ABOUT YOU ...

Name: _____ Age:_____ D.O.B:_____ Sex: **M F**

Home Address:_____ City/State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Marital Status: ____ Spouse: _____

Email Address:_____

Preferred Language:_____ Race:_____

Employer: _____ Occupation: _____

Work Phone:_____ How did you hear about Elite Sport & Spine Center?_____

Name and No. of Emergency Contact: _____

Have you ever received chiropractic care? **Y N** With whom? _____

Do you have a family medical doctor? **Y N** Who? _____

WOMEN: Are you pregnant? **Y N** Date of last monthly period: _____

CURRENT HEALTH CONDITION

Current health complaints/reason for consulting our office:

1. _____ For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

Were other doctors seen for this condition? **Y N** Who? _____ Results:_____

Has this condition occurred before? **Y N** Are the injuries a result of an accident? **Y N**

If yes, how did it occur? _____

Please list any medications/supplements currently taking (include dosage/frequency): _____

_____

Please list any allergies AND reactions to medications:_____

Please describe your daily activities for work, home, or school such as sitting, standing, lifting, phone use:

_____

PAST HEALTH HISTORY

Have you had an accident, even as a passenger, in a(n): **(Give dates)**

Automobile:_____ Motorcycle:_____ Bicycle: _____ Other: _____

Medical interventions: **(Circle all that apply)**

Hospitalizations PT Surgery Heart Appendix Hysterectomy Spinal Eye Organ Removal Other

Explain with dates: _____

Injuries: Have you ever had**.(Circle all that apply)**

Broken Bones Spinal/Nerve Disorder Used a crutch/walker Used Neck/Back Bracing Been Unconscious

Sports Injuries

Explain with dates: _____

Do you consume: Alcohol/Coffee/Caffeine Water Intake If so, how much: _____

Please Circle your smoking status: Everyday Some Days Former Never
Exercise: None Moderate Daily

Have you ever had/have any of the following diseases? (Circle all that apply)

Heart Diabetes Cancer Thyroid Issues Lymes Tuberculosis Hepatitis Chicken Pox STD AIDS MS

Circle any of the following conditions you have had in the past six months:

Musculo-skeletal
Arthritis/RA/Gout
Low Back Pain
Neck/Arm Pain
Shoulder Pain
Joint Pain/Stiffness
Knee Pain
Walking Difficulties
Difficulty Chewing/TMJ
General Stiffness

Nervous System
Anxiety
Headaches/Migraines
Numbness/Tingling
Paralysis
Dizziness/Fainting
Forgetfulness
Confusion/Depression
Fibromyalgia
Convulsions

Sensory
Cataracts/Glaucoma
Sore Throat/Frequent Colds
Earaches/Hearing Trouble
Stuffy Nose/Congestion
Ringing In Ears

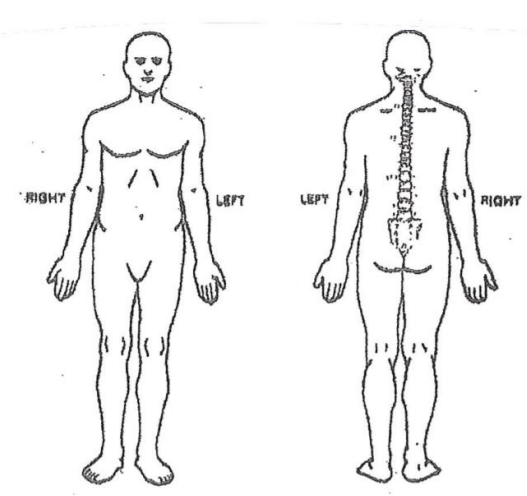
Male/Female
Menstrual Irregularity/Cramps
PMS
Vaginal Pain/Infections
Breast Pain/Lumps
Prostate Issues/ED
Sexual Dysfunction

Digestive Heartburn/Acid
RefluxDiarrhea/Constipation
Ulcer
Nausea/Vomiting
Poor/Excessive Appetite
Excessive Thirst
Hemorrhoids
Liver/Gall Bladder Issues
Sudden Weight Change
Food Sensitivities
IBS/GERD/Colitis

Cardiovascular/Respiratory
Shortness of Breath
High Blood Pressure
High Cholesterol
Heart Problems
Irregular Heartbeat/ Pacemaker
Chest Pains
Varicose Veins/Poor Circulation
Ankle Swelling
Emphysema/Pneumonia

Urinary
Frequent Urination/Leakage
UTI
Kidney Stones

Please outline the area(s) of your discomfort…



Quality of Symptoms (Please circle what it feels like)

Numbness	Burning
Tingling	Shooting
Stiffness	Throbbing
Aching	Sharp

Signature_____ Date _____

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Activities of Daily Living Questionnaire

When you experience difficulties from a painful or restrictive condition, you may find it difficult to do some of the things you normally do. In order to properly assess your condition, we must understand how much your problems have affected your ability to manage everyday activities.

For each item below, please rate how well you can do the following activities with the following:

0= NO ISSUES 1=MILD 2=MODERATE 3= SEVERE

_____Bending	_____Climbing Stairs	_____Lifting
_____Sitting	_____Standing	_____Walking 20 + minutes
_____Lying Down	_____Rising out of chair	_____Turning over in bed
_____Housework	_____Driving/riding	_____Dressing
_____Sleeping	_____Exercise	_____Yardwork
_____Golf	_____Cycling	_____Family activities
_____Work activities	_____Sleep Disturbances (less than 4 hours without interruption)	

Chiropractic Goals:_____

_____

NAME_____DATE_____

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INFORMED CONSENT FOR THE CHIROPRACTIC PATIENT

To the Patient: Please read document and sign. It is important that you understand the information contained in this document.

The nature of the chiropractic adjustment: The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The doctor will use that procedure to treat you. He or she may use her hands or 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 part of the analysis, examination and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpation, trigger point massage, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, ultrasound, cold therapy, biofreeze application, electric muscle therapy, and traction therapy.

The risks inherent in chiropractic adjustment: As with any other healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy that are very rare such as fractures or minor muscle pulls. It is common to feel stiffness or soreness following the first few days of treatment. Fractures are very rare occurrences and generally result from some underlying weakness of the bone. Stroke or vertebral artery dissection caused by chiropractic manipulation of the neck has not been proven but continues to be anecdotal. The doctor will make every reasonable effort during the examination to screen for contraindications to care, however if you have a condition that would not come to the Doctor's obvious attention, it is your responsibility to inform the doctor.

Authorization for the release of patient information: I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I hereby authorize Elite Sport & Spine Center to provide other health care providers with information regarding my healthcare as deemed appropriate. I give my permission for the use of medical records, including x-rays and information shared during the process of examinations and treatment to be released to insurance companies, other doctors, health consultants and or staff involved in my care. Do not sign until you have read and understand the above.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have had all my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to understand the treatment recommended. I hereby give my consent to chiropractic treatment and authorize any pertinent medical records exchange. I understand this consent to be effective until I am notified otherwise.

Signature (Patient/Parent/Legal Guardian)	Relation to Patient
Printed Name	Date

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Elite Sport & Spine Center. When you schedule an appointment with Elite Sport & Spine Center, we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Any established patient who fails to show or cancels/reschedules an appointment for another day and has not contacted our office with at least 24-hour notice will be charged a **$25.00 fee**.
- Any new patient who fails to show for their initial visit will not be rescheduled.
- The fee is charged to the patient and is due at the time of the patient's next office visit.
- As a courtesy, when time allows, we make reminder calls/texts for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be ableto keep your scheduled appointment. You may contact Elite Sport & Spine Center 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

Elite Sport & Spine Center (571)531-0825

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____	_____
Signature (Patient/Parent/Legal Guardian)	Relation to Patient
_____	_____
Printed Name	Date