NOVO
CHIROPRACTIC

Name:_____ Today's Date:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: ( )_____ Work: ( )_____ Cell: ( )_____

Email Address: _____ Male: ____ Female: ____

Occupation: _____ Birth Date: _____ Age: _____

Employer Name and Address: _____

□ Single □ Divorced □ Widowed □ Married Spouse's Name: _____

Have you seen a Chiropractor before? Yes No If yes, when?_____

Whom may we thank for referring you to our office? _____

YOUR HEALTH HISTORY

Please ☑ check all symptoms you have ever had, even if they do not seem related to your current problems.

___ Headaches	___ Ear Infections	___ Sinus Issues	___ Kidney Problems	___ Numb/Tingling Arms/Hands (L/R)
___ Migraines	___ Hearing Loss	___ Frequent Colds	___ Menstrual Problems	___ Numb/Tingling Legs/Feet (L/R)
___ Jaw/TMJ Pain	___ Ringing in the Ears	___ Thyroid Issues	___ Prostate Problems	___ Stroke
___ Neck Pain	___ Dizziness	___ Asthma	___ Sexual Dysfunction	___ Heart Attack
___ Shoulder Pain (L/R)	___ Loss of Energy	___ Difficulty Breathing	___ Infertility	___ Heart Problems
___ Elbow/Wrist Pain	___Sleep Problems	___ Nausea	___ Seizures	___ High/Low Blood Pressure
___ Upper Back Pain	___ Double/Blurry Vision	___ Ulcers	___ Epilepsy/Convulsions	___ GERD/Gastric Reflux
___ Mid Back Pain	___ Anxiety	___ Stomach Issues	___ Tremors	___ Chest Pain
___ Lower Back Pain	___Nervousness	___ Digestive Issues	___ Disc Problems	___ Cancer
___ Hip/Leg Pain (L/R)	___ Depression	___ Diarrhea	___ Scoliosis	___ Spinal Bone Fracture
___ Sciatic Pain (L/R)	___ Loss of Balance	___ Constipation	___ Poor Posture	___ Spinal Surgery
___ Knee Pain (L/R)	___ ADD/ADHD	___ Bed Wetting	___ Skin Problems	___ Diabetes (Type 1 or 2)
___ Foot Pain (L/R)	___ Allergies	___ Bladder Problems	___ Arthritis/Joint Pain	___ Fibromyalgia

Main Complaint:_____

List any medications you are taking: _____

Have you been in a car accident recently? Yes No If so, when? _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____
(if 18 years or younger)

Functional Rating Index

Regarding your **MAIN COMPLAINT**

In order to properly assess your condition, we must understand how much your main complaint problems have affected your ability to manage everyday activities.

For each item below, please circle the **ONE** choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25 % of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Name_____

PRINTED

_____ _____

Signature **Date**

Outcome Assessment Tool

Please **circle** the number that best describes the question asked for your **MAIN COMPLAINT.**

EXAMPLE:

No pain _____ Worst possible pain

0 1 2 3 4 5 6 7 (8) 9 10

1. How would you rate your pain **RIGHT NOW?**

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or **AVERAGE** pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its **BEST**? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level at its **WORST**? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians' certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is disclosed to carry out treatment, payment, or healthcare operation.

Release of Information:

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signature: _____ Date: _____

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, this will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care, and give consent to the examination and chiropractic care that the doctor deems necessary, including spinal adjustments, as reported following my assessment.

- I authorize and request payment of insurance benefits directly to Shane Davidson, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for all charges not covered.

Print Name: _____

Signature: _____ **Date:** _____

If This Health Profile Is for A Minor/Child, Please Fill Out and Sign Below

Written Consent for A Child

Name of Practice Member who is a Minor/Child: _____

I authorize Dr. Shane Davidson and any and all Novo Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Novo Chiropractic.

Guardian Signature: _____ **Date:** _____

Relationship to Minor/Child: _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays. Digital x-rays on a CD will be available within 72 hours of any regular practice hour day. Please note**:** X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Novo Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Print Full Legal Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

FEMALE PRACTICE MEMBERS ONLY: To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time the x-rays are taken at Novo Chiropractic.

Signature: _____ **Date:** _____