Rosemeyer Jones Chiropractic LLC
Office 608-348-4500 / Fax 608-348-6404
www.rosemeyerchiro.com

Today's Date____________________
Insurance Company_______________
Personal injury of auto accident (Y / N)

Section 1: Patient Information

Name____Date of Birth____________________________Sex (M / F)

Address____City, State and Zip Code________________________

Occupation____Employer______________________________

Home Phone____________________Cell Phone___________________Work Phone_________________________

Email Address____

May we send you a text reminder? (Y / N) Who is your cell phone carrier? __________________________________

How did you hear about our clinic? ____

May we thank someone for referring you to us? ____

Emergency Contact Name and phone #____

Smoking Status: ☐ Never Smoked ☐ Occasionally smoke ☐ Everyday smoker ☐ Former smoker

Current family physician's name_____________________________Office Location__________________________

Height_________________Weight______________Recent Blood Pressure (120/80 is normal)__________________

People choose chiropractic care for a number of reasons. How long you decede to benefit from our care is always up to you. Please check the type that you desire so that we can meet your needs the best possible way.

_____Relief care _____Corrective care _____Maintenance _____Check this line if you would like the doctor to recommend the best option for you

Section 2: Primary Complaint

Description of problem____

When did your pain start?____Have you had this before? (Y / N)

Have you sought other treatment? ☐ Medical Doctor ☐ Physical Therapist ☐ Other Chiropractor

How would you describe your pain? ☐ Dull/Ache ☐ Radiating ☐ Sharp ☐ Stiff ☐ Tight ☐ Tingling

What makes your pain feel better?____

What activities make your pain worse?____

Any associated symptoms or secondary complaints?____

Circle Pain on scale (1 = no pain / 10 = severe)

Pain at worst: 1 2 3 4 5 6 7 8 9 10

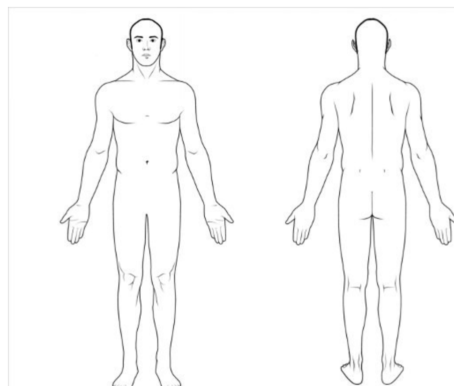
Pain at best: 1 2 3 4 5 6 7 8 9 10

Average pain 1 2 3 4 5 6 7 8 9 10

How often does it bother you?

☐0-25% ☐26-50% ☐51-75% ☐76-100%

Please circle areas of discomfort on the body



Section 3: Review of Systems: Please check off any that apply and provide an explanation if necessary

☐ Unexplained weight loss of gain ☐ Fatigue ☐ Fever ☐ Changes in appetite ☐ Heat or cold intolerance

☐ Eye vision problems:__________________________ ☐ Ear/nose/throat/sinus problems:___________________________

☐ Breathing/respiratory problems:_____________________ ☐ Heart problems:___________________________________

☐ Abdominal or bowel problems:_________________________ ☐ Blood condition:_______________________________

☐ Male problems:____________________________ ☐ Female problems:____

☐ Skin Problems:__________________________ ☐ Psychiatric problems:____

☐ Neurological disorder:______________________________ ☐ Allergies:____

Section 4: Health History: Please check off any that apply and provide an explanation if nexessary

☐ Arthritis ☐ Cancer:_____________________ ☐ Stroke ☐ Depression ☐ Diabetes ☐ Thyroid ☐ Scoliosis

☐ Fibromyalgia ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Disease ☐ Lupus ☐ Pneumonia

☐ Multiple Sclerosis ☐ Parkinson's ☐ Alzheimer's ☐ Seizures ☐ HIV ☐ Other:________________________

☐ Hospitalization ☐ Serious Illness ☐ Auto Accident ☐ Broken Bone ☐ Dislocation

☐ Spine surgery:__________________________year:______________ ☐ Joint replacement:_________________________

Please list any other surgeries:____

Do you have a pacemaker? (Y / N) Are you pregnant? (Y / N) Due Date:_____________________________

List medications w/ dosage and frequency *If you take more than 4 medications. Please provide a list at your next appt.

1.____3.____

2.____4.____

List any medication allergies: 1.________________________2.________________________3.______________________

Section 5: Please read and sign below

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill. I hereby authorize the doctor to treat my condition as he or she deems appropriate through the use of Chiropractic health care, and I give authority for these procedures to be performed. I understand and agree that x-rays are for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. I also agree that I am responsible for all bills incurred at this office and any co-pays, co-insurances, deductibles, non-covered services as well as charges that an insurance carrier denies, including worker's compensation and personal injury claims. I acknowledge that I have received the Chiropractic clinics notice of privacy practices and protected health information. By signing below, I also choose to decline receipt of my clinical summary after visits to this office. If you do choose to receive your clinical summary, notify the front desk staff and your doctor. By signing below, I am acknowledging that I filled the above paperwork out truthfully and to the best of my ability.

Patient Signature:____Date:___________________________________

Section 6: HIPPA compliance of our clinic

At Rosemeyer Jones Chiropractic, being compliant with HIPAA guidelines is something that we take very seriously. Keeping your 'protected health information' (PHI) private is a priority of ours and a legal duty. Our full notice of Privacy Protection Practices can be reviewed in the HIPAA compliance binder in our front lobby waiting room. There are also copies available upon request from our front desk staff. By signing below, you are acknowledging that you understand that Rosemeyer Jones Chiropractic is compliant with HIPAA regulations and is committed to protecting the privacy of your PHI. Additionally, that our policies are easily available for your review.

Section 7: Informed Consent to Care at Rosemeyer Jones Chiropractic Clinic

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as 'informed consent' and involves your understanding and agreement regarding the care that we recommend, the benefits and risks associated with that care, alternatives, and the potential effect on your health if you choose not to receive care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies (hot packs and ice), fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical artery dissection that involves an abnormal change in the wall of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over the counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name__________________________________ Signature______________________________ Date__________

Witness Name_________________________________ Signature______________________________ Date___________