LOUISVILLE
CHIROPRACTIC
RESULTS · RELIEF · RELAX

Patient Primary Complaint Form

(Please fill in or circle the most appropriate answer)

Name: _____ Date: _____

Address: _____ City: _____ State: ____ Zip Code:_____

Phone: _____ E-mail: _____

Emergency Contact: _____Phone: _____Relation:_____

Marital Status: Single Married Other SSN_____ DOB_____

Referred By: _____

Primary Care Physician: _____ Phone: _____

Primary Insurance: _____ Secondary Insurance: _____

What is the #1 thing that bothers you the most today? _____

How did your pain begin? _____

Pain Level: 1 2 3 4 5 6 7 8 9 10 (*1 is least, 10 is worst)*

Is your condition: Getting better? Or Getting worse? **Is your condition:** On & Off? or Constant?

Type of pain: Sharp Stabbing Burning Achy Dull Stiff & Sore

Radiating: Left/Right Base of skull Shoulder Arm Hand Hip Leg Knee Foot Ribs Other? _____

What makes it better? Ice Heat Rest Movement Stretching

What makes it worse? Sitting Standing Walking Laying Down Sleep Overuse Other? _____

Have you seen anyone else for this condition? _____

Were you involved in an accident? Automotive Fall Work Etc.? _____

List of medications you are currently taking: _____

List of past surgeries: _____

Do you have any other physical complaints? _____

Patient Signature: _____**Date:** _____

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Louisville, KY 40243
Phone: 502-489-8480
Email: Help@LouisvilleChiropractic.com

Are you *currently* experiencing any of these symptoms? *(Check all the apply)*
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: *(constitutional)*
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems _____
- ☐ Leg Problems _____
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones_____
- ☐ Other: _____
- ☐ *None in this Category*

Neurological:
- ☐ Numbness or tingling sensations
- ☐ Loss of Feeling
- ☐ Dizziness or light headed
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Other: _____
- ☐ *None in this Category*

Mind/Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____
- ☐ *None in this Category*

Genitourinary:
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/strain w Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: _____
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains
- ☐ Rapid or Heartbeat changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ Other: _____
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other: _____
- ☐ *None in this Category*

Eyes and Vision:
- ☐ Wear contacts/glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other: _____
- ☐ *None in this Category*

Ears, Nose and Throat:
- ☐ Bleeding gums / mouth sores
- ☐ Bad Breath or bad taste
- ☐ Dental Problems
- ☐ Swollen throat or voice change
- ☐ Swollen glands in neck
- ☐ Ringing in the ears
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Sinus / Allergy problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other: _____
- ☐ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive Thirst or urination
- ☐ Cold Extremities
- ☐ Heat or Cold intolerance
- ☐ Change in hat or glove size
- ☐ Dry skin
- ☐ Glandular or hormone problem
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other: _____
- ☐ *None in this Category*

Skin and Breasts:
- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change of appearance of a mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other: _____
- ☐ *None in this Category*

Women Only:

Are you pregnant?
- ☐ **Yes -** ***Due Date*** __/__/____
- ☐ **No -** ***Last Menstrual Period*** __/__/____
- ☐ Infertility
- ☐ Painful or Irregular periods
- ☐ Vaginal Discharge
- ☐ Other: _____
- ☐ *None in this Category*

Pregnancies:

Date	Outcome

Comments: _____

_____

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 with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date_____

Treating Doctor Signature _____ Date_____

Patient No: _____

Louisville Chiropractic

Patient Name: _____D.O.B.:_____Date:_____

Consent for Chiropractic Services

By reading below I have been made aware:

1. The process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually, with a table mechanism, or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold;
3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
4. That the chiropractor has made no guarantee of a positive outcome from treatment.

Additionally:

1. I have been afforded ample opportunity for questions and answers.

Therefore by signing below:

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature: _____

Witness Signature: _____

Louisville Chiropractic

Patient Name: _____ D.O.B.:_____ Date:_____

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation and examination on the above.

AUTHORIZATION FOR X-RAY WITH RELEASE: By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office. By signing below you are agreeing that if you chose self-pay care and declined to use your health insurance you have done so at your own will.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, text, e-mail and regular mail. Messages may be left on an answering device/ voicemail, text or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGEMENT: By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

RELEASE OF X-RAYS TO RADIOLOGIST (AUTHORIZATION TO RELEASE MEDICAL INFORMATION): I hereby authorize the release of x-rays and medical information necessary to SAFEGUARD RADIOLOGY for interpretation of my diagnostic imaging studies. I direct you, the Insurance Carrier/ Automobile Insurance Carrier/Attorney of record, to pay directly to SAFEGUARD RADIOLOGY, such sum as may be due for services rendered to me by reason of this claim and any other bills that are due the provider. You are authorized to withhold from any settlement, judgment or verdict as may be necessary to adequately protect said provider. Further, I hereby give a lien on my case (personal injury and workman's compensation claims only) to said provider against any and all proceeds of any settlement, judgment or verdict which may be paid by you or to myself as the result of injuries for which I have been treated in connection therewith. I fully understand that I am directly and fully responsible to the provider of services for all medical bills submitted for services rendered to me and that this agreement is made solely for said provider's additional protectio

RELEASE OF MEDICAL RECORDS AND TREATMENT TO YOUR PRIMARY CARE PHYSICAN, SPECIALIST OR ATTORNEY.
By signing below I authorize the release of my medical records to my primary care physician, specialist; and if applicable attorney.

Signature of Patient: _____ Date: _____

Signature of Parent of Guardian: _____

Patient Name: _____Date: _____ Account #: _____

Functional Rating Index

In order to properly assess your condition, we must understand how much your symptoms affect your ability to manage everyday activities. For each item below, **please circle the number, which most closely describes your condition right now.**

Pain Intensity

No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst possible pain
0	1	2	3	4

Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
0	1	2	3	4

Personal Care (washing, dressing, etc.)

No pain No restrictions	Mild pain No resctrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance
0	1	2	3	4

Travel (driving, etc.)

No Pain on long trips	Mild Pain on long trips	Moderate Pain on long trips	Moderate Pain on short trips	Severe Pain on short trips
0	1	2	3	4

Work

Can do usual work plus extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work
0	1	2	3	4

Recreation

Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities
0	1	2	3	4

Frequency of pain

No Pain	Occasional Pain 25% of the day	Intermittent Pain 50% of the day	Frequent Pain 75% of the day	Constant Pain 100% of the day
0	1	2	3	4

Lifting

No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
0	1	2	3	4

Walking

No pain after any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with walking
0	1	2	3	4

Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing
0	1	2	3	4

Score _____/ 40