CONFIDENTIAL PATIENT INFORMATION

Name: _____ Social Security: _____

Date of Birth: _____ Age: _____

Mailing Address: _____ Home: _____

_____ _____

Phone: _____ Email: _____

Employer: _____ Business Address: _____

Occupation: _____ _____

Business Phone: _____ _____

In Case of Emergency: _____ Phone: _____

Relationship: _____

PRIMARY INSURED INFORMATION

Primary Policy Holder: _____
Relationship to Patient: _____

SSN of Policy Holder: _____ DOB: _____

Address: _____

Employer: _____ Occupation: _____

Primary Insurance: _____ Ins. Phone: _____

Policy ID #: _____ Group #: _____

Is this injury related to work: _____ Yes _____ No Auto Related: _____Yes _____ No

If yes, give accident details and explanation: _____

_____

Have you seen another doctor for this problem? Doctor's name: _____

Whom may we thank for referring you? _____

OUR POLICY: Payments made to Dr. Fred Wilson
Payment is due at time of service unless prior arrangements have been made.

PLEASE READ AND SIGN: I hereby state that the above information is correct and complete. I authorize Aspen Chiropractic to examine me and provide treatment in accordance with the state statutes for the care and management of my condition. I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself. Therefore, I clearly understand and agree that all services rendered me are my personal responsibility. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Relationship: _____

PLEASE FILL OUT ALL PAGES

THANK YOU

ASPEN CHIROPRACTIC
INFORMED CONSENT FORM

I HEREBY REQUEST AND CONSENT TO THE PERFORMANCE OF CHIROPRACTIC ADJUSTMENTS AND OTHER CHIROPRACTIC PROCEDURES ON ME OR ON _____ BY FRED C. WILSON, BSC, DC.

I WILL HAVE AN OPPORTUNITY TO DISCUSS WITH THE DOCTOR THE NATURE AND PURPOSE OF CHIROPRACTIC ADJUSTMENTS AND OTHER PROCEDURES. I UNDERSTAND THAT THE PRACTICE OF NEITHER CHIROPRACTIC NOR MEDICINE IS AN EXACT SCIENCE, AND THAT MY CARE MAY INVOLVE MAKING OF JUDGEMENTS BASED UPON THE FACTS KNOWN TO THE DOCTOR TO BE ABLE TO ANTICIPATE OR EXPLAIN ALL RISKS AND COMPLICATIONS THAT AN UNDESIRABLE RESULT DOES NOT NECESSARILY INDICATE AN ERROR IN JUDGEMENT, THAT NO GUARANTEE AS TO RESULTS HAS BEEN MADE TO NOR RELIED UPON BY ME, AND I WISH TO RELY ON THE DOCTOR TO EXERCISE JUDGMENT DURING THE COURSE OF THE PROCEDURE WHICH THE DOCTOR FEELS AT THE TIME, BASED UPON THE FACTS THEN KNOWN, AS IN MY BEST INTERESTS.

I FURTHER UNDERSTAND THAT THERE ARE CERTAIN DEGREES OF RISKS ASSOCIATED WITH CHIROPRACTIC HEALTHCARE INCLUDING, BUT NOT LIMITED TO; FRACTURES, DISK INJURIES, STROKES, DISLOCATIONS AND STRAINS/SPRAINS. THEREFORE, I AM WILLING TO ACCEPT AND CONSENT TO THE RISK ASSOCIATED WITH THE CARE I AM ABOUT TO RECEIVE.

I HAVE READ OR WILL HAVE EXPLAINED TO ME THE ABOVE CONSENT. I WILL ALSO HAVE AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS' CONTENT. BY SIGNING BELOW I AGREE AND INTEND THIS CONSENT FORM TO COVER THE PROCEDURE(S) PRESCRIBED FOR MY CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK TREATMENT.

The availability and nature of other treatment options.
Other treatment options for your condition include:

- Self-administered, over-the-counter analgesics and rest.
- Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers.
- Hospitalization with traction.
- Surgery

_____ _____
PATIENT'S NAME DATE

_____
PATIENT'S (OR PARENT'S) SIGNATURE

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

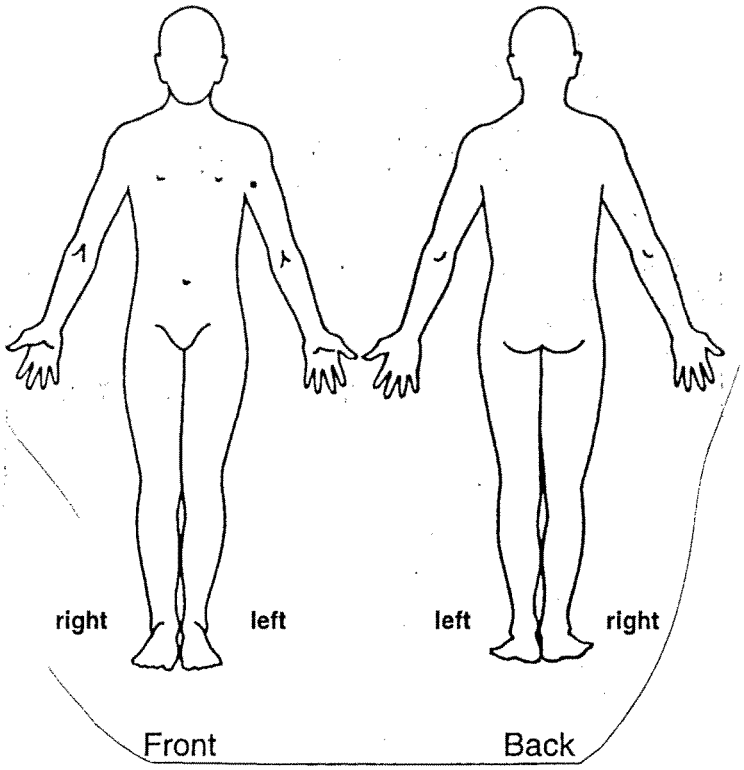
Name _____ Birthdate _____

Signature _____

Date _____

Show us where it hurts:
Indicate location of pain and/or chief complaint on the diagram below. Please mark the area(s) of injury or discomfort using the appropriate symbols.

Numbness	--------
Pins & Needles	ooooo
Burning	^^^^^
Aching	XXXX
Stabbing	●●●●



Does it radiate to any other area? ❑ Yes ❑ No If yes, where:_____

If there is pain or discomfort, please describe the feelings in your own words: (e.g. stabbing, nagging, burning, etc.).

As it was when you first experienced it:_____

_____

As it is now(if different):_____

_____

How often is the pain or discomfort experienced?
❑ Hourly ❑ Several times per day
❑ Daily ❑ Several times per week
❑ Monthly ❑ A few times per year

Is the onset sudden or slow? ❑ Sudden ❑ Slow

Is the pain constant, intermittent or infrequent? ❑ Constant ❑ Intermittent ❑ Infrequent

How long does it last when present?_____

What makes it better?_____

What makes it worse?_____

Have you noticed any other symptoms that seem to be associated with your current condition? (e.g. headache, other pains, abdominal distress, weakness, etc.) ▶ Yes ▶ No

If so, please list_____

_____

Does your condition limit your movement? ▶ Yes ▶ No

If so, is it ▶ Slight ▶ Moderate ▶ Severe

Does your condition interfere with your daily routine? ▶ Yes ▶ No

If so, is it ▶ Slight ▶ Moderate ▶ Severe

Have you lost time from work as a result of this? ▶ Yes ▶ No

If so, how long? (days, weeks)_____

In what position do you usually sleep?_____

Does your problem wake you up at night? ▶ Yes ▶ No

Does it occur or worsen at any particular time of day or night? ▶ Yes ▶ No If so, when?_____

Please give any other information that you think might be helpful in understanding your case fully._____

_____

_____

Is this your first visit to a chiropractor's office? ▶ Yes ▶ No

Name of your medical doctor:_____

Are you presently being treated by him/her? ▶ Yes ▶ No

If so, for what condition?_____

Are you presently taking any medication? ▶ Yes ▶ No

If so, please list them to the best of your knowledge. If you do not know the medication name, list the reason f taking it._____

_____

_____

_____

(Confidential)

Patient Name_____ Today's Date _____

Age_____ Birth date _____ Date of last physical examination _____

What is your reason for visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ❑ Chills
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ Loss of sleep
- ❑ Loss of weight
- ❑ Nervousness
- ❑ Numbness
- ❑ Sweats

MUSCLE / JOINT / BONE
Pain, weakness, numbness in:
- ❑ Arms ❑ Hips
- ❑ Back ❑ Legs
- ❑ Feet ❑ Neck
- ❑ Hands ❑ Shoulders

GENITO-URINARY
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination

GASTROINTESTINAL
- ❑ Appetite Poor
- ❑ Bloating
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Vomiting blood

CARDIOVASCULAR
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose veins

EYE, EAR, NOSE, THROAT
- ❑ Bleeding gums
- ❑ Blurred vision
- ❑ Crossed eyes
- ❑ Difficulty swallowing
- ❑ Double vision
- ❑ Earache
- ❑ Ear discharge
- ❑ Hay fever
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Persistent cough
- ❑ Ringing in ears
- ❑ Sinus problems
- ❑ Vision - Flashes
- ❑ Vision -Halos

SKIN
- ❑ Bruise easily
- ❑ Hives
- ❑ Itching
- ❑ Change in moles
- ❑ Rash
- ❑ Scars
- ❑ Sore that won't heal

MEN Only
- ❑ Breast lump
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge
- ❑ Sore on penis
- ❑ Other

WOMEN Only
- ❑ Abnormal Pap Smear
- ❑ Bleeding between periods
- ❑ Breast lump
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Other

Date of last menstrual period _____
Date of last Pap Smear _____
Have you had a mammogram?_____
Are you pregnant?_____
Number of children_____

Conditions

Check (✓) symptoms you currently have or have had in the past year.

- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problem
- ❑ Psychiatric care
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease

Medications

List medications you are currently taking.

_____
_____
_____
_____

Pharmacy Name_____ Phone _____

Allergies

_____
_____
_____
_____

_____

Health History

Family History

Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✔) if your blood relatives had any of the following: Disease		Relationship to you.
	Arthritis	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization & Outcome

Have you ever had a blood transfusion? ❑ Yes ❑ No

If yes, please give approximate dates _____

Serious Illness / Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✔) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational

Check (✔) if your work exposes you to the following:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his / her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ Signature

_____ Date

_____ Reviewed By

_____ Date