WELCOME TO JENSEN CHIROPRACTIC

PLEASE COMPLETE THIS CONFIDENTIAL PATIENT INFORMATION FORM

First Name_____ Last Name_____MI_____ Gender M/F_____

Address_____ City _____ Zip Code_____

Home Phone_____ Cell _____ email_____

SSN _ _ _ - _ _ - _ _ _ _ Marital Stat. M/S/D/W _____ Birthdate (mm-dd-yyyy) _ _-_ _-_ _ _ _

Occupation _____ Employer _____ Dept _____Work Phone_____

Emp Address _____ City _____ Zip Code_____

Spouse Name _____ Birthdate (mm-dd-yyyy) _ _-_ _-_ _ _ _ SSN _ _ _ - _ _ - _ _ _

Names of Children_____

Complaint Today? _____How long?_____

Whom may thank for referring you to our office? _____

What is the name of your primary care physician? _____

Address _____ Ste _____ City _____ Zip Code_____

We work closely with many primary care physicians and specialists. We routinely send status reports to primary care physicians in certain cases. This ensures they understand your chiropractic care.

I authorize Dr. Jensen to send routine status reports to my primary care physician.

I authorize Dr. Jensen to release any information requested by my insurance company pertaining to my examination and treatment.

I authorize and direct my insurance benefits to be paid directly to Dr. Jensen. I realize that I am solely responsible for all covered and non-covered services.

I give permission to Dr. Jensen to administer treatment and perform such general procedures as she may deem required for diagnosis and/or treatment of my condition.

Signature _____ Date _____

(I have read and agree to the above statements)

Have you ever received Chiropractic Care? Yes__ No__ If yes, when?_____

1. Primary reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

Other reasons: _____

2. Chief Complaint: _____

Location of Complaint: _____

What was the initial cause of this complaint? _____

When did this complaint begin? _____

Are you presently under a doctor's care for this complaint? Y/N Doctors name:_____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to other areas of your body? Y/N Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (0 No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (10 Worst possible pain/complaint imaginable)

How frequent is complaint present. How long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Does this complaint interfere with: work, home life, activities or sleep? Y/N _____

3. Previous interventions: treatments, medications, surgery, or care you've sought for your complaint

_____

4. Past Health History:

A. Previous illnesses you've had in your life: _____

B. Previous injury or trauma:_____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications: _____

Condition/s you are taking medications for: _____

F. Surgeries and dates: _____

G. Pregnancies, Date of Delivery & Outcomes _____

_____

H. Date of the beginning of your last menstrual period?_____ Any menstrual problems?_____

5. Family Health History:

Associated health problems of relatives: _____

Deaths in immediate family: _____

Cause of parents or siblings death & age at death _____

6. Social and Occupational History: _____

A. Level of Education: _____

B. Job description: _____

C. Recreational activities: _____

D. Do you take vitamins or supplements? Type and how often._____

E. Smoking and alcohol use. How often._____

On a scale of 1 – 10. How committed are you to resolving this complaint? ____

Are there any other health concerns you would like to address? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me/child with chiropractic care, in accordance with this state's statutes.

Parent or Guardian Signature _____ Date _____

Doctors Signature _____ Date _____

CONFIDENTIAL PATIENT QUESTIONAIRE

Please answer all questions completely

NAME_____ **SSN**___-___-_____ **DATE**_____/_____/_____

Please explain in detail how your accident happened_____

_____

_____

_____

_____

Date of Accident _____**Month** _____**Day** _____**Year** **Time of Accident** _____ **am / pm**

You were heading _____**North** _____**South** _____**East** _____**West on** _____**(street or highway)**

Other vehicle was heading _____**North** _____**South** _____**East** _____**West on** _____**(street or highway)**

You were ___**Driver** ___**Passenger** ___**Front Seat** ___**Back Seat** ___**Using Seat Belts** ___**Air Bag Deployed**

You were struck from ___**Behind** ___**Front** ___**Left Side** ___**Right Side**

Did you lose consciousness? ___**Yes** ___**No** **If yes, how long?** _____

Were the poice notified? ___**Yes** ___**No**

Did you feel pain immediately after the accident? ___**Yes** ___**No** **Where?**_____

Was an ambulance called? ___**Yes** ___**No** **If yes, where were you transported?**_____

What treatment was given immediately after the accident?_____

What doctors have you seen since the accident?:

Name_____ **When?**_____**Condition treated**_____

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Name_____ **When?**_____**Condition treated**_____

Have you had similar complaints in the involved area before? ___**Yes** ___**No** **If yes, what were they?**_____

_____ **When did you have them?** _____

Before the injury were you capable of working on an equal basis with others your age? ___**Yes** ___**No** **If No, explain**_____

_____

Are your activities restricted as a result of the accident? ___**Yes** ___**No** **If Yes, how?** _____

Since the accident are your symptoms ___ **Improving?** ___**Getting worse?** ___**Staying the same?**

Signature_____ **Date**_____

INFORMED CONSENT
DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complex (VSC). When either VSS or VSC are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. Results depend on the inherent recuperative powers of each individual body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medicine specialists. Every chiropractic patient should be mindful of his/her symptoms and should secure other opinions if she/he has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decisions regarding your health.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or health care if she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions that do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

If you have any questions or problems please discuss them with the doctor **before** signing this statement of policy.

I have read and understand the foregoing.

_____ _____

DATE SIGNATURE