

# Welcome to Rosser Chiropractic!

## All About You

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Home Phone \_\_\_\_\_  
Cell \_\_\_\_\_ Work \_\_\_\_\_  
E-mail Addr. \* \_\_\_\_\_  
Sex m  f  Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Social Security # \_\_\_\_\_  
Are you:  Single  Married/Partner  Divorced  Separated  
 Widowed  
Emergency Contact \_\_\_\_\_  
Their phone number \_\_\_\_\_  
Patient's Employer \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Whom may we thank for referring you here?  
\_\_\_\_\_

\* E-mails are used only for periodic office news and updates.

## Billing Details

We strive to offer a service that is of high quality and affordable. Since we can't guarantee that all health insurance plans will cover your care here, payment is required at the time of service unless other arrangements have been made with our office manager. We will gladly file any applicable insurance for you.

**(Please give your insurance card to the person at the front desk for copying.)**

How will you be handling your financial account?

Cash  Insurance  Medicare  Personal Injury  L&I claim

Health Insurance company (if any) \_\_\_\_\_

What is the patient's relationship to the insured? \_\_\_\_\_

Who is the insured's employer? \_\_\_\_\_

Does your insurance plan require a referral for you to be here? \_\_\_\_\_ If yes, did you get one? \_\_\_\_\_

**Would you like to know about our senior and student discounts, financial infeasibility plans and point-of-service arrangements?**  Yes  No thanks

## The Reason You're Here

For what concerns are you here today? Please describe your symptoms.

1. \_\_\_\_\_
2. \_\_\_\_\_

If you have pain, is it:  shooting  burning  sharp  dull ache  numb/tingling

When did the symptoms start? \_\_\_\_/\_\_\_\_/\_\_\_\_ Are they worsening?  Yes  No

Symptoms:  stay in one place  travel  are constant  are sporadic

What helps? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

Please rate your discomfort at it's **worst and best:** minor 1 2 3 4 5 6 7 8 9 10 severe

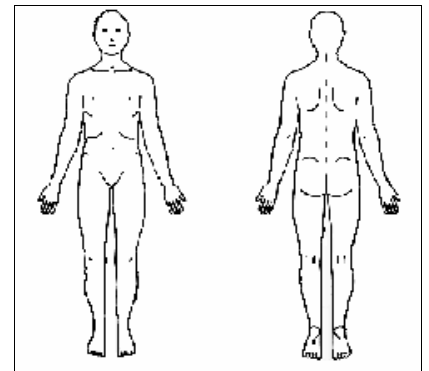
Likely causes?  trauma  auto  sports  work  unknown gradual  unknown sudden

Your present condition affects:  daily activity  work  sleep  walking  sports

What other health professionals have you seen for this? \_\_\_\_\_

What were his/her findings and what did they prescribe? \_\_\_\_\_

Have you had similar conditions/symptoms in the past? Y N If so, when? \_\_\_\_\_



Please circle areas of concern.

# Your Health History

## Past Trauma

*Please think hard and answer the following. Even accidents years back may be relevant.*

Have you ever had  serious falls/collisions  auto accidents  broken bones  major surgery  other injuries

Please describe how, why and when each occurred. \_\_\_\_\_

\_\_\_\_\_

Which parts of the body were involved? \_\_\_\_\_

Describe if/when you were hospitalized for these injuries. \_\_\_\_\_

Describe any other hospitalizations/surgeries and dates. \_\_\_\_\_

List medications you are currently taking. \_\_\_\_\_

Have you had spinal x-rays taken within the past 2 years?  Yes  No If yes, why? \_\_\_\_\_

## Medical History Please check those that apply and underline those that have occurred within the last 6 months.

- Bleeding disorder    Diabetes mellitus    Stroke/TIA    Low blood pressure    High blood pressure    Hypertension
- Heart attack    Angina    Edema    Bypass surgery    Pacemaker    Irregular heartbeat
- Headaches    Fainting    Nausea    Vertigo/dizziness    Visual disturbances    Lost coordination
- Meningitis    Encephalitis    Concussion    Brain tumor    Other brain pathologies    Skull fracture
- Epilepsy    Parkinsons    Alzheimers    Dementia    Confusion/depression    Mental illness
- Paralysis    Ringing in ears    Numbness    Muscle weakness    Tingling hands/feet    Carpal Tunner
- Raynauds    Lupus    Gout    Osteoarthritis    Rheumatoid arthritis    Psoriasis
- Lyme disease    Pagets    Spina bifida    Tuberculosis    Ankylosing spondylitis    Trouble swallowing
- MS    Lou Gehrig's    Duchenne's    Syphillis    Myasthenia gravis    Fibromyalgia
- Back surgery    Neck surgery    Epidural    Spinal tap    Neck pain/stiffness    Low back pain
- Cancer    Prosthesis    Broken leg    Hip problems    Short leg/heel lifts    Knee/ankle pain
- Night sweats    Hot Flashes    Change in bowels    Loss of bladder control    Other

For Women only   Are you pregnant? \_\_\_\_\_ If yes, due date. \_\_\_\_\_ Date of last period. \_\_\_\_\_

## Your Health Habits

What is your level of exercise?    None  Light  Moderate  Heavy

How do you rate your diet?    Healthy  Average  Poor

Check those that apply:    Smoke \_\_\_\_\_ packs/day    Alcohol \_\_\_\_\_ drinks/week

Do you take Nutritional Supplements?  Yes  No   Please List \_\_\_\_\_

\_\_\_\_\_

To my knowledge, this is a full and truthful record of my health. (signed) \_\_\_\_\_ Date \_\_\_\_\_

Patient name \_\_\_\_\_ Date \_\_\_\_\_

### Consent For Treatment

I, the undersigned, a patient at Rosser Chiropractic, hereby authorize Dr. Andy Rosser to administer chiropractic treatment as needed. I understand that each individual case is unique so there have been no guarantees regarding the results that may be obtained while under care. I understand that Dr. Rosser is treating me solely for the correction of spinal misalignments and posture abnormalities. I understand that while there are many associated health benefits from having a healthy spine, this office and practitioner are not treating me for any specific disease or condition.

Patient signature \_\_\_\_\_

### Authorization for Insurance Payment

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that ultimately, I am responsible for the final settlement of my account.

I understand that as a courtesy to me, this office may file my insurance according to the particulars of my policy. If so, I authorize my insurance carrier(s) to make payment for the expense benefits allowed and otherwise payable to me, directly to Rosser Chiropractic for professional services I have received while under Dr. Rosser's care. I have agreed to pay, in a current manner, any balance of said professional charges.

Patient signature \_\_\_\_\_

### Authorization to Release Medical Information

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information provided to this office is accurate and complete.

Patient signature \_\_\_\_\_

### Authorization for X-Rays

I authorize Dr. Andy Rosser to take the x-rays needed to understand the condition of my spine. I understand that he will inform me of any abnormal, non-chiropractic findings that he sees, if any, but that it is not his responsibility to diagnose any disease or condition outside of issues directly concerning the health of my spine.

Patient signature \_\_\_\_\_

### Authorization for Treatment of a Minor

I authorize Dr. Andy Rosser to administer treatment and x-rays as needed to my child, \_\_\_\_\_.

I understand that x-rays will only be used in the event of a trauma and not as part of a routine initial exam for a child under 13 years of age.

Patient signature \_\_\_\_\_

## Our Privacy Pledge:

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please know that we have and always will respect the privacy of your health information.

There are a few situations in which we may have to disclose your health care information:

- We may need to disclose it to another healthcare provider or hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your condition.
- We may need to disclose your health or billing details to another party (such as your insurance company or claimant's insurance company in an accident) if they are potentially responsible for the payment of your services.
- We may need to use your information within our practice for quality control or other operational purposes.

You are entitled to review a more detailed description of this notice before signing this consent form. It is available in the reception area of our office. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

## Your right to limit uses or disclosure

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. Please provide us (in writing) with your specific restrictions for the use or disclosure of your health information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

## Your right to revoke authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your revocation request. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

## Acknowledgement of Privacy Practices

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice, if desired.

Printed Name \_\_\_\_\_  Parent, Guardian or Patient's Legal Representative

Signature \_\_\_\_\_ Date \_\_\_\_\_

Optional Authorizations (Please initial/complete the following as you choose.)

- You have my permission to leave me a voice mail message if the need arises. \_\_\_\_\_
- You may discuss my health information with the following people (family/friends). \_\_\_\_\_

\_\_\_\_\_