OPTIMALPERFORMANCE
CHIROPRACTIC

# NEW PATIENT INFORMATION

## 1 PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Sex ☐ M ☐ F Age _____ Birthdate _____

Patient Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ ZIP _____

E-mail _____ ☐ Married ☐ Single ☐ Other _____

Cell Phone _____ Home Phone _____ Best time and place to reach you _____

Occupation _____ Employer/School _____

Employer/School Address _____ Employer/School Phone _____

Spouse's Name _____ Spouse's Birthdate _____ Spouse's SS# _____

Spouse's Employer _____ Whom may we thank for referring you? _____

**IN CASE OF EMERGENCY, CONTACT:**

Name _____ Relationship _____ Home Phone _____ Work Phone _____

## 2 INSURANCE INFORMATION

Who is responsible for this account? _____ Relationship to patient _____

Insurance Co _____ ID # _____ Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____ Subscriber's Birthdate _____ Relationship to patient _____

Insurance Co. _____ ID# _____ Group # _____

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with [Name of Insurance Company(ies)] and assign directly to Dr. Graig Shapiro, DC, MS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient _____

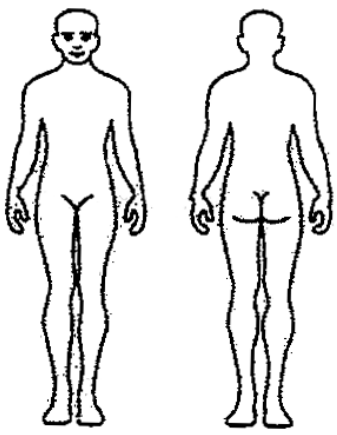
## 3 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you have pain, numbness or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

## 4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date_____ Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other _____ Attorney Name (if applicable) _____

## 5 HEALTH HISTORY

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other_____

Name and address of other doctor(s) who have treated you for your condition_____

Date of last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____ Spinal Exam _____

Chest X-Ray_____ Urine Test _____ Dental X-Ray_____ MRI, CT Scan, Bone Scan _____

Please check the box to indicate if you've had any of the following:

| | | | |
|---|---|---|---|
| ☐ AIDS/HIV | ☐ Diabetes | ☐ Liver Disease | ☐ Rheumatoid Arthritis |
| ☐ Alcoholism | ☐ Emphysema | ☐ Measles | ☐ Rheumatic Fever |
| ☐ Allergy Shots | ☐ Epilepsy | ☐ Migraine Headaches | ☐ Scarlet Fever |
| ☐ Anemia | ☐ Fractures | ☐ Miscarriage | ☐ STD |
| ☐ Anorexia | ☐ Glaucoma | ☐ Mononucleosis | ☐ Stroke |
| ☐ Appendicitis | ☐ Goiter | ☐ Multiple Sclerosis | ☐ Suicide Attempt |
| ☐ Arthritis | ☐ Gonorrhea | ☐ Mumps | ☐ Thyroid Problems |
| ☐ Asthma | ☐ Gout | ☐ Osteoporosis | ☐ Tonsillitis |
| ☐ Bleeding Disorders | ☐ Heart Disease | ☐ Pacemaker | ☐ Tuberculosis |
| ☐ Breast Lump | ☐ Hepatitis | ☐ Parkinson's Disease | ☐ Tumors,Growths |
| ☐ Bronchitis | ☐ Hernia | ☐ Pinched Nerve | ☐ Typhoid Fever |
| ☐ Bulimia | ☐ Herniated Disk | ☐ Pneumonia | ☐ Ulcers |
| ☐ Cancer | ☐ Herpes | ☐ Polio | ☐ Vaginal Infections |
| ☐ Cataracts | ☐ High Blood Pressure | ☐ Prostate Problem | ☐ Whooping Cough |
| ☐ Chemical Dependency | ☐ High Cholesterol | ☐ Prosthesis | ☐ Other |
| ☐ Chicken Pox | ☐ Kidney Disease | ☐ Psychiatric Care | |

**Exercise**
☐ None
☐ Moderate
☐ Daily
☐ Heavy

**Work Activity**
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

**Habits**
☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day_____
☐ High Stress Level Reason_____

Are you pregnant?
☐ Yes ☐ No
Due Date _____

| Injuries/Surgeries you have had | Description | Date |
|---|---|---|
| Falls | _____ | _____ |
| Head Injuries | _____ | _____ |
| Broken Bones | _____ | _____ |
| Dislocations | _____ | _____ |
| Surgeries | _____ | _____ |

## 7 MEDICATIONS ALLERGIES VITAMINS/HERBS/MINERALS

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| Pharmacy Name_____ | _____ | _____ |
| Pharmacy Phone _____ | _____ | _____ |

# PRIVACY STATEMENT

This practice is committed to maintaining the privacy of your protected health information (PHI), which includes information about your health condition and the care you receive from the practice. This notice details how this information may be used by this office.

**With your consent it is the policy of this office to use your PHI in the following ways:**

1. Treatment: Your PHI will be given to those professionals that require it to provide care.
2. Appointment Reminders: our staff may call you from time to time to remind you of appointments and may leave a message on an answering machine.
3. Medical Doctors: It is the policy of this office to share our findings with your other medical doctors as needed. This helps build a better understanding of how we may work together to improve your health.

**In the following special circumstances your PHI may be disclosed:**

1. Personal Representative: In accordance with applicable law that may represent you.
2. Emergency Situations
3. Abuse, neglect, domestic violence, as required by law.
4. Law enforcement issues
5. Workers' compensation claims
6. Avert a health threat to yourself or another.

**Your rights regarding your health information:**

1. Right to inspect and copy your records: A written request must be submitted and cost of copying may be applied to such a request.
2. Amend your PHI by submitting a written request with an explicit reason, however, it is this practice's right to disagree with any amendment.
3. Request restrictions on your PHI. It is this practices right, however, to disagree to any such restrictions.
4. Revoke consent at any time.

Printed Name: _____Signature: _____Date: _____

# INFORMED CONSENT TO RECEIVE TREATMENT

I _____, do hereby give my consent to the performance of conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving the movement of joints and soft tissues. Physiotherapy and exercises may also be used in treatment.

Although spinal manipulation is considered one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

**Soreness:** I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

**Dizziness:** Temporary symptoms like dizziness and nausea can occur but are very rare.

**Fractures/Joint Injury:** I further understand that in isolated cases, underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk disease, or other abnormalities are detected this office will proceed with extra caution.

**Stroke:** In the past there has been a noted correlation between stroke and chiropractic adjustments. The reported cases of this occurring are shown to be roughly 90 cases in 100,000,000 people annually, which is the same risk of stroke associated with visiting a primary care medical doctor. It must be noted that correlation does not necessarily mean causation and most of the research now points to the fact that in these cases the patient sought chiropractic care for the symptoms associated with the stroke they were likely already suffering. To give perspective, death caused by a normal dose of aspirin or Tylenol is approximately 1 in 10,000,000.

**Physical Therapy Burns:** Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor immediately.

Tests will be performed on the patient to minimize the risk of any complication from treatment and the patient freely assumes these risks.

**Treatment Results**

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, as well as reduced muscle spasm. I appreciate that there is no certainty to the achievement of these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

**Alternative Treatments Available**

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises, and possible surgery.

**Medications:** Medication can be used to reduce pain or inflammation. I am aware that long term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may also involve serious risks.

**Rest/Exercise:** It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce pain and inflammation. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones, muscles, and joint stiffness. Although exercises are of limited value, they are not solely corrective of injured nerve or joint tissue.

**Surgery:** Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

**Non-Treatment**

I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. I understand that my compliance with the assigned treatment plan is crucial to my recovery. Not complying with the above may complicate treatment making future recovery and rehabilitation more difficult and prolonged.

**Patient Questions/Comments:**

_____

_____

_____

Printed Name: _____Signature: _____Date: _____

Signature of Doctor:_____