Lifeline

Dr. Gregory K. Penniston

CHIROPRACTIC

CONFEDENTIAL PATIENT INFORMATION

DATE_____ IS VISIT ACCIDENT RELATED? ____YES ____ NO
(If YES, please notify receptionist)

Who referred you to this office? _____

NAME_____ AGE_____ BIRTH DATE_____
HOME PHONE _____ WORK (_____) _____
ADDRESS _____ CITY _____ STATE_____ ZIP_____
MARITAL STATUS_____SEX____ NO. OF CHILDREN _____
OCCUPATION _____ EMPLOYED BY _____
SOCIAL SECURITY NO._____

NAME OF SPOUSE_____ SOCIAL SECURITY NO._____
OCCUPATION_____ EMPLOYED BY_____

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU_____
ADDRESS_____ PHONE_____

PRESENT COMPLAINT- Briefly describe symptoms_____

_____
_____

Terms of Acceptance

When a patient seeks chiropractic care, and when a chiropractic accepts a patient for such care, it is essential that they both be seeking and working for the same goals.

Chiropractic has only one goal, it is, therefore, important that the patient understands the goal and the means that will be used to attain it. It this way, there will be no confusion, misunderstanding or disappointment. Patients usually want to get rid of whatever ailments are bothering them. This, however, is **NOT** the goal of the chiropractor.

The purpose of chiropractic is to correct the cause of the bodies malfunction, particularly in the areas of trauma and stress. When the nervous system is functioning in a more balanced way better alignment of the spine is possible as well as improved organ and tissue function throughout the body. This allows the innate healing ability of the body to work at maximum efficiency.

With proper nerve supply and nutrition, health improves, in some patients, symptoms clear up quickly. In others, the process is slower, and in some, it is only partial or not at all. Regardless if what the disease is called, the chiropractor does not offer to heal or even treat it. Nor does he offer advice regarding the treatment of the disease. His only goal is to allow the body to do its job. He promises no cure from and offers treatment of disease.

Print Name_____ Signature_____ Date_____

Consent to evaluate and adjust a minor child:

I, _____being the parent or legal guardian of _____ have read and fully understand the above agreement and hereby grant permission for my child to receive chiropractic care.

Patient Name: _____DATE: _____MR#: _____

MEDICATIONS AND ALLERGIES

Are you currently taking any medications?			
○	Yes	○	No

Patient Current Medications:

	Medication Name	Dose	For what purpose
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Do you have any allergies			
	Yes		No

Please list all allergies (including iodine and contract dyes):

	Allergy	**Severity**			
1		○ Mild	○ Moderate	○ Severe	
2		○ Mild	○ Moderate	○ Severe	
3		○ Mild	○ Moderate	○ Severe	
4		○ Mild	○ Moderate	○ Severe	
5		○ Mild	○ Moderate	○ Severe	
6		○ Mild	○ Moderate	○ Severe	
7		○ Mild	○ Moderate	○ Severe	

Patient Name: _____ Date: _____ MR#: _____

What conservative treatment have you had on or since your injury/problem began?

○	Injection	○	Chiropractic care
○	Aspiration	○	Bracing
○	Physical Therapy	○	Heat
○	Exercise	○	Ice
○	Anti-inflammatory medication	○	Massage
○	Pain medication	○	Rest

Date you began conservative treatment

Have you received non-surgical treatment for at least 3 months for this problem?		**Are you receiving or have you applied for worker compensation concerning your problem/injury?**	
○	Yes	○	Yes
○	No	○	No

Have you talked to a lawyer concerning your problem/injury		**Is your problem the result of an auto accident?**	
○	Yes	○	Yes
○	No	○	No

PAIN

Are you having pain today?				**Is your pain today:**	
○	Yes	○	No	○ Occasional	○ Continuous/constant

On a scale of 0-10 (with 10 being the worst pain imaginable, how would you score your pain today									
○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

Do you have pain that keeps you awake?					
○	Never	○	Occasionally	○	Frequently

What type of day is Your pain worsts?		**Check the works that best describe the character of the pain you are having today:**					
○	morning	○	Aching	○	Nagging	○	Shooting
○	afternoon	○	Burning	○	Numb	○	Tender
○	evening	○	Exhausting	○	Throbbing	○	Unbearable
○	nighttime	○	Gnawing	○	Sharp	○	
○	All the time	○	miserable	○	stabbing	○	

Patient Name: _____Date: _____ MR#_____

Please describe your current problem. IF YOU ARE SEEING THE DOCTOR FOR MULTIPLE PROBLEMS, ANSWER FOR THE MOST SEVERE:	
○	New injury or problem (less than 6 weeks duration)
○	Subacute problem (6 week- 3 months duration)
○	Chronic problem (problem has been treated over time period of more than 3 months and never been restored to normal)
○	Re-injury

What caused your injury/problem?		**Other cause of injury/problem?**
○	Fall	
○	Lifting	
○	Throwing	
○	Reaching	
○	Pulling	
○	Fighting	
○	Twisting	
○	Sports	
○	Collision/contact	
○	Other	

If the problem/injury is a result of an injury, where did it occur?		**Other:**
○	At home	
○	At work	
○	Via a motor vehicle accident	
○	While exercising	
○	At a sport competition	
○	Other	

Check any of the following that happened at the time of your injury/problem:			
○ Felt pain	○ Had swelling	○ Fracture	○ Bruising
○ Heard popping	○ Dislocation	○ Deformity	

Have you had surgery related to the problem you are being seen for today?	
○	Yes
○	No

Patient Name: _____Date: _____ MR#: _____

GENERAL NEW PATIENT HISTORY

CURRENT INJURY/PROBLEM

What is the MAIN injury/problem you are seeing the doctor for today? IF UNLISTED CHOOSE THE CLOSEST.		
□ right shoulder	□ left shoulder	□ head
□ right arm	□ left arm	□ neck
□ right elbow	□ left elbow	□ chest
□ right forearm	□ left forearm	□ midback
□ right wrist/hand	□ left wrist/hand	□ low back
□ right hip	□ left hip	□ problems walking
□ right thigh	□ left leg	□ weakness, numbness, tingling
□ right knee	□ left knee	□ other
□ right calf	□ left calf	
□ right foot/ankle	□ left foot/ankle	

If more than one injury/problem, which is worse? SELECT ONLY ONE- IF UNLISTED CHOOSE THE CLOSEST.		
o right shoulder	o left shoulder	o head
o right arm	o left arm	o neck
o right elbow	o left elbow	o chest
o right forearm	o left forearm	o midback
o right wrist/hand	o left wrist/hand	o low back
o right hip	o left hip	o problems walking
o right thigh	o left thigh	o weakness, numbness, tingling
o right knee	o left knee	o other
o right calf	o left calf	
o right foot/ankle	o left foot/ankle	

Date injury/problem began (APPROXIMATE IF UNSURE)

Is your problem a result of an injury/problem?	
o	Yes
o	No

Patient Name: _____DATE: _____ MR#: _____

SURGERY/PROCEDURES

Arthroscopy				**Fracture Repair**	
○	Right shoulder	○	Left shoulder	○ right shoulder	○ Left shoulder
○	Right elbow	○	Left elbow	○ right arm	○ left arm
○	Right wrist/hand	○	Left wrist/hand	○ right elbow	○ left elbow
○	Right hip	○	Left hip	○ right forearm	○ left forearm
○	Right knee	○	Left knee	○ right wrist/hand	○ left wrist/hand
○	Right foot/ankle	○	Left foot/ankle	○ right pelvis	○ left pelvis
				○ right hip	○ left hip
Joint Replacement Surgery				○ right femur (thigh)	○ left femur (thigh)
○	Right shoulder	○	Left shoulder	○ right knee	○ left knee
○	Right elbow	○	Left elbow	○ Right tibia/fibula	○ Left tibia/fibula
○	Right wrist/hand	○	Left wrist/hand	○ Right foot/ankle	○ Left foot/ankle
○	Right hip	○	Left hip		
○	Right knee	○	Left knee	**Spine Surgery**	
○	Right foot/ankle	○	Left foot/ankle	○ cervical ○ Thoracic ○ Lumbar	

Other Orthopedic Surgery

Non-Orthopedic Surgeries				**Other Surgeries**
○	Abdominal surgery	○	Hernia repair	
○	Brain surgery	○	Plastic surgery	
○	Cancer surgery	○	Sinus surgery	
○	Cardiothoracic surgery	○	tonsillectomy	
○	Eye surgery	○	Urology surgeries	
○	Gallbladder surgery	○	Vascular surgery	
○	Gynecologic surgery	○	other	

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CHIROPRACTIC & APPLIED KINESIOLOGY P.C.

Agreement for Record Release and Payment

I authorize you to release medical records to my family doctor and/or to my prescribing physician, and to release any medical information necessary for processing insurance claims. ____ (initial please)

I hereby authorize assignment of my Medicare/Insurance benefits to you. I will be responsible for any difference (balance) that my benefits do not cover. I acknowledge full financial responsibility for health care services. I agree to pay my bill in full at time of service or make arrangements for payment. I understand that there will be a finance charge of 1.5% per month (18% per annum) on all unpaid balances. If my bill must be placed for collection, I acknowledge responsibility for associated collection expenses in addition to the regular fees for medical services. In the event action is brought hereof, the prevailing party shall be entitled to recover from the other party the court costs and attorney fees determined and awarded by the court. If this account is referred for collection, I/we agree to pay collection fees up to 50% on the balance owing. If legal action is deemed necessary, I/We agree to pay reasonable attorney's fees and court costs in addition to the above costs. _____ (initial please)

I understand that Medicare does not pay for exams, x-rays, supplements, or supplies. If the doctor suggests any of the above for my benefit and treatment, the charge will be billed to my account and become my responsibility. _____ (initial please)

It is our office policy that we do not bill Medicare for auto accidents. Please notify us if this is the case and we can help you make other arrangements. ____ (initial please)

For patients with liens only: An administrative charge of $80.00 will be added to your account to help set up liens other than those filed with an attorney. This charge helps to offset the fee we have to pay for the lien to filed with Pima County. ____ (initial please)

We may enforce a $50.00 charge for chronically missed appointments. If you cannot keep your appointment, kindly notify us 24 hours in advance so that we may offer it to another patient. If charged, this fee will not go to your insurance or towards a lien, but will go to the patient directly, to be paid at the next appointment. ____ (initial please)

Date: _____ Signature: _____

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