LEITNER CHIROPRACTIC

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Patient Information

Patient Name: _____ **DOB:** _____ **Sex:** M/F/X

Cell Phone: _____ **Home Phone:** _____

Message Ok? Yes/No **Email:** _____

Address: _____

City: _____**State:** _____ **Zip Code:** _____

Preferred Contact Method: Phone/Text/Email **Marital Status:** Single/Married/Divorced/Other

Employer: _____ **Occupation:** _____

How did you hear about us/referred by:

_____

Emergency Contact Name: _____

Phone: _____ **Relationship to Patient:** _____

Case History

Reason for seeking care:

_____

_____

_____

_____

_____

List any other Providers seen for this: _____

List any diagnosis and treatment received: _____

X-ray, CT scan, or MRI results: _____

Present condition due to injury? Y/N **On the job?** Y/N **Auto accident?** Y/N **Other:** _____

Has the accident been reported? Y/N **To employer or Auto carrier?** _____

Have you had similar complaints or injuries before? Y/N
If yes, explain**:**

_____

_____

Have you previously received chiropractic treatment? Y/N
If yes, for what condition:

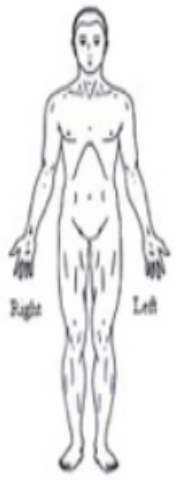
_____

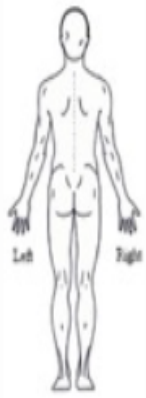
_____

Have you been treated for any health condition by a physician in the last year? Y/N
If yes, explain:

_____

_____





On the diagram, please mark your area(s) of pain:

Are you in pain ❑ Yes ? ❑ No ? If yes, indicate where on the drawing. Or, please explain below:

_____

Rate your pain at its worst in the last week 0 1 2 3 4 5 6 7 8 9 10

Rate your current pain right now 0 1 2 3 4 5 6 7 8 9 10

When did you first notice this (days/weeks/months/years)?

_____

Was there a specific cause?

_____

Are your symptoms **always present? Episodic? Specific** to a motion or position? Is it **tight? Painful? Sharp? Sometimes sharp? Dull? Aching? Sore?** Please explain:

_____

What activities (lying down, medication, heat, etc.) reduce/relieve your symptoms?

_____

Which activities (sitting, standing, desk work) aggravate your symptoms?

_____

Is this condition worse during certain times of the day? Y/N
If yes, explain: _____

Is this condition interfering with: work/sleep/other

Is this condition progressively getting: worse/better/staying the same

Have these symptoms occurred before? Y/N
If yes, when? _____

What, if any, health care specialists have you seen for these symptoms?

_____

What, if any, medications have you taken for these symptoms?

_____

Are you currently taking medication for other issues? Y/N
If yes, list medications and the reason for taking them:

_____

_____

Do you take vitamins/supplements? Y/N
If yes, type and how often: _____

Surgical History: Y/N
If yes, type and approximate date: _____

Do you smoke? Y/N If yes, how often: _____ **Caffeinated drinks per day:** _____

Family History: Health conditions, age and cause of death.
Father: _____
Mother: _____
Brother(s) & Sister(s): _____

Personal Health History

Mark each item below with a **C** (current) or **P** (past) for each sign or symptom you have had:

GENERAL SYMPTOMS
Convulsions C ❑ P ❑
Dizziness C ❑ P ❑
Fainting C ❑ P ❑
Headache C ❑ P ❑
Nervousness C ❑ P ❑
Numbness C ❑ P ❑

MUSCLES & JOINTS
Low Back Problems C ❑ P ❑
Pain between Shoulders C ❑ P❑
Neck Problems C ❑ P ❑
Arm Problems C ❑ P ❑
Leg Problems C ❑ P ❑
Swollen Joints C ❑ P ❑
Painful Joints C ❑ P ❑
Stiff Joints C ❑ P ❑
Sore Muscles C ❑ P ❑
Weak Muscles C ❑ P ❑
Walking Problems C ❑ P ❑
Sprains/Strains C ❑ P ❑
Broken Bones C ❑ P ❑

CARDIO-VASCULAR
High Blood Pressure C ❑ P ❑
Heart Attack C ❑ P ❑
Pain over Heart C ❑ P ❑
Poor Circulation C ❑ P ❑
Heart Trouble C ❑ P ❑
Rapid Heart C ❑ P ❑
Slow Heart C ❑ P ❑
Strokes C ❑ P ❑
Swelling Ankles C ❑ P ❑
Varicose Veins C ❑ P ❑

EAR/NOSE/THROAT
Earache C ❑ P ❑
Ear Noises C ❑ P ❑
Enlarged Thyroid C ❑ P ❑
Frequent Colds C ❑ P ❑
Hay Fever C ❑ P ❑
Nasal Blockage C ❑ P ❑
Nose Bleeds C ❑ P ❑
Pain Behind Eyes C ❑ P ❑
Poor Vision C ❑ P ❑
Sinusitis C ❑ P ❑
Sore Throats C ❑ P ❑
Tonsillitis C ❑ P ❑

RESPIRATORY
Asthma C ❑ P ❑
Chronic Cough C ❑ P ❑
Difficulty Breathing C ❑ P ❑
Spitting Blood C ❑ P ❑
Spitting Phlegm C ❑ P ❑

GENITO-URINARY
Blood in Urine C ❑ P ❑
Frequent Urination C ❑ P ❑
Kidney Infection C ❑ P ❑
Painful Urination C ❑ P ❑
Prostate Problems C ❑ P ❑
Loss of Bladder Control C ❑ P ❑

SKIN OR ALLERGIES
Boils C ❑ P ❑
Bruising Easily C ❑ P ❑
Dryness C ❑ P ❑
Eczema/Rash/Dermatitis C ❑ P ❑
Hives C ❑ P ❑
Itching C ❑ P ❑
Sensitive Skin C ❑ P ❑
Allergy C ❑ P ❑

GASTRO-INTESTINAL Belching/Gas C ❑ P ❑ Colon Problems C ❑ P ❑ Constipation C ❑ P ❑ Diarrhea C ❑ P ❑ Excessive Hunger C ❑ P ❑ Excessive Thirst C ❑ P ❑ Gall Bladder Trouble C ❑ P ❑ Hemorrhoids C ❑ P ❑ Liver/Gallbladder C ❑ P ❑ Nausea C ❑ P ❑ Abdominal Pain C ❑ P ❑ Ulcer C ❑ P ❑ Poor Appetite C ❑ P ❑ Poor Digestion C ❑ P ❑ Vomiting C ❑ P ❑ Vomiting Blood C ❑ P ❑ Black Stool C ❑ P ❑ Bloody Stool C ❑ P ❑ Weight Loss/Gain C ❑ P ❑	**FOR WOMEN ONLY** Birth Control C ❑ P ❑ Hormone Replacement C ❑ P ❑ Cramps/Backaches C ❑ P ❑ Excessive Flow C ❑ P ❑ Hot Flashes C ❑ P ❑ Irregular Cycle C ❑ P ❑ Miscarriage C ❑ P ❑ Painful Periods C ❑ P ❑ Vaginal Discharge C ❑ P ❑ Breast Pain C ❑ P ❑ Currently pregnant? Y ❑ N ❑

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health, personal information or insurance. I consent to examination and treatment for my present condition and for any future conditions for which I seek treatment from Dr. Leitner.

Patient Signature_____**Date**_____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his hands or a mechanical device in order to mobilize your joints. You may feel a "click" or "pop" such as the noise when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, including a variety of soft tissue massage or joint mobilization techniques, may also be used.

Possible Risks: As with any health care procedure, complications are possible following chiropractic manipulation. Complications, while rare, could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation or other minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare"—about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated to be one in four million (1:4,000,000) to one in twenty-five million (1:25,000,000). As a comparison, the risk of an exercise stress test performed during a physical examination on the general population is approximately one in ten thousand (1:10,000). The probability of adverse reaction due to ancillary procedures is also considered "rare."

Other treatment options which could be considered may include the following:

-Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

- Medical care, typically anti-inflammatory drugs, muscle relaxers, and analgesics. Risks of these drugs may include a multitude of undesirable side effects and patient dependence.

-Surgery may include the risk of adverse reaction to anesthesia, as well as an extended convalescent period.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

Printed Name: _____

Signature: _____ **Date:** _____

Billing and Cancellation Policies

Charges are assessed on an itemized basis for each service provided, and it is understood that the patient assumes financial responsibility for the full amount. Patients with chiropractic/massage insurance benefits assume financial responsibility for any portion not covered by their carrier. Payment is required at the time of the office visit.

• We will bill your insurance company when possible. We request that you pay your Co-Pay, Coinsurance, Deductible or non-covered service fee(s) at the time of service.

• If your insurance policy requires a referral for care, you are responsible for obtaining this referral prior to your visits. Any care that is not covered by the referral is your financial responsibility.

• We make every effort to get accurate information from your insurance company to estimate costs. Additional charges may be incurred after the claim is processed by your insurance company.

• Information received from your insurance company IS NOT A GUARANTEE OF BENEFITS. You are responsible for all charges incurred in this office.

• If you have had a personal injury (automobile accident), we will bill your personal injury protection carrier (your auto insurance). The insurance company may not cover 100% of the billings and you are responsible for any difference. We will keep you updated on the payment activity on your account and ask that you keep us updated on any new information you may receive regarding your account.

• Personal injury accounts (automobile accidents) require the injured party to complete paperwork with their insurance company in order for us to bill for services rendered. If you choose not to fill out this paperwork, you will be required to pay at time of service for your care, you are then solely responsible for any reimbursements through your insurance company.

• Patients paying at the time of service will receive our discounted Time of Service pricing. If you choose to pay at Time of Service, WE DO NOT BILL FOR THESE SERVICES. If, at a later date, you ask that we bill your insurance; the discount will be reversed prior to the submission of any billing.

**A $35 charge will be applied if an appointment is missed/cancelled/rescheduled with 24 hours of the original appointment. **

I have checked my health care benefits and know my chiropractic/massage coverage. If not, I acknowledge that I may be charged the full cost of my treatment.

Printed Name: _____

Signature: _____ **Date:** _____