Patient Information

Full Name: Last: ______________________________ First: ______________________________

Address: ______________________________ City: ____________ ST: ______ Zip: ________

Cell #: ________________ Do you want to receive text reminders for upcoming appts? Y N

Home #: ________________ Preferred #: Cell / Home

Date of Birth: ____/____/____ Age: ____ Gender: M / F Marital Status: S / M / W / D / P Number of children: ____

Spouse/Emergency Contact Name: ________________ Emergency Contact #: ________________

Email Address: ______________________________ Primary Care Provider: ________________

Occupation: ______________________________ Employer: ______________________________

How did you hear of our office? ______________________________

Insurance Information

Primary Insurance Company: ______________________ HSA Policy: Y / N Responsible party: You /Spouse /Parent

If Responsible Party is not you, please provide the following information:

Last Name: ______________________ First: ______________________

Date of Birth: ____/____/____ Employer: ______________________

Secondary Insurance Company? Y/N If yes, please list: ______________________ Responsible Party: You/ Spouse/ Parent

Our Privacy Policy

While the law requires us to give you this disclosure, please understand that here at Plainfield Family Chiropractic, we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health insurance information.

- Your health information to another health care provider if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- Your health information and billing records to another party if they are potentially responsible for the payment of your services.
- Your health information and billing records for in office operational purposes.

You have the right to request that we do not disclose your health information to certain individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information please let us know in writing. We are not required to agree to your restrictions.
You may revoke your consent to us at any time: however, your revocation must be in writing.
I have read your privacy policy and agree to its terms.

Please Initial: __________

Informed Consent to Chiropractic Treatment

Dr. Jennifer Worsman will take your history and perform an evaluation to determine your diagnosis and make appropriate treatment recommendations. If treatment is initiated, she will use her hands and/or any mechanical device(s) necessary to deliver adjustments in an attempt to restore normal function to your joints and muscles. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or other soft tissue techniques may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation and/or ancillary procedures. Extremely rare complications could include muscle strain, ligamentous sprain, and injury to intervertebral discs, rib fracture, or nerve injury. A small minority of patients may notice stiffness or soreness with the first few treatments. The ancillary procedures/hot packs could produce skin irritation, burns, or minor complications.

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

Please Initial: __________

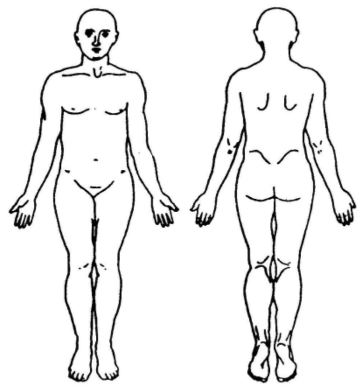
Assignment of Benefits

I understand that all services are to be paid at the time of service. I hereby authorize Dr. Jennifer Worsman/Plainfield Family Chiropractic, LLC to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable. I authorize the use of this signature on any insurance submissions.

Signature: ______________________________ Date: ________________
Signature: ______________________________ Date: ________________
Signature: ______________________________ Date: ________________

Name: ______________________________ Today's Date: ____/____/____

Clinical Information



1. **Main complaint/symptoms:** ______________________________
2. **When did the symptoms start?** ______________________________
3. **How did the symptoms start?** ______________________________
____

4. **What makes it better? Check all that apply:**
   __ Rest __ Sitting __ Standing __ Moving
   __ Ice __ Heat __ Medication __ Changing Positions
   __Walking __Stretching __Other: ____________________

5. **What makes it worse? Check all that apply:**
   __Sitting __Standing __Walking __Driving __Exercise
   __Reaching __Lifting __Bending __Heat __Ice
   __Work Duties __Computer use __Sleeping __Other: ________________

6. **Circle your pain level for today:** (10 being the worst) 1 2 3 4 5 6 7 8 9 10

7. **Check all that apply to describe your symptoms:**
   __Constant __On and off __Getting better __Getting worse __Worse in AM __Worse in PM
   __Sharp __Deep/Achy __Stiff/Tight __Burning __Tingling
   __Numbness __Weakness __Other: ______________________________

8. **Previous episodes of current pain?** Y / N If Yes, describe frequency: ______________________________

9. **Do you currently have any of the following associated with your symptoms?**
   __Dizziness __Loss of Bowel/Bladder function __Loss of Vision/Blurry Vision
   __Ringing in the Ears __Extreme pain with Coughing/Sneezing/Straining

Medical History

1. **Height**: ________ **Approximate Weight:** ________ **Smoker?** Y / N **Do you have a Medication List? Y / N**

2. **Past or Present Health Conditions; check all that apply & circle the M if you take medication for it: (__Med List Attached)**
   __Allergies M __Anxiety M __Arthritis M __Asthma M
   __Cholesterol M __Diabetes M __Depression M __GERD/Ulcers M
   __Heart Dz. M __Hepatitis M __High Bl. Pr. M __HIV/AIDS M
   __Lung Dz. M __Pacemaker __Thyroid Dz. M __Stroke M
   __Cancer/type: ________________ Past / Present

3. **List any other major health concerns not listed above:**
______________________________ ______________________________

4. **List major surgeries (__ Surgery List Attached)** ______________________________
____

5. **Family History (check any that apply to immediate family members)**: __Cancer __Stroke __Heart Dz. __Osteoporosis
6. **Past injuries:**
   Motor Vehicle/list year(s): ____________________ Fractures: ____________________
   Concussions: ____________________ Chronic sprains/list: ____________________
   Other (describe): ______________________________

7. **Previous Chiropractic Care?** Y / N If Yes, when was your last adjustment? __________

If you feel there are any other major health concerns not addressed with these questions, please inform Dr. Worsman. Initials: ________