SMITH
Chiropractic & Rehabilitation

730 N Mt. Juliet Rd., 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 ____/____/____ Social Security # _____-____-_____ Gender ☐ Male ☐ Female
MM DD YYYY

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 treamtent? ☐ 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 ☐ Practice Rep (Kathy) ☐ Facebook ☐ Patient Referral: _____ ☐ Other:_____

PCP Name & Location of Practice _____

SMITH Chiropractic & Rehabilitation

1400 N Mt. Juliet Rd., Suite 104, Mount Juliet, TN 37122

Phone (615)758-8560 Fax (615)758-8562

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?

☐ Bending	☐ Bowel Movements	☐ Pushing
☐ Reading	☐ Coughing	☐ Sitting
☐ Daily Routine	☐ Sleeping	☐ Driving
☐ Sneezing	☐ Getting Up	☐ Standing
☐ Lifting	☐ Turning my head	☐ Lying Down
☐ Urination	☐ Pulling	☐ Walking
☐ Other	☐ 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

Pease 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

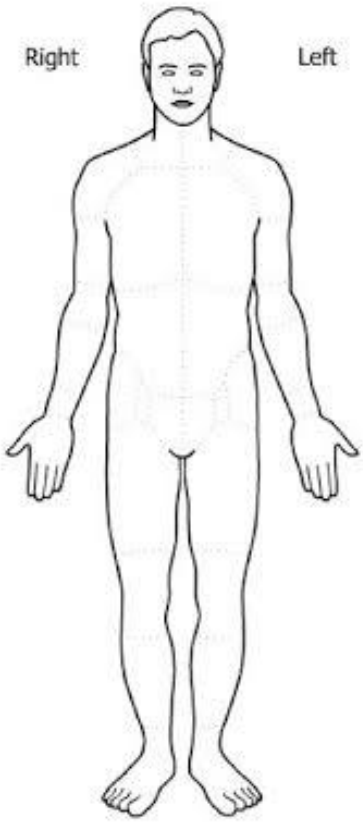
___Pacemaker
___Headaches
___Neck Pain
___Stiff Neck
___Back Pain
___Tension
___Sleep Problems
___Muscle Spasms
___Neck/arm Pain
___Leg Cramps
___Numbness in Fingers
___Diabetes
___High Blood Pressure
___Difficulty Urinating
___ HIV/Aids
___ Stroke
___ Osteoporosis

___Loss of Balance
___Buzzing in Ears
___Ringing in Ears
___Feet/hands Cold
___Sudden Weight Loss
___Shortness of Breath
___Swelling Joints
___Shoulder Pain
___Tingling in Arms
___Tingling in Legs
___Numbness in Toes
___Weakness in Arms
___Weakness in Legs
___Depression
___ Seizures
___ Shingles
___ Pinched Nerve
___ TMJ

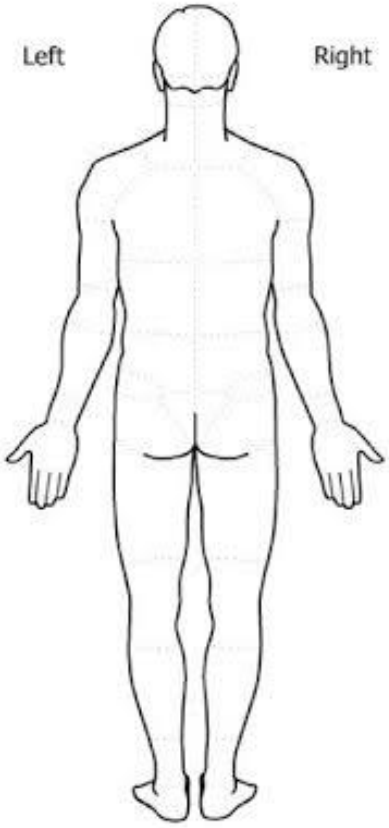
___Loss of Smell
___Loss of Taste
___Colitis
___Stomach Upset
___Frequent Colds
___Arthritis
___Cold Sweats
___Dizziness
___Knee Pain
___Fever
___Sinus Problems
___Nervousness
___Fatigue
___Allergies
___ Fibromyalgia
___ Herniated Disk
___ Sciatica

Patient Symptom Illustrator

Front



Back



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.

		Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Swelling	Stiffness	0 = No Discomfort 10 = Severe Discomfort
Ex.	L (R) Lower Back			X			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