Todd Porter, DC

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Chiropractic & Acupuncture

New Patient Information

Please Print

Name (First)____________________(M.I. Required)______(Last)________________________________Date____________

Address____City_____________________________State ____ Zip__________

Male ____ Female ____ Married ____ Single ____ Widowed ____ Divorced ____ Separated ____

***Birthdate _____________________ ***SSN _____________________________ (SSN required for insurance only)

Place of Employment ____

EMAIL ADDRESS: ***Bills and Credit Card Receipts are sent via EMAIL***. Your email address is part of your medical record and HIPPA prohibits us from revealing it to anyone without your permission. **We cannot use workplace email**.

PLEASE PRINT EMAIL VERY CLEARLY: ____

Phones: Cell___________________________Home___________________________

Emergency Contact: Phone: __________________Relationship ____

Symptoms

Main Complaint: ____

How Bad?____How Often? ____

Whom may we thank for referring you to us? ____

Patient Signature____Date______________________________________

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. It should be noted that:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques:

b) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment and may on rare occasion result in injuries including paralysis. The possibly of such injuries resulting from upper cervical spinal adjustment is extremely remote;

c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spam, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall wellbeing. The risk of injuries or complications from chiropractic treatment or substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same treatments.

d) Patients who take blood thinners and NSAIDS such as aspirin, especially Coumadin, should be aware that manual adjustment, and soft tissue work could cause bruising due to the effects of the drug.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Patient Signature (Or Legal Guardian Signature): ____ Date: ____________________

RELEASE OF INFORMATION

You are authorized to release information (including photographs or copies) concerning my condition and treatment to my insurance carriers, electronic clearing house, attorney, employer, and primary care physician, consulting doctor, insurance adjuster, for the purpose of reviewing or processing claim for benefits or settlement. Patient consents to use disclosed health information for treatment, payment and/or healthcare operations: I understand that as part of my healthcare Lifestyle Chiropractic /Dr. Todd L. Porter originates and maintains paper and or electronic reports describing history, health results, tests and symptoms for treatment. I understand that this information serves as a basis for planning for care and treatment. A means of communication with other healthcare professionals who contribute to my care of a source applying my diagnosis to my bills– a means in which a third part payer can verify the balance on a patient's account. I understand that in certain cases where I have given permission where my records are requested that if the requester of the records fails to make payment on the records that I will be held liable for the request and submission of such records.

I understand that as a part of this facilities treatment, payment, or health care operation it may become necessary to disclose my protected health information to another entity, and I consent to such disclosures, via fax, email, holiday, postal service, clearing house or phone. I give the permission to the above-named facility to contact me via email, postal service, phone, fax, cards, newsletters, and promotional information. By signing this form, I am giving Lifestyle Chiropractic/Dr. Todd Porter permission to use and/or disclose my protected health information when appropriate. This notice will stay in effect until Lifestyle Chiropractic replaces it. I understand that I am fully responsible for charges incurred by I/us for services rendered. I fully and understand and accept the terms of this form. A photocopy of this document shall serve as the original.

Printed Name:____Signature ____

Name ____ Date ____________________

When did pain start? _________________

What started it? ____ Getting Better or Worse? ______

What activity bothers it the most? ____

Rate the pain. (0 is pain free-10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10

Other Chiropractors?____Positive Experience? ________

Other type of physician or therapist?____Positive Experience? ________

Secondary Complaint ____

Health History - Please circle all that apply

AIDS/HIV	Allergy Shots	Anemia	Arthritis	Asthma	Cancer	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Gout	Heart Disease	Hepatitis	Hernia
Herniated disc	Kidney Disease	Liver Disease	Migraines	M. S.	Tumors	Osteoporosis	Parkinson's
Pacemaker	Implants	Rheumatoid	Stroke	Thyroid	Tuberculosis	Blood Pressure	Fibromyalgia
Other							

List Medications, Vitamins, and Supplements you are currently taking or attach a list:

____

What kind of exercise do you do? ____

What supplements do you take? (List or attach Listing:

____

____

____

____

How much do you smoke per day?_________________________________

Drink per week?____

Previous Surgeries and Dates? ____

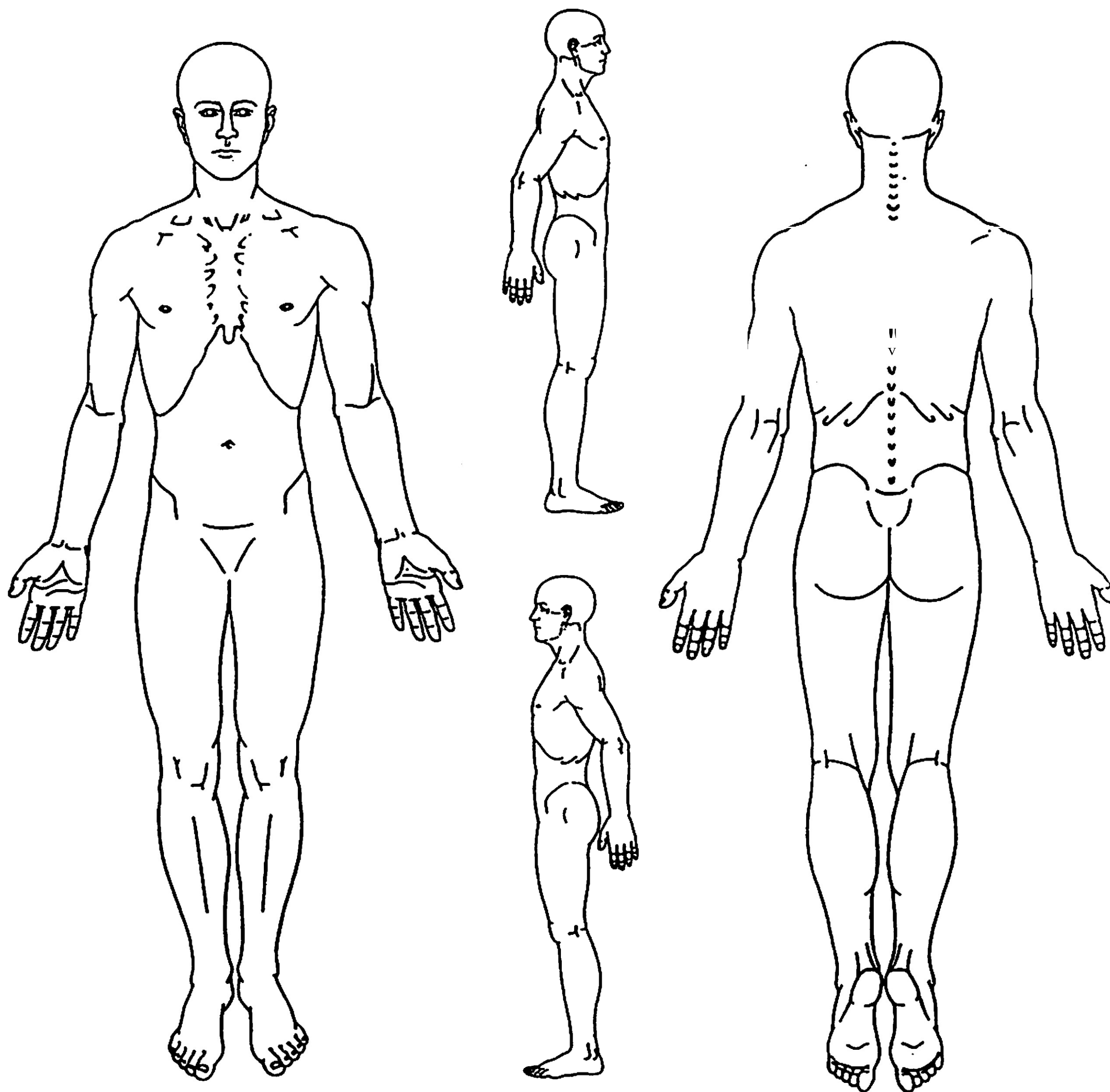
Women - How many children?_____Pregnant?____Nursing?_____Taking Birth Control Pills? ___

SYMPTOM DIAGRAM

Name ____ Date ___________________

Please be sure to fill this form out very accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

Aches AAA   Numbness O O O   Pins/Needles •••   Burning XXX   Stabbing////



PAIN SCALE: 0 1 2 3 4 5 6 7 8 9 10

Reference: Randsford. Spine, Vol. 1, No 2, June 1976

FORM 504

Name ________________________________ Date ____________________

General Pain Index Questionnaire

We would like to know how much your pain presently ***prevents*** you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **Family/at -home responsibilities** such as yard work, chores around the house or driving the kids to school -

Completely able to function	0	1	2	3	4	5	6	7	8	9	10	totally unable to function

2. **Recreation** including hobbies, sports or other leisure activities –

Completely able to function	0	1	2	3	4	5	6	7	8	9	10	totally unable to function

3. **Social activities** including parties, theater, concerts, dining –out and attending other social functions with friends -

Completely able to function	0	1	2	3	4	5	6	7	8	9	10	totally unable to function

4. **Employment** including volunteer work and homemaking tasks -

Completely able to function	0	1	2	3	4	5	6	7	8	9	10	totally unable to function

5. **Self -care** such as taking a shower, driving or getting dressed -

Completely able to function	0	1	2	3	4	5	6	7	8	9	10	totally unable to function

6. **Life -support activities** such as eating and sleeping -

Completely able to function	0	1	2	3	4	5	6	7	8	9	10	totally unable to function

PATIENT NAME________________________________ DATE ________________________

OFFICE USE:

Score __________[60] Benchmark -5 = __________