Cambridge Clinic of Chiropractic
Patient Questionnaire

Patient Information

Patient I.D. _____

PLEASE PRINT USING BLACK INK

Name_____ **Date**_____

Address_____**City**_____ **State**_____ **Zip**_____

❑**Male** ❑**Female** ❑**Married** ❑**Single** ❑**Widowed** ❑**Divorced** ❑**Separated**

Birthdate_____ **Phone**_____

E-mail Address_____

Preferred method of contact = ❑**Mail** ❑**Cell phone** ❑**Home phone** ❑**E mail**

Occupation_____ **#years**_____

Spouse or Parent's Name_____ **Birthdate**_____ **Phone** _____

Emergency Contact_____ **Phone** _____ **Relation**_____

Whom may we thank for referring you to us? _____

Name of local primary Physician_____ **May we contact them?**___

Insurance Information – *If Insured, Please provide copy of insurance card*

SYMPTOMS

Main Complaint_____ **How Bad?**_____ **How Often?**_____

When did it start?_____**Getting Worse?**_____**Getting Better?**_____

What activity bothers it the most? _____

When is it at its best?_____ **When is it at its worst?**_____

Rate the pain - (0 is pain free - 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10

Other Chiropractors?_____ **Positive Experience?**_____

Other type of physician or therapist?_____ **Positive Experience?**_____

Secondary Complaint_____

Health History - *Please circle all that apply*

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M. S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V. D.	Whooping Cough	
Chronic Fatigue	High Blood Pressure	Fibromyalgia	Other_____				

Women - How many children?____**Pregnant?**____**Date of last Menstrual Cycle**_____

Nursing?____**Taking Birth Control Pills?**____

Previous Surgeries and Dates? _____

_____

List ALL Medications you are currently taking _____

_____

Any known allergies?_____

Any known drug allergies?_____

What kind of exercise do you do? _____

Smoking: ❑**Current smoker** ❑**Former smoker** ❑**Never smoked** **Drinks per week?**___

Do you have any high stress activities?_____

***All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.**

Patient Signature_____ **Date**_____

PATIENT NAME _____

DATE _____ Doctor: Timothy Wilbanks, DC_

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

Signature of Patient/Legal Guardian _____

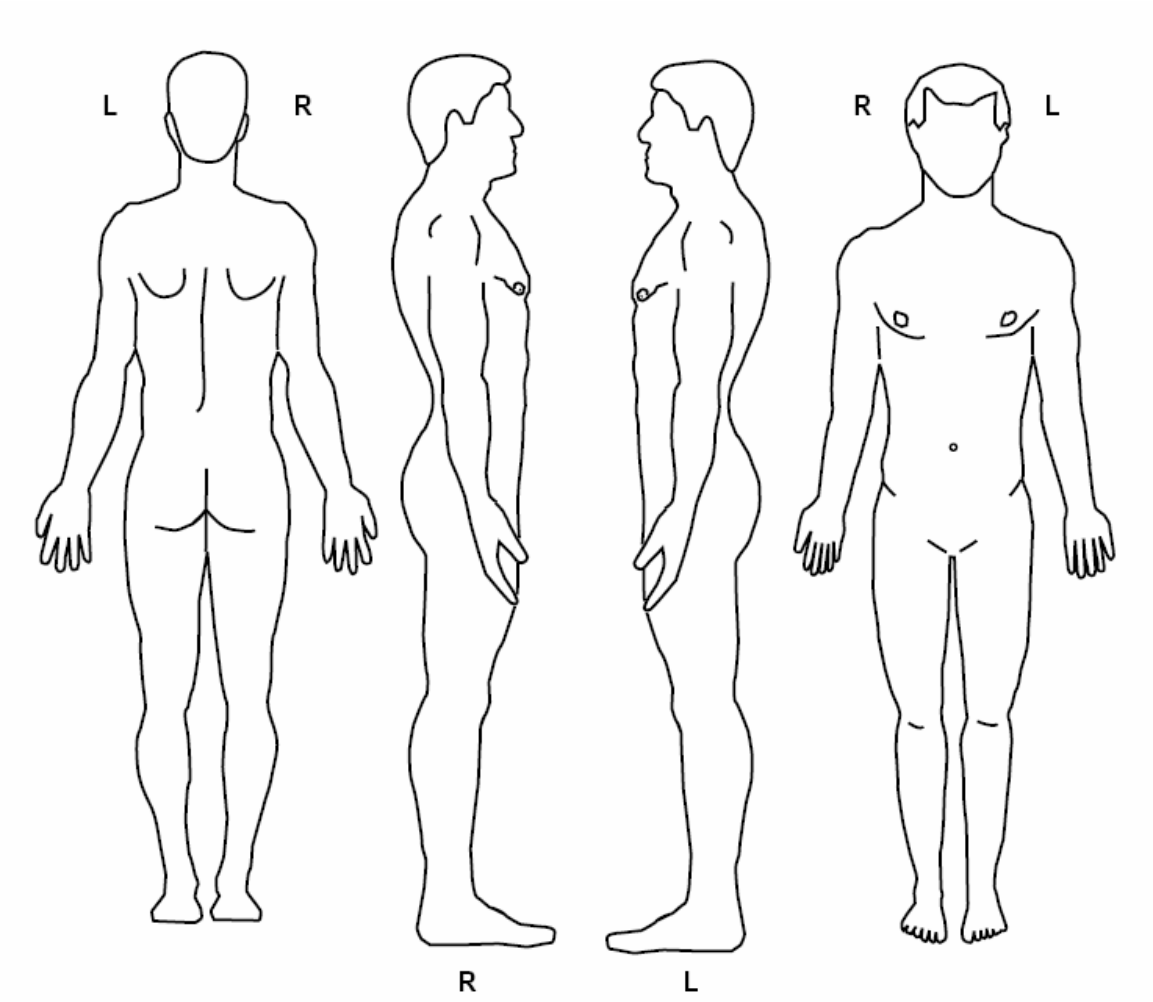
Date _____

PAIN DRAWING

Name: _____ Date: _____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness ----------	Pins & Needles ooooooo	Burning Pain xxxxxxxxx	Stabbing Pain //////////	Aching Pain ((((((((



VISUAL ANALOGUE SCALE

Please mark on the line the pain level that most accurately represents your pain:

NO PAIN:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**UNBEARABLE PAIN**
a) Right Now:----	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
b) Average Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
c) At Best ------	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
d) At Worst-------	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

HIPPA Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing the consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature_____