ABOUT THE PATIENT

Potent Chiropractic

Name _____ Today's Date_____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____Gender ❑ M ❑ F

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Type of Work _____

e-Mail Address _____ Have you been to a chiropractor before? ❑ No ❑ Yes

Emergency Contact _____ ph # _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and/or my child.
- I authorize Potent Chiropractic LLC to release and/or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Patient / Parent Signature (This represents a long-term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctor's have you seen for this?_____

_____

9. Type of treatment:_____

10. Results: _____

NOTES: _____

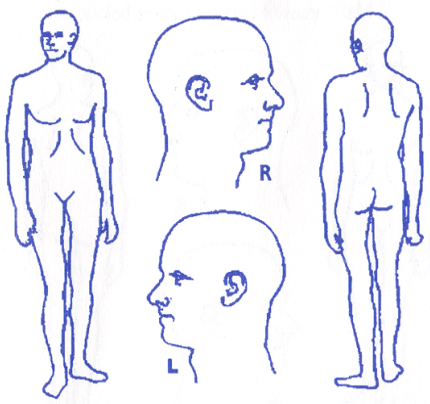
_____

_____

Are you pregnant?

❑ Yes ❑ No

Please mark all areas of concern.



GENERAL HEALTH HISTORY

Potent Chiropractic

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. List any medications you are taking:_____

_____

2. Please list all doctors you are currently seeing: _____

_____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": ❑ No ❑ Yes, Name_____

_____

_____

PAST HISTORY

4. List any past auto collisions:_____ Was any care received?_____
5. List any past work injuries: _____ Was any care received?_____
6. List any past sport, recreational, or home injuries_____
7. Please describe any past conditions and treatment received: _____

_____

8. Please list any past hospitalizations and surgeries: _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

COLLISION INFORMATION

Potent Chiropractic LLC

Name: _____Today's Date: _____
Where did the collision occur: Street:_____ City:_____State:_____
Date when collision occurred: _____ AM or PM. Was the road: ❑ Dry ❑ Wet ❑ Snowy ❑ Icy
Where you the: ❑ Driver ❑ Front middle passenger ❑ Front right passenger ❑ Back left ❑ Back middle ❑ Back right
Describe what happened:_____
_____
_____
_____
_____

CRASH DETAILS

❑ Yes ❑ No If driving, were both hands on the wheel at impact?
❑ Yes ❑ No If passenger, did your hands brace yourself?
❑ Yes ❑ No Did you have your seat belt and shoulder strap on?
❑ Yes ❑ No Was your seat up at the time of impact?
❑ Yes ❑ No Where you wearing a bulky coat or slippery pants?
❑ Yes ❑ No Did the seat belt engage?
❑ Yes ❑ No Did the airbag engage?
❑ Yes ❑ No Did you hit the dash, steering wheel or window?
❑ Yes ❑ No Did you know you were going to be hit?
❑ Yes ❑ No Did you brace yourself with hands or feet?
❑ Yes ❑ No If driving, was your foot on the brake at impact?
❑ Yes ❑ No Was your head turned at impact?
❑ Yes ❑ No Were you leaning forward?
❑ Yes ❑ No Did your glasses fly-off at impact?
❑ Yes ❑ No Was your body turned at the moment of impact?
❑ Yes ❑ No Did you get hit into another car, tree, railing, etc?
❑ Yes ❑ No Any damage or marks on your vehicle, the vehicle that hit you, or another object that was hit?
What part of the vehicle was hit? _____

1. What make and model of vehicle were you in?_____ The other vehicle?_____
2. What kind of seat were you in? __ Bucket __ Bench __ Fabric __ Leather/Vinyl
3. Did the car have headrests? ❑ Yes ❑ No
4. Did you hit your head on the headrest? ❑ Yes ❑ No On the back window if in a small truck? ❑ Yes ❑ No
5. Was the headrest positioned: __ below __ level with __ above the center of your head
6. Did your head hurt after the collision? ❑ Yes ❑ No Did your TMJ/jaw hurt after the collision? ❑ Yes ❑ No
7. How soon after the collision did you notice any pain? _____
8. Did the crash affect: ❑ dizziness ❑ memory ❑ concentration ❑ headaches ❑ balance ❑ nightmares ❑ breathing
❑ fatigue ❑ irritability ❑ ability to read ❑ ability to listen ❑ appetite ❑ nausea ❑ vision
9. Is there anything else you want us to know?_____
_____

PROVIDERS SEEN

List **all** providers seen since injury occurred:

1. Clinic/Doctor/Hospital Name_____City_____
2. Clinic/Doctor/Hospital Name_____City_____
3. Clinic/Doctor/Hospital Name_____City_____
4. Clinic/Doctor/Hospital Name_____City_____
5. Clinic/Doctor/Hospital Name_____City_____

❑ Yes ❑ No Do you have pictures of your vehicle? Where is it being repaired?_____

❑ Yes ❑ No Do you have a copy of the police report?

Name of your Attorney if you have one:_____

Name of Your Car Insurance Co._____ Your Health Ins. Co. _____

Name of the Other Divers car Insurance if Applicable_____

OFFICE POLICY

Potent Chiropractic LLC

SPINAL CHECK-UP:

- We recommend everyone have their spine checked early for spinal problems. Prevention is the best medicine.
- Children especially to see if their spine is developing abnormally. A spinal check–up is easy and fun for kids.

WE ALSO OFFER:

- Intersegmental traction, ice packs, and spinal orthotics.
  Please ask if you have any questions about these services!

AGREEMENTS FOR TOP RESULTS:

- Remember it takes time and effort to improve your health. *No time + No effort = No results*
- Please keep your appointments and make-up any missed or rescheduled visits within a day whenever possible.
- Please call if you are going to be late or need to reschedule.
- Feel welcome to refer your family and friends in for care. We are here to help them too.
- If you're paid ahead, understand you will get any unused money back if care ends early.
- I agree to allow my/family name, photo, video, or testimonial to be used during the normal course of business.
- I understand that adjusting time is for adjustments and I can always talk to the Doctor by special appointment or phone call. He is here to help you any way he can. We want you to do great! ☺

OFFICE VISITS MAY INCLUDE:

- **Specific Chiropractic Adjustments** to promote mobility, stimulate tissue, enhance alignment. This is when the Doctor works directly on your neck or back, sometimes making a popping sound. $50 - $65
- **Extremity Adjustments** to promote mobility, stimulate tissue, enhance alignment of extremity joints. $25
- **Intersegmental / Mechanical traction** to tense / relax soft tissues, aid healing and mobility. This is the black table with the rollers that effectively extend, stretch, and traction the spine. $45
- **Heat** for sub-acute or chronic conditions. The digital heat pack used on the area of concern. $10
- **Cold** to reduce swelling, this is the ice pack used on the area of concern. $10
- **Therapeutic Exercises** to improve spinal flexibility, strength and motion. These are stretches or exercises that you perform or the Doctor administers to you. Excellent for the neck, mid, and lower back. $45 per unit
- **Neuro Muscular Re-Education** to develop and improve coordination and balance, as well as promote flexibility and strength. An example is the Wobble chair the Doctor has you exercise with. $45 per unit
- **Home** and / or **Work** Activity of Daily Living Counseling $50
- **Supports/Pillow/Braces** if needed and as priced.

Patient: _____ Date _____ Staff_____