Welcome to

CTC INTEGRATED HEALTHCARE

CHIROPRACTIC • MEDICAL • PHYSICAL THERAPY

Please take a few minutes to fill out this form completely. If you have questions we'll be glad to help you. We look forward to working with you to achieve your optimum health!

Patient Information

Today's date: _____/_____/_____

Name_____ Sex ☐M ☐F **Birth Date _____/_____/_____**
Last First MI

Address _____City _____ State _____ Zip _____

Home #_____ Cell # _____ Work # _____

Email _____ Would you prefer email, text message or both? E T B

Social Security # _____-_____-_____ ☐Single ☐Married ☐Separated ☐Divorced

Notify in case of emergency _____ Relation_____ Cell _____ Other Phone _____

Employer _____ Occupation _____

Have you ever seen a chiropractor before? ☐Yes ☐No If yes, state name of doctor, when seen, why? _____
_____

Primary Insurance

Person Responsible for Account _____ Relationship to patient_____
Last Name First Name MI

Please complete if responsible person is not the patient:

Date of Birth: ___/___/___ Social Sec. ____-____-_____ Phone _____ Email:_____

Address _____City _____ State _____ Zip _____

Employer _____Occupation _____ Business Address _____ Business Phone _____

Names of other dependents under plan _____
Relationship:_____

Reason for Visit

Reason for this visit: _____

Date symptoms began ____/____/____ Have you had a similar condition in the past? ☐Yes ☐No If yes, when: _____

Have you seen another healthcare professional for this condition? ☐Yes ☐No If yes, state name, date seen and effectiveness of treatment _____

Are your symptoms related to an injury or accident? ☐Yes ☐No If yes, did you go the Emergency Room? ☐Yes ☐No
Did you sustain other injuries? ☐Yes ☐No If yes, please describe_____

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please describe incident _____

Please Continue

Please Describe Your Symptoms

Symptom Description:

☐ Aching ☐ Burning ☐ Numbness ☐ Pins and Needles ☐ Stabbing ☐ Sharp ☐ Dull ☐ Throbbing ☐ Tingling ☐ Cramping
☐ Stiffness ☐ Swelling ☐ Shooting ☐ Other, Please describe _____
Rate the intensity of you pain: *(Circle the appropriate number)*
(no pain) 0 1 2 3 4 5 6 7 8 9 10 *(severe pain)*

Is pain getting: ☐ Worse ☐ Better ☐ Same ☐ Comes and goes

How often do you have this pain? ☐ Constant (81-100%) ☐ Frequent (51-80%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)

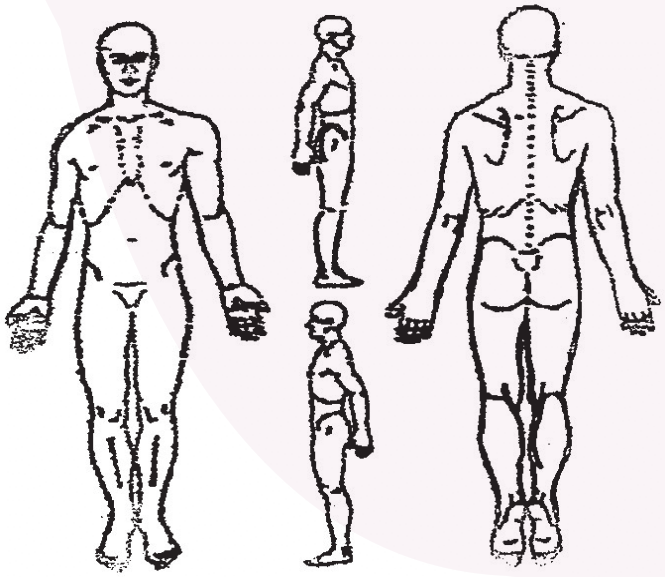
What time of day is your worst pain? ☐ Morning ☐ Afternoon ☐ Evening/nighttime ☐ Constant

Activities or movements difficult or painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying Down ☐ Lifting ☐ Standing

Activities or movements that make the pain better: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying Down ☐ Lifting ☐ Standing

Is pain interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other, please describe

USE THE LETTERS BELOW TO MARK THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW



Key:
A = ACHE
B = BURNING
N = NUMBNESS
P = PINS & NEEDLES
S = STABBING
T = TIGHT / STIFF
O = OTHER

Health History

Please list all medications (including over the counter medications) you are currently taking: _____
_____

Please list all nutritional supplements you are currently taking _____

Please list & date injuries or accidents you've ever had in your life (i.e.: falls, broken bones, traumas, etc. including when you were a child or in school) _____
_____
_____

Please list & date hospitalizations, surgeries or severe illnesses you've ever had in your life _____
_____

Please list any allergies or sensitivity reactions you have to anything _____

Please Continue

Medical Conditions

Have ***YOU or any FAMILY members*** ever had or currently have any of the following? (Check all that apply)
Please answer all the questions and mark "None" if it does not apply.

	Me	Family	Both	None	Notes / Specifics
Heart Disease					
Stroke					
High Blood Pressure					
Diabetes					
Cancer					
Frequent or Severe Headaches					
High Cholesterol					
Seizures					
Dizziness / Fainting					
Alcohol/Drug Abuse					
HIV(+) / AIDS or any STD					
STD					
Arthritis					
Numbness / Tingling					
Psychiatric Issues					
Eye / Vision Issues					
Ear / Nose / Throat Issues					
Respiratory / Breathing Issues					
Circulatory / Blood Issues					
Digestive Issues					
Urinary / Kidney Issues					
Reproductive System Issues					
Skin / Hair Issues					
Liver / Gall Bladder Issues					
Neck / Shoulder Pain					
Arm / Elbow / Wrist / Hand Pain					
Back Pain (Upper / Lower)					
Hip / Leg Pain					
Knee / Ankle / Foot Pain					
Other diseases					

Personal Habits

Please rate the following **1 (low)** to **5 (high)** regarding weekly frequency: Alcohol ____, Coffee ____, Tobacco ____, Candy ____, Sugar, ___, Dairy ___, Red Meat ___, Margarine ___ Diet Soda ___, Drugs ___, Recreational Drugs ___, Diet Pills ___, Stress____
Please rate the following **1 (poor)** to **5 (good)** regarding quality on a regular basis: Sleep ____, Diet_____, Exercise ____

Most of our new patients are referred to us by our current patients
Whom may we thank for referring you? _____
If not a referral, how did you hear about us?_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by CTC Integrated Healthcare to help determine the appropriate health services. If there is any change in my medical status, I will inform this office immediately. I also understand that all patient related information is kept strictly confidential by CTC Integrated Healthcare and released only by prior authorization of the patient or a legal guardian of the patient. I authorize my insurance company to pay CTC Integrated Healthcare all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize CTC Integrated Healthcare to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that if the insurance company pays me instead of CTC Integrated Healthcare, I will bring the checks to CTC Integrated Healthcare; otherwise CTC Integrated Healthcare is authorized to charge my credit card for them.

Signature_____ Date _____/_____/_____

****Payment is due in full at the time services are rendered unless prior arrangements have been approved****

HEALTHCARE AUTHORIZATION FORM

Patient's Name_____

Patient's SS# _____Date of Birth_____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES CTC Integrated HealthcareTO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING ITEMS: (If you do not authorize any item listed in the paragraphs below, please indicate which one you do not authorize by circling the item and putting an X over it. If you agree to everything within the paragraph then place a check mark in the box next to the paragraph.)

SPECIFIC AUTHORIZATIONS

☐ I give permission to CTC Integrated Healthcare to use my address, home, cell or work phone numbers, e-mail and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, thank you cards, information about upcoming office events, treatment alternatives or other health related information.

☐ If CTC Integrated Healthcare contacts me by phone, I give them permission to leave a phone message on my answering machine at home, voice mail at work or cell phone, or with another person at any of the numbers given.

☐ I give CTC Integrated Healthcare permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of protected health information during the course of care. Should I need to speak with the doctor privately at any time, the doctor will provide a room for this purpose.

EXPIRATION The Authorization shall expire on the following date: _____

RIGHT TO REVOKE AUTHORIZATION You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to: "The Privacy Official of Chiropractic Transformation Center". The written notice must contain the following information: Your name, social security number, date of birth, a clear statement of your intent to revoke this AUTHORIZATION, the date of your request, and your signature. This revocation is effective on the date the Privacy Official receives it.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, CTC Integrated Healthcare will not refuse to provide treatment. You have the right to inspect or copy your Protected Health Information. **A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU IF REQUESTED.**

This AUTHORIZATION is requested by CTC Integrated Healthcare for its own use/disclosure of Protected Health Information (PHI), which are the minimum legal standards that apply.

Signature of Patient or Legal Representative

_____**Date**_____

If not patient, describe relationship to patient _____

Informed Consent* to *Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move 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, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation, Complications 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, burns or 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 at one in one million to one in twenty million, and can be even further reduced by screening procedures. 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, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

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

Unusual risks: I have had the following unusual risks of my case explained to me.

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: _____

WITNESS:_____

Printed Name, Signature, Date:_____