DEMOGRAPHICS FORM

Patient Info:

First: ______________ Middle: ________ Last: ______________

Sex: **M / F** Marital Status: ____ Date of Birth: ____________ SSN #: ______________

Home Address: ______________________________ Apt #: ________

City: ______________________ State: ______ Zip: ____________

Home Phone: ______________ Email: ______________________

Cell Phone: ________________ Cell Phone Provider: ______________

Employer Info:

Employer: ____________________________ Phone: ____________

Job Description: ______________________________________

Business Address: ______________________________________

Is the patient here as a result of an accident? **Y / N** Date of Accident: ______________

Type of Accident: ________ (**A**)uto (**W**)ork (**H**)ome (**S**)ports (**N**)one

Insurance Info:

Type of Insurance: ____ (**A**)uto (**W**)ork (**H**)ealth (**W**)orkers Comp. (**L**)etter of Protection

Primary: ________________ **(if Auto)** Claim #: ______________

Insurance Company Address and Phone Number

__________________________ Group Number: ____________

__________________________ I.D. Number: ____________

Secondary: ________________

Insurance Company Address and Phone Number

__________________________ Group Number: ____________

__________________________ I.D. Number: ____________

Attorney Info:

Attorney's Office: ______________________

Attorney's Name: ______________________ Phone: ____________

Address: ______________________________________

City: ______________________ State: ______ Zip: ____________

Signature: ____________________________ **Date:** ____________

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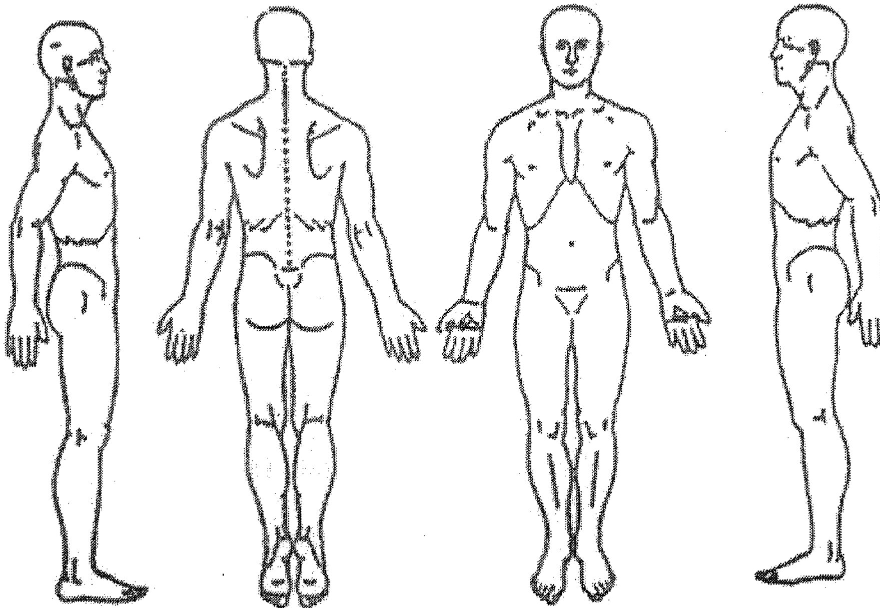
Primary Area/s of Complaint	***Pain Level (circle one)***
1. ______________________________	0 1 2 3 4 5 6 7 8 9 10
2. ______________________________	0 1 2 3 4 5 6 7 8 9 10
3. ______________________________	0 1 2 3 4 5 6 7 8 9 10
4. ______________________________	0 1 2 3 4 5 6 7 8 9 10
5. ______________________________	0 1 2 3 4 5 6 7 8 9 10

QUALITY OF PAIN

Use the LETTERS below to indicate the type and location of your sensation right now.

A=Ache P=Pins & Needles B=Burning N=Numbness S=Stabbing O=other



Print Name: ____

Signature: ______________________________ Date: ______________

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MEDICAL HISTORY

Name: ____ Date: ___________

FAMILY HISTORY: If any blood relative has suffered any of the following, please **check** the condition **AND** indicate which relative. (*ie: mother, father, grandmother, grandfather, etc..*)

__ Arthritis: ________
__ Diabetes: ________
__ Thyroid: ________
__ Osteoporosis: ________
__ Heart Disease: ________
__ Asthma: ________
__ Stroke: ________
__ Hypertension: ________
__ Anemia: ________
__ Glaucoma: ________
__ Cancer: ________
__ Alcoholism: ________
__ Bleeds Easily: ________
__ Migraine: ________
__ Mental Illness: ________
__ Epilepsy: ________

HOPSITAL ADMISSIONS: (NOT including pregnancy)

Year _____ Illness or Operation ____________________
Year _____ Illness or Operation ____________________
Year _____ Illness or Operation ____________________
Year _____ Illness or Operation ____________________

ALLERGIES: ____

MEDICAL HISTORY: Instructions: ✓ Check any ***CURRENT*** problems. P Mark ***"P"*** for any ***PAST*** problems.

Reason for Today's Visit: 1. ____________ 2. ____________ 3. ____________

☐ Diabetes
☐ Stroke
☐ Heart Attack
☐ Hypertension
☐ HIV/AIDS
☐ Hepatitis A B C D
☐ Thyroid Disease
☐ Decreased Hearing
☐ Ringing in the ears
☐ Frequent Ear Infections
☐ Dizzy Spells
☐ Failing vision or Eye Pain
☐ Sinus trouble
☐ Hay fever/Allergies
☐ Hoarseness-prolonged
☐ Pneumonia/Pleurisy
☐ Bronchitis/Chronic Cough
☐ Asthma/Wheezing
☐ Chest Pain
☐ High Blood Pressure
☐ Shortness of Breath
☐ Tuberculosis
☐ Heart Murmurs
☐ Swollen Ankles
☐ Sudden Weight Loss
☐ Cancer
☐ Difficulty Swallowing
☐ Indigestion or Heartburn

☐ Peptic Ulcers
☐ Gallbladder Trouble
☐ Diarrhea
☐ Constipation
☐ Bloody or Tarry stools
☐ Hemorrhoids
☐ Hernia
☐ Diverticulitis or Crohns/Colitis
☐ Urination-overnight 2+
☐ Decrease force/flow urination
☐ Bowel dysfunction
☐ Sleeping Difficulty
☐ Chronic Fatigue
☐ Fibromyalgia
☐ Loss of Appetite
☐ Anemia
☐ Convulsions/Seizures
☐ Tremors/Shaking Hands
☐ Epilepsy
☐ Muscle Weakness-progressive
☐ Leg pain
☐ Neck Pain-recurrent
☐ Back Pain-recurrent
☐ Numbness/Tingling
☐ Foot Pain/Cold Numb Feet
☐ Arthritis/Rheumatism
☐ Bone Fracture
☐ Gout

☐ Osteoporosis
☐ Rashes/Hives
☐ Herpes
☐ Bruise Easily
☐ Psoriasis/Eczema
☐ Phobias
☐ Depression/Anxiety
☐ Memory Loss
☐ Mental Illness
☐ Substance Abuse
☐ Alcohol use __drinks/day
☐ Smoking__cig./day
☐ Coffee/Tea __day

FEMALES ONLY:
Menstrual Flow: Reg. / Irreg.
# of Pregnancies – ____
Live:
Miscarriages:
Birth Control Name:
Last PAP Date:_____
Normal Abnormal
Last Mammogram Date: ____
Normal Abnormal

MALES ONLY:
Last Prostate Exam date:
Normal Abnormal

Other: ____

Signature: ______________________________________ Date: ___________

CURRENT MEDICATIONS:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________
9. ______________________
10. ______________________

☐ I am currently NOT taking any medications.

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Main (904) 764-3434
Fax (904) 764-3211

X-Ray / Treatment Consent Form

Patient consent to X-Ray

I, ______________________________, authorize the performance of diagnostic X-Ray examination of myself, which the above doctor or his associate may consider necessary or advisable in the course of my examination and treatment.

Signed: ______________________________ Date: ______________

Non-Pregnancy Verification

This is to certify that to the best of my knowledge, I am **NOT pregnant** and the above doctor and his associates have my permission to perform a diagnostic X-Ray examination. I have been advised that X-Ray can be hazardous to an unborn child.

Date of Last Menstrual Period: ______________

Signed: ______________________________ Date: ______________

Consent to X-Ray / Treat a Minor

I, ______________________________, authorize the performance of treatment and / or diagnostic X-Ray examination of my child or ward ______________________________ which the above doctor or his associate to consider necessary or advisable in the course of examination and treatment. The minor is _____ years of age.

Signed: ______________________________ Date: ______________

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Notice of Privacy Practices (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ THIS FORM CAREFULLY AND SIGN BELOW:

- If you are involved in a third party litigation, any law firm involved in the case may request copies of any and all notes, reports, and billing statements within our possession. We must receive a signed consent from you to release this information.
- You insurance company may request copies of any and all notes, reports, and billing statements within our possession.
- We may send your referring doctor, primary care physician, and workman's compensation claims manager any and all evaluations, progress notes, lift assessment's, and discharge summary so that they are kept aware of your progress and to authorize continued care.
- We may use your personal information to obtain a referral authorization from your primary care physician or specialist so that your insurance company will cover the cost of your treatment.
- We may release your personal information to our contracted billing service, Medical Billing Services, so that they may assist us in billing your insurance company for the services provided by this office.
- We may use your information to verify benefits, co-payment amounts, and billing information with your insurance company.
- You are entitled to a copy of any and all notes, reports, and billing statements within our possession and you may request them at any time. We must have a signed release from you within the previous 30 days to release this information.
- You are entitled to request any and all names of companies and individuals that have requested your information from this office.

By signing below, I acknowledge that I have read and understand how my personal health information may be used and disclosed by TheraMed Medical Clinics.

Signature: ______________________________ Date: ______________

INFORMED CONSENT

It is our responsibility to fully inform you of all aspects of your treatment. Part of this includes a discussion of any potential side effects or complications. All treatments can potentially cause these reactions and chiropractic manipulation is no different; however, it has one of the safest records of wide ranges of treatment that can be used for spinal disorders.

Possible adverse effects of spinal manipulation can include soreness in the area of treatment, reactive muscle spasms, injury to the disc causing pressure on nerve tissue, fractures in weakened bone such as ribs, and injury to arteries in the neck resulting in a stroke. Soreness or reactive muscle spasms or tightening are common but usually brief reaction to treatment. The other potential complications are rare. It is best to examine the frequency of these potential complications versus the relative frequency of the complications of the other typical treatments which may be used for spinal disorder.

Disc injury from manipulation Causing spinal cord pressure	Neurologic complication from Neck Surgery	 Back Surgery
1 per 100 million	1 per 64	1 per 333
Artery injury from Manipulation causing stroke	Death rate from neck surgery	
1 per million	1 per 145	

Perhaps the most common alternative to spinal manipulation is the use of anti-inflammatory drugs. These cause fairly common and potentially serious complications.

Complications associated with anti-inflammatory drug use:

Serious stomach or intestinal bleeding	1-4 per 1000 users
Hospitalization from complications	20,600 per year
Deaths from compilations	2,600 per year

I have read the above and understand the risk of complications that may occur from spinal manipulation. With this understanding, I consent to treatment with spinal manipulation at TheraMed Medical Clinics.

Signature: ____ Date: ____________

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Please list all hospitals and emergency rooms that you have been treated or seen at since **THIS** incident.

Hospital/ER	**Date of Service**
1. ______________________	1. ______________
2. ______________________	2. ______________
3. ______________________	3. ______________
4. ______________________	4. ______________
5. ______________________	5. ______________

Please list all doctors and/or medical offices that you have been treated or seen at since **THIS** incident.

Facility	**Date of Service**
1. ______________________	1. ______________
2. ______________________	2. ______________
3. ______________________	3. ______________
4. ______________________	4. ______________
5. ______________________	5. ______________

Print Name: ______________________________ Date: ______________

Patient Signature: ______________________________ Date: ______________

Medical Assistant Signature: ______________________ Date: ______________

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RECORDS RELEASE AUTHORIZATION

To: ____

(Doctor/Clinic/Hospital)

Fax #: ____

Address: ____

I, ______________________________, HEREBY AUTHORIZE

AND REQUEST YOU TO RELEASE & FAX TO:

TheraMed Medical Clinics

FAX: (904) 764-3211

MY COMPLETE MEDICAL HISTORY RECORDS IN YOUR POSESSION

CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE TIME

PERIOD OF ______________ TO ______________.

Patient Name: ____

Address: ____

Date of Birth: ____

Patient Signature: ______________________________ Date: ______________

www.FromWhiplashToWellness.com