

**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:** \_\_\_\_\_

**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 arrangement 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: \_\_\_\_\_

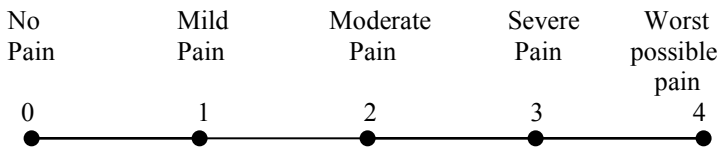
Signature of Parent of Guardian: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Account #: \_\_\_\_\_

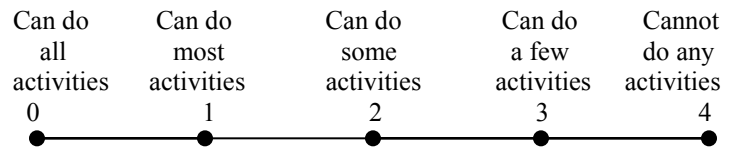
## Functional Rating Index

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.**

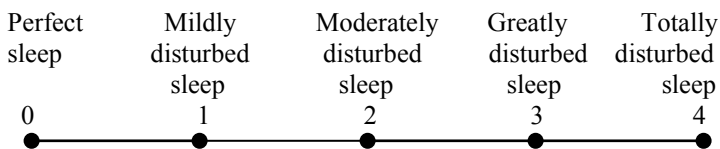
### Pain Intensity



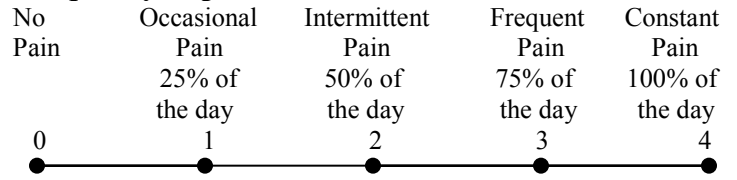
### Recreation



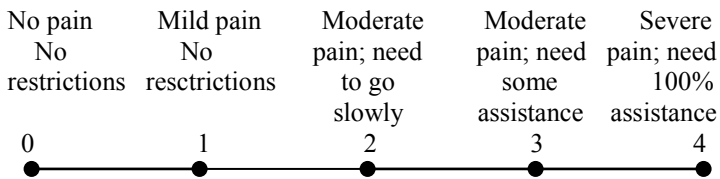
### Sleeping



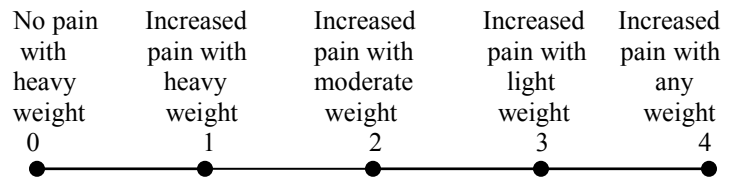
### Frequency of pain



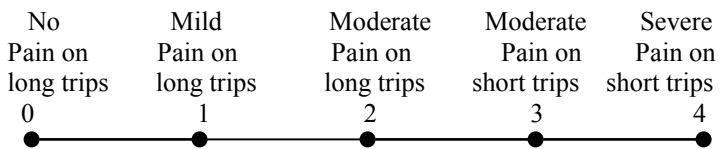
### Personal Care (washing, dressing, etc.)



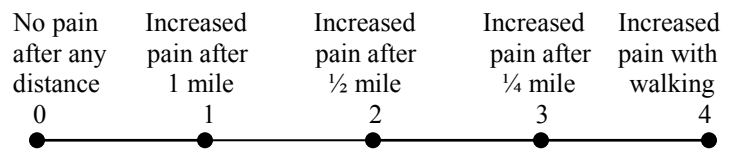
### Lifting



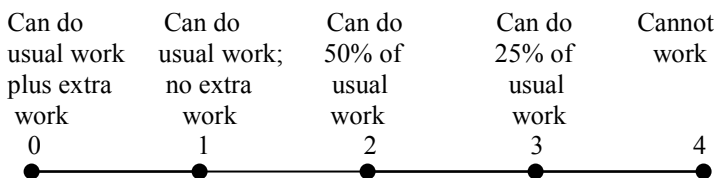
### Travel (driving, etc.)



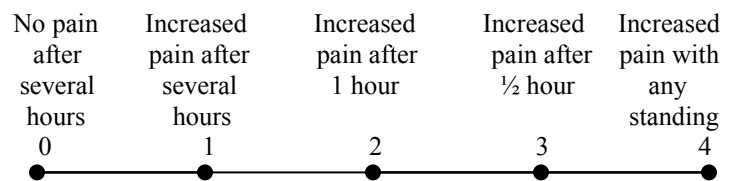
### Walking



### Work



### Standing



Score \_\_\_\_\_ / 40