Vogt Family Chiropractic New Patient Questionnaire

Required Patient Intake Information

Name _____Today's Date_____ SS#_____
Home Address _____City_____ State ____Zip_____
❑Male ❑Female ❑Married # of Children_____ Your Birthdate_____
Spouse's Name_____ Spouse's Birthdate _____
Primary Phone#_____ E-mail _____
Occupation_____ Employer _____ #years_____
Emergency Contact_____ Phone _____ Relation _____
Whom may we thank for referring you? _____
Name of local primary Physician_____

Insurance Information – If insured, please provide copy of insurance card

What brings you in today? _____
When did it start? _____
Is it *staying the same*, *getting better* or *getting worse*? (circle one)
What makes it better? _____
What makes it worse? _____
Rate the pain - (0 is pain free and 10 is unbearable pain) 0 1 2 3 4 5 6 7 8 9 10
Other Chiropractors?_____
Other type of doctor or therapist? _____
Other Health Issues? _____
Pregnant? Y or N Date of last Menstrual Cycle_____
Previous Surgeries and Dates? _____
_____
Do you use tobacco products? Yes or No
Do you drink alcohol? Yes or No
Medications:_____
_____
_____

Health History - Please circle all that apply

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M. S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V. D.	Whooping Cough	
Chronic Fatigue	High Blood Pressure	Fibromyalgia	Other_____				

All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.

Patient Signature_____ Date_____

PATIENT NAME:_____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

____spinal manipulative therapy	____palpation	____vital signs
____range of motion/strength test	____orthopedic testing	____basic neurological testing
____spinal traction therapy	____postural analysis	____hot/cold therapy
____radiographic studies(x-rays)	____attended electric stim	____cold laser tx

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read **[ ]** or have read to me **[ ]** the above explanation of the chiropractic adjustment and related treatment. I have discussed it with **Dr. Ben Vogt** and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

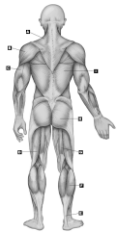
Dated:_____ **Dated:**_____

_____ **Ben Vogt, D.C.**
Patient's Name (print) **Doctor's Name**

_____ _____
Signature **Doctor's Signature**

_____
Signature of Parent of Guardian

The rest of this form is to be performed by clinic staff:



Height: _____inches **Weight:** _____pounds **BP:**____ / _____

DTR: Bicep____Tricep____Brachirad____Patellar____Achilles____

PATIENT CASE HISTORY

FOR OFFICE USE ONLY

CHIEF CONCERNS:
HISTORY OF CONDITION:
INTENSITY: 0 1 2 3 4 5 6 7 8 9 10 FREQUENCY: INTERMITTENT OCCASIONAL FREQUENT CONSTANT ASSOCIATED SYMPTOMS:
AGGRAVATING FACTORS: RELIEF FACTORS:
WHAT HAS BEEN DONE TO TREAT THIS CONDITION:
PRIOR ILLNESS, SURGERY, ACCIDENTS:
FAMILY HEALTH HISTORY:
Help You?: