

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please, if you have any questions or concerns, do not hesitate to ask for our assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ S/S ____-____-____
 First MI Last

Address _____ City _____ State ____ Zip _____

Sex: Female ____ Male ____ E-mail address _____

Birth Date ____-____-____ Home Phone# ____-____-____ Work # ____-____-____

Do you prefer to receive calls at: Home ____ Work ____ Either ____

Are you: Married ____ Divorced ____ Widowed ____ Single ____ Separated ____

Your Employer _____ Occupation _____

Business Address _____ City _____ State ____ Zip _____

Spouse's or Parent's Name _____ Work Place _____ Phone# _____

Children's Names/Ages _____

Who can we thank for referring you _____

Person to contact in case of an emergency _____ **Phone#** _____

Insurance Information

(please make sure front office has a copy of your card)

Name of Insurance _____ ID# _____ Group# _____

Complete below information if insured information is different than patient information

Insured's Name _____ Insured's Date of Birth ____-____-____

Insured's Work Place _____ Insured's Work Phone# ____-____-____

Insured's Address if different than patient address: _____

Chief Complaint

Reason for visit _____ When did you first notice symptoms _____

Is condition getting progressively worse? ____ Where specifically is problem? _____

Which activities are difficult to perform? ____ Sitting ____ Standing ____ Walking ____ Bending

____ Lying Down ____ Other _____

Type of pain: ____ Sharp ____ Dull ____ Throbbing ____ Numbness ____ Aching ____ Shooting

____ Burning ____ Tingling ____ Cramps ____ Stiffness ____ Swelling ____ Other

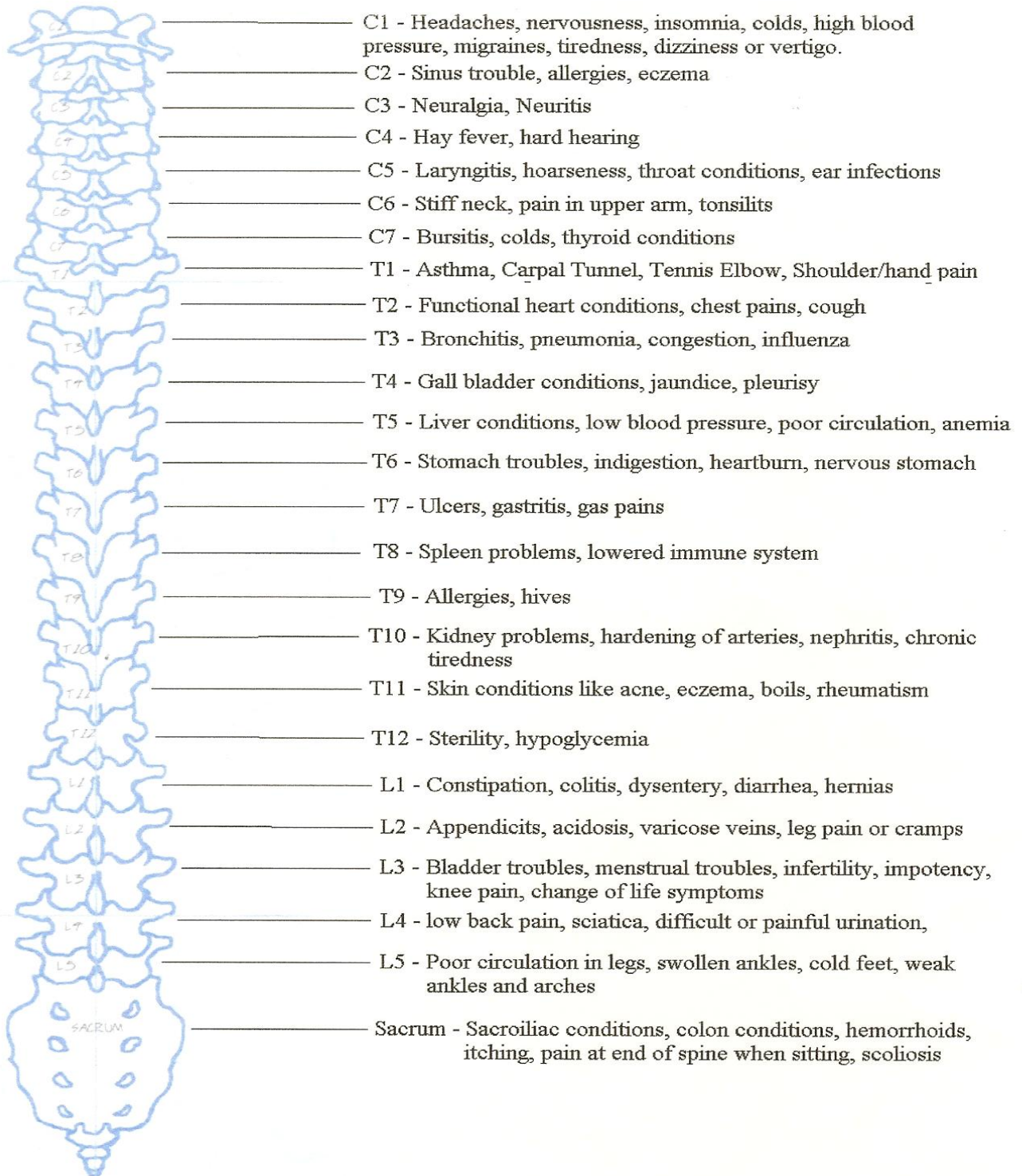
Rate severity of pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition? _____

Name of other doctor(s) who have treated you for your condition? _____

Read the symptoms listed below and circle the corresponding vertebra.



Health History

Check only those conditions which are applicable:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Chest Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Suicide Attempt | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Tumors, Growths | <input type="checkbox"/> Vaginal Infections | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Venereal Disease | |

Dates of last exam _____

(Women) Are you pregnant? Yes No Taking birth control? Yes No Nursing? Yes No

List any types of surgeries which you have had and the dates which they occurred:

Please list all medications you are currently taking: _____

Allergies: _____

Daily Habits

What type of exercise do you perform on a daily basis? None Moderate Heavy

What do your daily work habits include? (Ex. sitting, light labor, heavy labor, computer work)

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take? _____

Do you smoke? Yes No How much per day? _____

How much alcohol do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Do you consume diet products (ex. diet soda) that contain Nutrasweet? Yes No

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor insurance benefits otherwise payable to me. **I understand my chiropractic insurance carrier may pay less than the actual bill for services, I agree to be responsible for payment of all services rendered on my behalf or my dependent.**

X _____

Signature of patient(or parent of minor)

Date

STUCKEY FAMILY CHIROPRACTIC HAS MY PERMISSION TO SEND ME ANY NECESSARY CORRESPONDENCE.

_____ YES

_____ NO

STUCKEY FAMILY CHIROPRACTIC HAS MY PERMISSION TO LEAVE A VERBAL MESSAGE REGARDING APPOINTMENT INFORMATION WITH:

_____ ONLY MYSELF

_____ WHOEVER ANSWERS THE PHONE

_____ PLEASE DO NOT CALL ME

I HAVE HAD THE OPPORTUNITY TO REVIEW THE STUCKEY FAMILY CHIROPRACTIC PRIVACY (HIPPA) POLICY.

_____ YES

_____ NO

SIGNATURE _____

DATE _____

Stuckey Family Chiropractic
2510 Mineral Point Avenue
Suite 100
Janesville, WI 53548

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT-An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

HEALTH-A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION-A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contradicted. Again, it is the responsibility of the patient to make it known or to learn through health care procedures, whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures.

I, _____ have read and fully understand the above statements.

(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(Signature)

(Date)

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period _____

(Signature)

(Date)