"Revive your life, Restore your health"

Welcome to Revive and Restore Chiropractic. Our mission is to provide a conservative method of quality driven health care to the community. Our commitment is to help patients reach their health goals, giving them the opportunity to live life to the fullest.

Revive & Restore Chiropractic

Date ____________

PATIENT INFORMATION

Name: (Last, First MI) _______________________________________Preferred Name:___________

Address: ____

City: ______________________________________ State:____________ Zip:_______________

Primary Phone: ________________________ Secondary Phone __________________________

Email:_________________________________ Gender: M / F Marital Status: Married / Single

Social Security #: ___________________________ Date of Birth: __________________

Student Status: Full Student / Part Student / Non-Student School:____________________

Military Status: Present Military / Past Military / Non-Military Military Branch: ____________________

Employer: Past or present __________________________ Describe your duties: ___________________

____

How did you hear about our office? Newspaper Phonebook Drive By Walk-In Internet Facebook

Referral (Please tell us whom, so we can thank them!) ____________________________________

Would you like to receive text message appointment reminders? Yes No

If yes, Cell phone provider _______________ Phone number to send to _______________________

MEDICAL INFORMATION

Primary Care Physician:_______________________________Last Seen for: _____________________

CHIROPRACTIC INFORMATION

Have you ever seen a chiropractor before? Yes / No Approximate last visit date:_______________

FINANCIAL INFORMATION

Insurance Self-Pay (Cash) Worker's Comp Personal Injury/Auto

Other (please explain): ____

If you have insurance, please provide insurance card(s) to our front desk with a valid driver's license.

It is usual and customary to pay for services as rendered unless otherwise arranged.

Revive & Restore Chiropractic

Date ____________

PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

List WORST complaint: ______________________________ How long have you had it?______________

Does anything make the complaint better? ________________________________

Does anything make the complaint worse? ________________________________

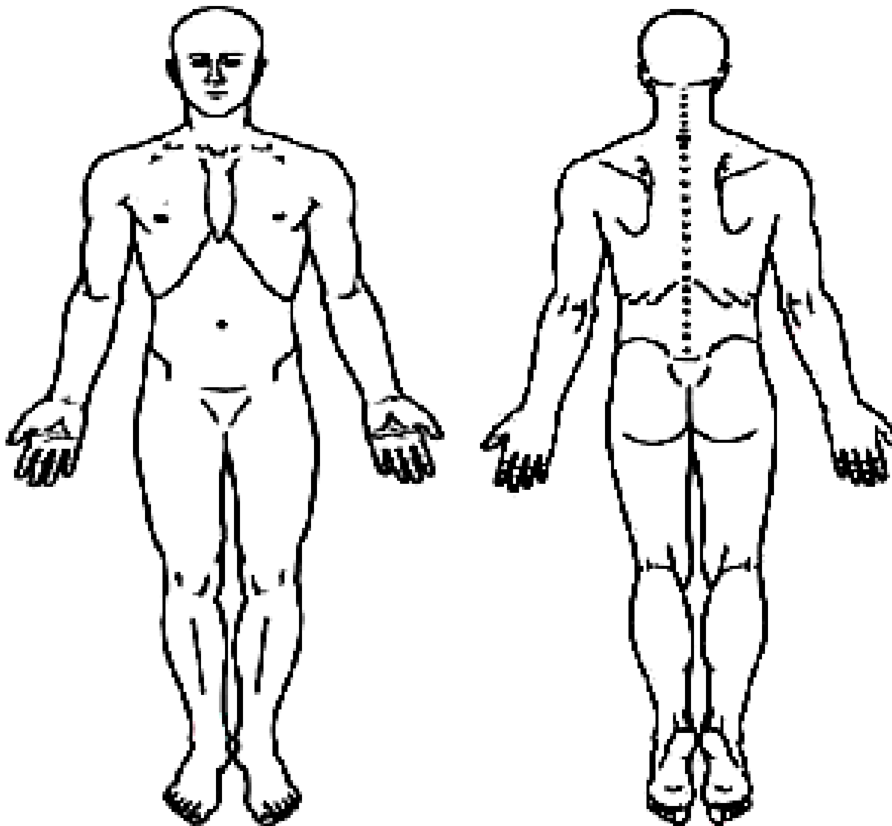
Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other:

Rate complaint on a scale of 1-10 (10 being the worst): _________

Explain any of other complaints ____

____

Please mark the exact locations of all your pain on the diagram below with an X.



Date ____________

HEALTH HISTORY

List any condition you have been diagnosed with: ____

List any current vitamins or medications, as well as reasons for taking (If you have a list, we can make a copy):____

____

List hobbies/activities you like to do: ____

How many cigarettes do you smoke a day? _____/ day

How much alcohol do you drink per week? ______/week

Do you use recreational drugs? Yes / No List: ____

REVIEW OF SYSTEMS

Are you currently experiencing any of these symptoms? (Circle all the apply)

Many of the following conditions respond to Chiropractic treatment.

Recent Weight Change	Stroke	Asthma
Fever	Nervousness	Lung Problems
Fatigue	Depression	Sinus / Allergy problems
Low Back Pain	Sleep Problems	Thyroid problems
Mid Back Pain	Sexual Difficulty	Diabetes
Neck Pain	Change in Bowel Movements	Excessive Thirst or urination
Arm Problems	Abdominal Pain	
Leg Problems	Chest Pains	Women Only:
Painful/Stiff Joints	Heart Problems	Are you pregnant?
Weak Muscles or Joints	Rapid or Heartbeat changes	Yes No–LMP _________
Muscle Spasms/Cramps	Blood Pressure Problems	Number of Children _____
Dizziness or light headed	Swelling in extremities	
Headaches	Difficulty Breathing	

CONSENT TO TREAT

Informed Consent for Chiropractic Treatment: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or of said minor) by the physicians of Revive and Restore and/or its employees. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations and sprains. Patients must inform the practitioner of any possibility of pregnancy at any point during the treatment process. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her, is in my best interest. I understand that results are not guaranteed. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_______________________________________ ______________________

Patient or Guardian Signature Date

HIPAA NOTICE

HIPAA Notice: I understand and agree to allow this chiropractic office to use their protected health information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your protected health information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your protected health information, we encourage you to read the HIPAA Compliance Form that is available for you at the front desk before signing this consent. If there is anyone you would like to be able to receive your medical records, please inform our office.

_______________________________________ ______________________

Patient or Guardian Signature Date

MEDICARE PATIENTS

Medicare does not pay for maintenance chiropractic care. However, with an x-ray, examination, and treatment plan (Medicare does not pay for), Medicare will pay for the adjustments only in acute chiropractic care. The co-pay for this care is 20% of the cost of the adjustment. If you have questions on what qualifies as acute chiropractic care, please ask the doctor on staff or the front desk.

_______________________________________ ______________________

Medicare Patient Signature Date