Urteaga Chiropractic & Sports Medicine

Name: _____

General Info

Patient Name: _____ Today's Date: _____

Home Address: _____

City: _____ State: _____ Zip Code _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Email Address: _____

DOB: _____ ID # _____ SSN#: _____

Emergency Contact: _____

Relationship to Patient: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Employment Info

☐ Student ☐ Other: _____

Employer/School: _____

Work Address: _____

City: _____ State: _____ Zip Code _____

Work Phone: _____ Ext: _____ Work Email: _____

Health Insurance Info

Name of Insured: _____

Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other: _____

Insurance Provider: _____

☐ PPO ☐ HMO ☐ Medicare ☐ Other: _____

ID #: _____ Policy #: _____ Group # _____

Insurance Phone # (on back of card): _____

Primary Physician: _____ Phone #: _____

Party Responsible for account

☐ Above Patient is Responsible - or - Name: _____

Relationship to Patient: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

DOB: _____ ID # _____ SSN#: _____

Medical Information

Age: _____ Height: feet= _____ Inches= _____ Weight: _____ lbs

Date of last Medical Exam: _____ Doctor's Name: _____

Recent medical procedures: _____ Date: _____

Results: _____

ALL Prescribed Medications: _____

ALL Over-the-Counter Medications: _____

Known congenital (from birth) factors that relate to your condition?

☐ No ☐ Yes ➤ _____

Previous illnesses/complications from previous injuries?

☐ No ☐ Yes ➤ _____

Hospitalizations or surgeries? Including childhood?

☐ No ☐ Yes ➤ _____

Is there any chance you may be pregnant? ☐ No ☐ Yes ➤ # of weeks _____

Check ALL that apply to you:

Yes	No		Yes	No	
☐	☐	Loss of consciousness/ head Injuries	☐	☐	Lupus
☐	☐	Seizures/epilepsy/convulsions	☐	☐	Diabetes
☐	☐	Dizziness/fainting	☐	☐	Pacemaker
☐	☐	Visual disturbances/eye problems	☐	☐	Hernia
☐	☐	Nose. Throat, breathing problems	☐	☐	Osteoporosis
☐	☐	Asthma, allergies, allergic reactions	☐	☐	Sleep apnea/sleep conditions
☐	☐	Diarrhea, constipation	☐	☐	Menstrual problems
☐	☐	Numbness In groin/buttocks/legs/feet	☐	☐	Urinary/bladder control problems
☐	☐	Abnormal/rapid weight gain/loss	☐	☐	Recent fever
☐	☐	High blood pressure	☐	☐	Corticosteroid - cortisone, prednisone
☐	☐	Artificial joints	☐	☐	Birth control pills
☐	☐	Night sweats	☐	☐	Pain killers/muscle relaxants
☐	☐	Pain at night	☐	☐	Alcohol/tobacco/drug abuse
☐	☐	Pain unrelieved by position/rest	☐	☐	Rheumatoid arthritis
☐	☐	Morning pain/stiffness	☐	☐	Blood disease: _____
☐	☐	Cancer/tumor/lumps: _____	☐	☐	Stroke - date: _____

Organ problems/diseases: ☐ Heart ☐ Liver ☐ Kidney ☐ Stomach ☐ Pancreas ☐ Gallbladder
☐ Lungs ☐ Intestines ☐ Prostate ☐ Uterus ☐ Ovaries ☐ Thyroid ☐ Other: _____

Social Hostory - Check ALL that apply to you:

Daily work/home habits ☐ prolonged sitting/standing ☐ Heavy lifting ☐ Poor posture ☐ Other: _____

Eating Habits: ☐ Balanced ☐ Fast food ☐ Vegetarian ☐ High fat/carbs ☐ Other: _____

Exercise: ☐ Walk ☐ Jog/run ☐ Lift weights ☐ Stretch/yoga ☐ Other ➤ _____

Daily Work Habits

Sports/activities/hobbies: _____

Family Medical History

Family Member	Age	Health Conditions (cancer, heart disease, arthritis, etc…)

Patient Health Information

What is the primary purpose of your visit?

☐ Injury Care ☐ Temporary relief care ☐ Preventative/correction care ☐ Wellness care

Did you injure yourself recently? ☐ No ☐ Yes ➤ How? ☐ Auto accident ☐ Work ☐ Other: _____

☐ No ☐ Yes➤ _____

When did you injure yourself? Date: _____

Are you currently receiving treatment for this injury? ☐ No ☐ Yes➤ _____

What are your health goals? (Check all that apply)

☐ Reduce/eliminate pain ☐ Reduce stress/tension ☐ Manage weight/diet ☐ Manage diet/nutrition

☐ Increase strength/flexibility ☐ Increase energy ☐ Maintain health ☐Other ➤ _____

What services are you seeking?

☐ Chiropractic ☐ Massage Therapy ☐ Mechanical traction ☐ Physiotherapy

☐ Rock tape. ☐ Custom fit orthotics ☐ Exercise education/prescription ☐ Sports physical

What are your areas of concern? (Check ALL that apply)

☐ Headache:___ /10	☐ R/L Shoulder:___ /10	☐ R/L Thigh: ___ /10
☐ Jaw Pain:___ /10	☐ R/L Elbow:___ /10	☐ R/L Hip: ___ /10
☐ Neck Pain:___ /10	☐ R/L Wrist:___ /10	☐ R/L Knee: ___ /10
☐ Upper back pain:___ /10	☐ R/L Hand:___ /10	☐ R/L Foot: ___ /10
☐ Mid-back Pain:___ /10	☐ R/L Upper Arm:___ /10	☐ R/L Ankle: ___ /10
☐ Low back pain:___ /10	☐ R/L Forearm:___ /10	☐ R/L Upper Leg: ___ /10
☐ Chest:___ /10	☐ Abdomen:___ /10	☐ Lower leg: ___ /10

☐ Other: _____

What makes your condition worse? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending forward ☐ Lying down

☐Other: _____

What makes your condition better? ☐ Ice ☐ Heat/warmth ☐ Rest ☐ Medication➤ _____

☐ Other: _____

Is your condition becoming progressively worse? ☐ No ☐ Yes➤ Details: _____

_____

Have you previously received treatment for this condition? ☐ No ☐ Yes➤ Check all that apply

☐ Surgery ☐ Medications ☐ Injections ☐ Chiropractic ☐ Physical therapy ☐ Acupuncture

☐ Other treatment: _____

How long have you had this condition? Since (month/day/year): _____

hours _____ # days _____ # weeks _____ # months _____ # years _____

Does your pain travel/radiate to another area of your body?

☐ No ☐ Yes ➤ body region: _____

Has your condition interfered with your: ☐ daily activities ☐ work ☐ house duties ☐ sports

☐ Other: _____

Patient Signature: _____ Date: _____

Urteaga Chiropractic Policies, Terms & Conditions

Initials→_____ If I fail to attend my scheduled appointment without cancellation notice 24 hours prior, I agree to pay a $25 no show/late cancellationfee.

Initials→_____ I am responsible & directly liable for payment of any outstanding balances. Any deductibles, co-payments, co- insurance or other fess for any office service rendered are payable at the time of my visit, unless other arrangements have been made & agreed upon prior to treatment.

Initials→_____ I agree to notify the office promptly of any changes to my health insurance policy, or other pertinent information.

Initials→_____ I have and will notify the office of any previous auto/work related injuries that I may suffer hereafter.

Initials→_____ A $25 fee will be charged for all returned checks.

Authorization & Assignment

I give authorization to this office to contact my primary care physician and/or relevant health care providers & specialists regarding co-management of my health. I request & authorize direct payment of any medical or automotive insurance company benefits or any

Informed consent

I hereby request and consent to the consultation, examination, performance of chiropractic adjustments and related chiropractic procedures on patient named below for which I am legally responsible, by the doctor or intern directly supervised by doctor, as needed. Results are not guaranteed and there is no promise to cure any health condition. I understand that there are some risks to treatment, including but not limited to muscle soreness, spasms, sprains, strains, dislocations, disc injuries, fractures and strokes, most with extremely rare incidence. I do not expect the provider to be able to anticipate and explain all risks and complications. I wish to rely on the provider to exercise judgment during the course of the procedures which the provider feels at the time, based on the facts then known, is in my best interest. The provider will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I agree to inform staff of any pre-existing conditions, limitations, specific sensitivities or discomfort at any time. I have read the above consent and I understand that I can ask the doctor and staff at anytime regarding any risks or concerns. Any questions, comments, or complaints may be brought to the attention of staff. By signing below, I agree to the above, and allow the provider or supervised chiropractic intern affiliated with Urteaga Chiropractic to perform such as described above. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. Urteaga Chiropractic is not responsible for lost or stolen articles or items.

Privacy Confidentiality Statement

I am aware of this office has privacy notice and understand my rights. I understand that this privacy notice is also available at www.urteagachiropractic.com. By signing below, I provide this office with my authorization and consent to use in disclose my personal health information for the purpose of treatment, payment and healthcare operations as described in the notice. I certify that all the information I have entered on all accompanying pages to this form is complete & accurate to the best of my knowledge. I have read and understand the above terms.

X_____ X_____ X_____

Signature of Patient/Parent Patient/Parent PrintFull Name Date

Consent to treat minor

I am the parent/legal guardian of the patient who is of minor age. I hereby give my consent and authorize & request all procedures & treatments as stated above as deemed advisable on this minor patient.

Signature of Minor's Parent/Guardian:_____ Date: _____