

# 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 \_\_\_\_\_

# 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.

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DATE

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SIGNATURE