# WELCOME

## one ABOUT YOU

Today's Date: ____/____/____ File #:____

**Patient Name:** ____
LAST FIRST MI

What You Prefer To Be Called: ____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: ____ SS#: ____

Mailing Address: ____

____
CITY STATE ZIP

Home Phone #: (____) ____

Work Phone #: (____) ____ Ext: ____

Cell Phone #: (____) ____

E-mail Address: ____

Referred By: ____

**Employer:** ____ How Long? ____

Employer's Address: ____

____
CITY STATE ZIP

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How many? ____

## two INSURANCE INFO

Primary Insurance

Co. Name: ____

Address: ____

____
CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

Secondary Insurance

Co. Name: ____

Address: ____

____
CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

## three ACCOUNT INFO

**Person ultimately responsible for account**

Name: ____

Relation: ____

Billing Address: ____

____
CITY STATE ZIP

SS #: ____

Drivers License #: ____

Work Phone #: (____) ____

**Payment method:** ❑ Cash ❑ Check

____ ____/____
❑ Credit Card - Enter card # above (if accepted)

____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

## four IN EVENT OF EMERGENCY

Whom should we contact? ____

Relation: ____

Home Phone #: (____) ____

Work Phone #: (____) ____

Cell Phone #: (____) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: (____) ____

PLEASE CONTINUE ON BACK

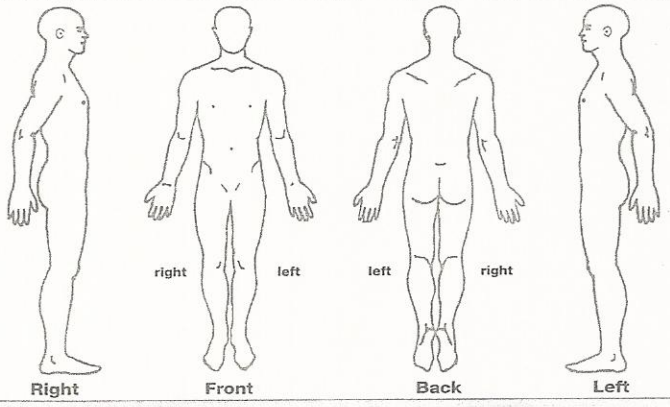
## five 5 REASON FOR VISIT

Reason for today's visit: ❑ Emergency ❑ New injury ❑ Old injury ❑ Chronic pain ❑ Wellness
Are you in pain: ❑ Yes ❑ No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense
Did your injury occur during: ❑ Work ❑ Sports/play ❑ Auto Accident ❑ Routine/Household activity
When did your condition/accident occur? ___/___/___ Where did your injury occur? _____
Please explain what happened: _____
Is your condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes.
Is your condition interfering with your: ❑ Work ❑ Sleep or ❑ Daily routine? If so, how: _____

Has this or something similar happened in the past?
❑ Yes ❑ No Explain: _____

**Using the adjacent body charts, please circle all affected areas.**
Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where? _____

Have you ever been treated by a Chiropractor? ❑Yes ❑No
Clinic or Dr's name: _____
Clinic phone#: _____




## six 6 HEALTH HISTORY

**Are you taking any of the following medications?** ❑ Nerve pills ❑ Pain killers(including aspirin) ❑ Muscle relaxers
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

**Do you have or have you had any of the following diseases, medical conditions or procedures?**

| | | | | |
|---|---|---|---|---|
| Y N Heart Attack / Stroke | Y N Heart Surg./Pacemaker | Y N Heart Murmur | Y N Congenital Heart Defect | Y N Mitral Valve Prolapse |
| Y N Artificial Valves | Y N Alcohol / Drug Abuse | Y N Venereal Disease | Y N Hepatitis | Y N HIV+ / AIDS / ARC |
| Y N Shingles | Y N Cancer | Y N Frequent Neck Pain | Y N Glaucoma | Y N Anemia / Diabetes |
| Y N High/Low Blood Pressure | Y N Psychiatric Problems | Y N Rheumatic Fever | Y N Severe / Frequent Headaches | Y N Kidney Problems |
| Y N Ulcers / Colitis | Y N Fainting/Seizures/Epilepsy | Y N Sinus Problems | Y N Emphysema / Asthma | Y N Tuberculosis |
| Y N Difficulty Breathing | Y N Chemotherapy | Y N Lower Back Problems | Y N Artificial Bones/Joints/Implants | Y N Arthritis |

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____
List any past serious accidents with dates: _____
Please list anything that you may be allergic to: _____
Family Health History: _____
Do you take Supplements or Vitamins? ❑ Yes ❑ No Do you exercise? ❑ No ❑ Yes ____ hours per week
Do you smoke? ❑ No ❑ Yes How much? _____ How long? _____
Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports Are you dieting: ❑No ❑Yes Since: ___/___/___
**For woman:** Are you taking Birth Control? ❑ Yes ❑ No
Are you Nursing? ❑ Yes ❑ No Are you Pregnant? ❑ No ❑ Yes If so, how many weeks? _____

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

**UPDATE** (OFFICE USE)

| Initials | Date | Comments |
|---|---|---|
| | / / | |
| | / / | |
| | / / | |

## QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

**Please read carefully:**

**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

**Example:**

| | Headache | | | | Neck | | | | Low Back | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No pain** | 0 | 1 | (2) | 3 | 4 | (5) | 6 | 7 | (8) | 9 | 10 | **worst possible pain** |

---

**1 – What is your pain RIGHT NOW?**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No pain** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **worst possible pain** |

**2 – What is your TYPICAL or AVERAGE pain?**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No pain** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **worst possible pain** |

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

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No pain** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **worst possible pain** |

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

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No pain** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **worst possible pain** |

**OTHER COMMENTS:**

_____

_____

_____

Examiner

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CLIFFORD CHIROPRACTIC
(615) 672-3568
2759 HWY 31 WEST
WHITE HOUSE, TN 37188

I understand that my health information is private and confidential. I understand that the staff of Clifford Chiropractic work hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means that Clifford Chiropractic may use and disclose my personal health information to help provide my healthcare, to handle my billing and payments and to take care of other healthcare operations.

Clifford Chiropractic has a document called "Notice of Privacy Practices." It contains more information about policies and practices used to protect their patient's privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this agreement. A written copy will be provided upon request.

Under the terms of this consent, I can ask Clifford Chiropractic to restrict how my personal health information is used or disclosed to carry out treatment, payment or other healthcare operations. I understand that Clifford Chiropractic does not have to agree with my request. If Clifford Chiropractic does agree with my request, I understand that agreed limits would be followed.

I understand that I have the right to cancel this consent in writing to Clifford Chiropractic. If I do cancel the consent, I understand that Clifford Chiropractic may have used or disclosed information about me and canceling this consent would not apply to information already used or disclosed.

I understand that if I cancel this consent, Clifford Chiropractic does not have to provide further healthcare services to me.

To be completed by the patient:

_____
Print name

_____
Signature

_____
Date

Authorized patient representative:

_____
Print name

_____
Signature

_____
Relation to patient

_____
Date

To be completed by doctor or staff:

_____
Witness to patient's signature

_____
Date

# DISCLOSURE & CONSENT
## For
## CHIROPRACTIC ADJUSTMENTS AND CARE

**TO THE PATIENT:** You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Rick Clifford, D.C. and/or other licensed Doctors of Chiropractic or those working at the clinic of office who now or in the future treat me while employed by, working or associated with, or serving as a backup for Rick Clifford, D.C.

I have had the opportunity to discuss with Rick Clifford, D.C., my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

---

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

Authorized Person(s) or Legal Guardian:

_____
print name

_____
signature of authorized person(s)

_____
relation to patient

_____
date signed

---

To be completed by doctor or staff

_____ _____
witness to patient's signature date