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: _____

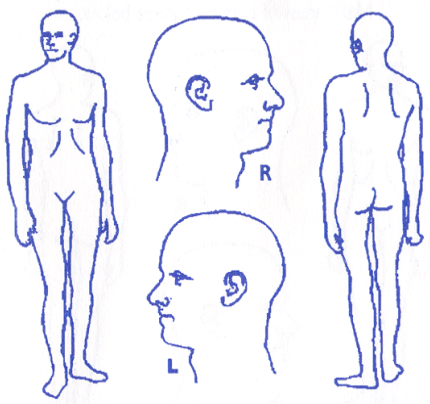
_____

_____

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?_____

WORKER COMPENSATION INFORMATION

Potent Chiropractic

Patient Information

Name:_____ Birthdate:_____ Social Security #_____

Address:_____

Home Phone: (____) _____ E-mail:_____

Cell Phone: (____) _____ Occupation:_____

Employer

Employer Name:_____

Employer Address:_____

Employer Phone: (____) _____ Injury Verified by (For Office Use Only) _____

Contact Person:_____ E-mail:_____

Worker Compensation Carrier (For Office Use)

Worker Compensation Carrier:_____

Carrier Address:_____

Carrier Phone: (____) _____ Coverage Verified by:_____

Adjuster's Name:_____ Claim Number:_____

Injury Information

Date of Injury:_____ Time:_____ ❑ AM ❑ PM Place of Injury:_____

Accident reported to employer? ❑ Yes ❑ No Name of Person you reported accident to:_____

Give full description of how accident happened:_____

_____

_____

Have you lost time from work? ❑ Yes ❑ No How much?_____

Other doctors seen for this condition: Doctor's Name_____

Diagnosis:_____ Were X-Rays taken? ❑ Yes ❑ No Other tests? ❑ Yes ❑ No

If yes, by whom? Please list test(s) and result(s) _____

_____

_____

Any previous Worker Compensation injuries? ❑ Yes ❑ No Date(s) of previous injuries:_____

Describe previous Worker Compensation injuries:_____

Authorization

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

Signature of Patient, Parent, Guardian or Personal Representative:_____ Date:_____

Please Print Name:_____ Relationship to Patient:_____

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_____