
print name of patient's representative

____________________________
signature of patient's representative

as:____________________________
relationship or authority of patient's representative

____________________________
date signed

____________________________ ____________
witness to patient's signature date