



1400 N Mt. Juliet Rd., Suite 104, Mount Juliet, TN 37122
Phone (615)758-8560 Fax (615)758-8562

Patient Profile

ALL PAGES ARE FRONT AND BACK. PLEASE FILL OUT COMPLETELY! THANK YOU!

Full Name Last First Middle Initial

Address Street Apt/Unit #

City State Zip Code

Mobile Phone* () E-mail Address

Alternate Phone () *We will use mobile phone as primary contact, unless you specify another preference.

Birthdate MM/DD/YYYY Social Security # - - Gender Male Female

Race American Indian/Alaska Native Asian Black/African American
Caucasian/White Native Hawaiian/Other Pacific Islander
Unknown Declined

Ethnicity Hispanic or Latino Not Hispanic or Latino Unknown

Primary Language English Spanish Other

Emergency Contact Name Phone Number ()

Marital Status Single Married Divorced Widowed

Health Insurance? Yes No Insurance Company

If not yourself, please provide: Policy Holder Name, Relationship and Date of Birth:

Who is responsible for payment for your treatment? Myself Other: Name and Relationship

Do you have a health savings account/health reimbursement account? Yes No

How would you like to receive appointment reminders? Text Message Voice Call E-mail

How did you hear about us? Google Drive By Community Event: Practice Rep (Sabrina)
Friend or Family Member: Other:

PCP Name & Location of Practice



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Authorization & Releases

Patient Name _____

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time.

INITIAL _____

Consent to Perform and Interpret X-rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate.

I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor. INITIAL _____

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. For more information about Health Information Portability and Accountability Act (HIPAA) and health information privacy visit: hhs.gov - Understanding Health Information Privacy

INITIAL _____

Financial Obligation and Appointment Policy

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.

You may direct any questions regarding this financial obligation to the clinic manager or physician. INITIAL _____

Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

INITIAL _____

Insurance / Medicare payment-Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct.

I authorize this office and/or doctor to act as my agent in helping me obtain payment of my insurance and/ or Medicare benefits, and I authorize payment of these benefits to this clinic and/or doctor of record on my behalf for any services and materials furnished. INITIAL _____

Consent to Chiropractic Treatment

Please read this entire section regarding chiropractic care prior to accepting it. It is important that you understand the information contained in this section. Please ask questions before you accept it if there is anything that is unclear.

You are the decision maker for your health care. Part of the role of this clinic 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 that this clinic recommends, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

The nature of the chiropractic analysis and treatment: The primary treatment that is performed by a Doctor of Chiropractic is spinal manipulative therapy. This clinic may use that procedure to treat you. This may include the use of the hands or a mechanical instrument upon your body in such a way as restore normal joint motion. It 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 a part of the analysis, examination, and treatment, the doctor may want to employ a variety of procedures as may be deemed necessary. These procedures include but are not limited to: Spinal manipulative therapy, chiropractic adjustments, vital signs, range of motion testing, palpation, orthopedic testing, basic neurological testing, postural analysis testing, muscle strength testing, radiographic studies, scanning of feet, EMS, exercises, acupuncture, myofascial treatments, hot/cold therapy, mechanical traction, traction/decompression, laser therapy, vibrational pivot platform, or cranial balloon adjustments (CFR). By accepting this document you are consenting to these procedures as recommended/prescribed by this clinic.

The material risks inherent in chiropractic adjustment: 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 or 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.

The probability of those risks occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which the provider will check during the taking of your history during examination and X-ray. 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 one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admissions attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons and the risk of death has been estimated at 140 per one million users.

The availability and nature of other treatment options... Other treatment options for your condition may include: Self-administered, over-the-counter analgesics and rest;

Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain-killers; Hospitalization; Surgery
If you chose to use one of the above noted other treatment options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers to remaining untreated: Remaining untreated may allow the formulation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed with the clinic any questions and concerns I have and they have been answered to my satisfaction. By accepting, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Signature _____

Date _____

FOR OFFICE USE → Name _____ PIN _____
Smith Chiropractic & Rehabilitation, P.C. First M.I. Last Case Type _____ DOB _____

Chief Complaint

What is the reason for your visit?

When did your symptoms begin? ____/____/____
MM DD YYYY

Have you previously been seen by a chiropractor? Yes No

If yes, was it for your current symptoms? Yes No

For Women Only: Most Recent Menstrual Cycle ____/____/____
MM DD YYYY

Are you pregnant? Yes No

Which describes the frequency of your discomfort?

Occasional Frequent Intermittent Constant

When is your pain the worst?

Morning Afternoon Night Changes with weather It does not change

What helps relieve your symptoms?

Ice Heat Medication Nothing Helps Other: _____

What activities are limited by your symptoms?

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Bowel Movements | <input type="checkbox"/> Pushing |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Coughing | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Daily Routine | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Getting Up | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Turning my head | <input type="checkbox"/> Lying Down |
| <input type="checkbox"/> Urination | <input type="checkbox"/> Pulling | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Other | <input type="checkbox"/> Working | |

Dates of your most recent: Physical Exam ____/____/____ Spinal X-Ray ____/____/____
MRI ____/____/____ Dental X-Ray ____/____/____
CT Scan ____/____/____ Other scans or X-Rays ____/____/____

Have you tried other treatments for this condition? Yes No

If yes, please specify the type of treatment:

Hospital/Urgent Care Clinic Chiropractor/Other Physician Other: _____

Are your symptoms the result of an accident? (Car accident/Work related injury) Yes No

Health History

Please list any prescription/over the counter medications, supplements, or vitamins that you currently take:

Do you: Smoke? No Yes: _____ pack(s) per day Occasionally Former Smoker

Drink Alcohol? No Yes Drinks per week: _____

Exercise? No Yes Days per week: _____

Have any allergies? No Yes If yes, please list: _____

Please list any surgeries you have had, and the approximate dates:

Please list any implants, screws, plates, or other foreign objects in your body:

Have you ever been diagnosed with cancer? No Yes If yes, what kind? _____

When were you diagnosed? _____ Are you currently under treatment? _____

Have any of your family members been diagnosed with cancer? No Yes

If yes, what was their relationship to you and what were they diagnosed with?

Health History

Do you currently have, or have you previously had any of the following symptoms that have caused you significant distress?

Please indicate with the appropriate letter.



= You have these conditions now **P** = You have previously had these conditions

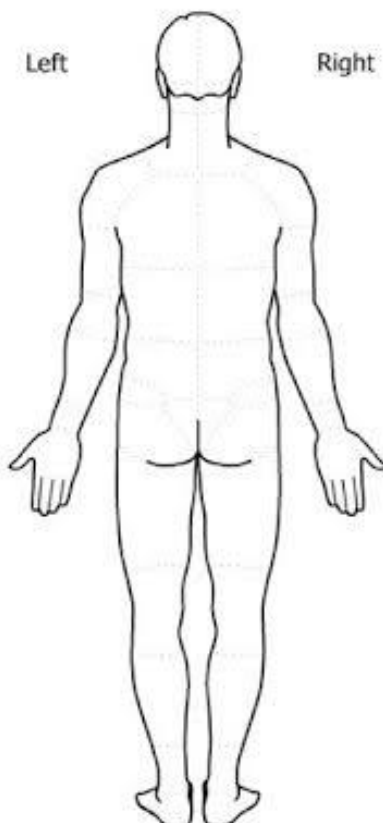
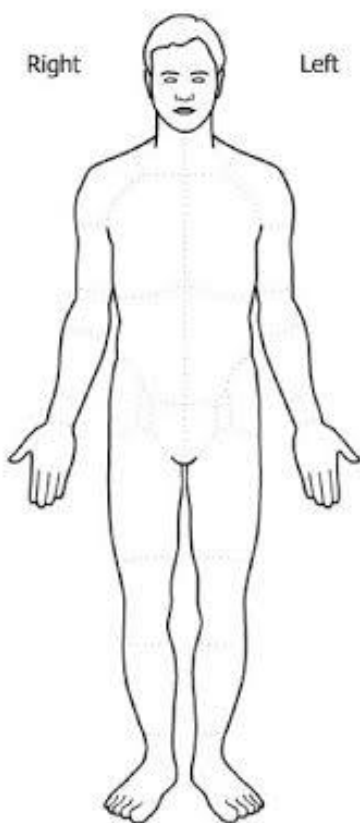
- | | | |
|---|--|---|
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Feet/hands Cold | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Sudden Weight Loss | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Swelling Joints | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Neck/arm Pain | <input type="checkbox"/> Tingling in Arms | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Tingling in Legs | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Weakness in Arms | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Weakness in Legs | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Depression | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Seizures | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Shingles | <input type="checkbox"/> Herniated Disk |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Sciatica |
| | <input type="checkbox"/> TMJ | |

Patient Symptom Illustrator

Front

Back

1



Instructions:

1 Identify your areas of discomfort by marking the affected body parts in the illustration.

2 Indicate the area name along with your specific symptoms associated with each selected area.

3 Rate your discomfort associated with each selected area.

2

Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Swelling	Stiffness
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3

0 = No Discomfort 10 = Severe Discomfort

Ex.	L	R	Area	Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Swelling	Stiffness	0	1	2	3	4	5	6	7	8	9	10
Ex.	L	R	Lower Back			X			X				0	1	2	3	4	5	6	X	8	9	10
1.	L	R											0	1	2	3	4	5	6	7	8	9	10
2.	L	R											0	1	2	3	4	5	6	7	8	9	10
3.	L	R											0	1	2	3	4	5	6	7	8	9	10
4.	L	R											0	1	2	3	4	5	6	7	8	9	10