PERFORMANCE CHIROPRACTIC

13206 Cottner Street, Omaha, NE 68137 (402) 896-2496

PATIENT INFORMATION

Name:_____ Soc Sec #_____
First MI Last

Address:_____
City State Zip

Home Phone:_____Work Phone:_____ Cell Phone:_____

Please list your cell phone provider company: _____
How would you prefer your appointment reminders: O 2 hours prior to appointment O 1 day prior to appointment

Email: _____

Sex: O Male O Female Date of Birth:_____ O Single O Married O Other

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Whom may we thank for referring you: _____

Is this an accident and/or work related injury: O Yes O No If yes, Please ask for an Accident form.

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____

Policy Holder: _____
First MI Last

Address:_____
(if different from patient) City State Zip

Sex: O Male O Female Date of Birth:_____ Soc Sec #_____

Relation to Patient:_____ Employer Name: _____

REASON FOR VISIT

Have you ever seen a Chiropractor: O Yes O No If yes, when and why: _____

Your reason for today's visit: _____

When did symptoms start for THIS episode (most recent date): _____

Have you had these symptoms before: O Yes O No

Rate the pain today on a scale of 1 to 10, 10 being the worst pain possible: 0 1 2 3 4 5 6 7 8 9 10

How did this happen: _____

Since the symptoms started is it: O Worse O Same O Come and Goes O Better

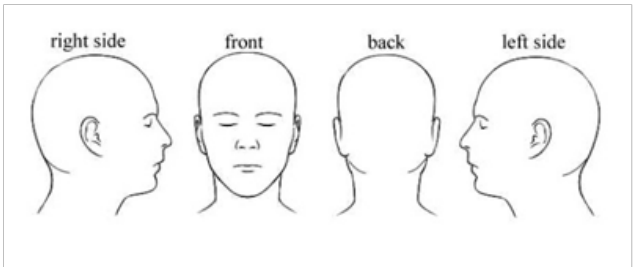
Have you been seen by a Medical Physician for this condition: O Yes O No If yes, When:_____

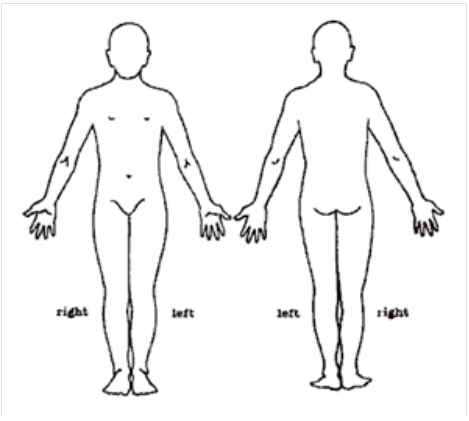
What activities make it worse: O Sitting O Walking/Running O Bending O Lifting O Laying Down O Other _____

What activities make it better: O Sitting O Walking/Running O Bending O Lifting O Laying Down O Other_____

Type of Pain: O Sharp O Dull O Throbbing O Aching O Burning O Tingling O Numbness O Stiffness
O Swelling O Other: _____ Does Pain interfere with your daily routine? O Yes O No

Shade the areas of pain and discomfort:





HEALTH INFORMATION

Date of last physical exam by your primary care Physician: _____

Please list any medication (including painkillers) you are taking: _____

Please answer Yes or No to the following **injuries** or **surgeries**:

Fall:	O Yes	O No	When:_____
Head Injuries:	O Yes	O No	When:_____
Broken Bones:	O Yes	O No	When:_____
Dislocations:	O Yes	O No	When:_____

Other **injuries** or **surgeries**: _____

_____

Have you **EVER** had or **CURRENTLY** have any of the following:

O Arthritis_____	O Heart Attack/Stroke	O Ringing in Ears
O Frequent Neck Pain	O Congenital Heart Defect	O Headaches/Migraines
O Jaw Pain	O Alcohol/Drug Abuse	O Diabetes/Tuberculosis
O Wrist Pain	O Fainting/Seizures/Epilepsy	O Cancer_____
O Shoulder Pain	O Shingles	O Emphysema/Glaucoma
O Arm Pain	O Psychiatric Problems	O Kidney Problems
O Leg Pain	O Difficulty Breathing	O Artificial Bone/Joints
O Low Back Pain	O Hepatitis	O HIV Positive/AIDS
O Dizziness/Earaches	O Anemia_____	O Ulcer/Colitis/Gout
O Osteoporosis	O Multiple Sclerosis/ALS	O Fibromyalgia
O Chronic Fatigue	O Lupus	O Ankylosing Spondylitis
O Difficulty Sleeping	O Appetite Problems	O Other _____

Do you consume any of the following on a regular basis:

Alcohol	O Yes	O No	Drinks per week: _____
Caffeine	O Yes	O No	Cups per day:_____
Tobacco	O Yes	O No	Packs per week: _____
Drugs	O Yes	O No	
Do you Exercise:	O Yes	O No	If yes, how often:_____

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 the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

Signature: _____ Date: _____

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AUTHORIZATION OF PAYMENT

I authorize my insurance company to pay Performance Chiropractic all insurance benefits otherwise payable to me for services rendered. I authorize the use of the signature on all insurance submissions. I authorize Performance Chiropractic 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.

Signature: _____ Date: _____

HIPAA

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Performance Chiropractic, LLC, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice. I consent Performance Chiropractic, LLC the use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operation purposes.

Signature: _____ Date: _____

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy including: Active Release Techniques, Graston Technique, Kinesio-taping etc. on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which is checked for in a thorough examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature: _____ Date: _____