Chart#:_________

Medical History Form
(Please use black ink)

Patient Name:____ **Appointment Date:**_______________ **with Dr.** _________________________

Age:__________ **Sex:** ☐ F ☐ M **Height:** ________ **Weight:**________ **Dominant hand:** ☐ R ☐ L **Did you bring X-rays?** ☐ Y ☐ N

Who is your primary physician? (name): ____________________________________ ☐ MD ☐ PA **Clinic Name?** ______________________

What is the reason for this visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness ☐ Other____________________________

Latex Allergy? ☐ Y ☐ N ____

What body part is involved? (Please mark the table below)

Shoulder	Elbow	Wrist	Hand	Hip	Knee	Ankle	Foot	Neck	Back
☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐	☐

How long ago did it start?______ Days______Weeks______Months______Years.

Have you had a problem like this before? ☐ Y ☐ N

In this section, check the ONE BOX which best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

☐ **NO INJURY** (or onset was: ☐ Gradual or ☐ Sudden)
Please indicate why do you think it started?

☐ **INJURY** (☐ Accident ☐ Sport (NOT Auto or Work)
Date:__________ Please specify where and how it happened.
What Sport?________________ School?________________

☐ **INJURY AT WORK** Date:____________________
From a: ☐ lift ☐ twist ☐ fall ☐ bend ☐ pull ☐ reach

☐ **WORK RELATED** (BUT NO INJURY)
Date:_______________ How did your job cause the problem?

☐ **AUTO ACCIDENT** Date:_________ How was your car hit?

COMMENTS:
____
____
____
____
____
____
____
____

On a scale of 0 – 10 (10 is the worst) how severe is your pain? (circle) **0 1 2 3 4 5 6 7 8 9 10**

What is the quality of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

The pain is: ☐ Constant ☐ Comes and goes (intermittent).

Does your pain wake you from your sleep? ☐ Y ☐ N

Do you have: ☐ Swelling ☐ Bruises ☐ Numbness ☐ Tingling ☐ Weakness
☐ Loss of control of bowel or bladder ☐ Locking/Catching ☐ Giving way

Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged

What makes your symptoms worse? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting ☐ Lying in bed
☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sitting ☐ Coughing ☐ Sneezing

Which make your symptoms better? ☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ Other: ____

What medications are you taking now?____

ALLERGIC TO ANY MEDICATIONS? ☐ Y ☐ N if yes please list and describe reaction:__________________________________

Have you had any of these treatments? Injection: ☐ Y ☐ N Brace: ☐ Y ☐ N Physical Therapy: ☐ Y ☐ N Cane/Crutch: ☐ Y ☐ N

Were you seen in the E.R. for this problem? ☐ N ☐ Y Which E.R.?__________________Date:______________________________

Are you here today as a result of an E.R. Visit? ☐ N ☐ Y Who saw you in E.R.?___________________________ ☐ MD ☐ PA

What test/scans have you had for this problem?
☐ X-Rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ Nerve Test (EMG/NCV) **Where**?______________________________________

Have you already had surgery for a problem in this same area either recently or in the past? ☐ N ☐ Y

Please list below:

Procedure #1________________________Surgeon___________________________City_____________________Date__________________

Procedure #2________________________Surgeon___________________________City_____________________Date__________________

Current work status? ☐ Regular ☐ Light duty - (how long?________________) ☐ Not working due to this problem
☐ Disabled ☐ Retired ☐ Student

When is the last date you worked your regular job?____

Are you currently receiving or plan to apply for: Disability: ☐ Y ☐ N Worker’s Comp: ☐ Y ☐ N Unemployment: ☐ Y ☐ N

Patient Name:___________________________ **REVIEW OF SYSTEMS** **Chart#:**_________

Have you had a prior problem with this same Orthopedic condition in the past? ☐ N ☐ Y (explain below)

____

Do your other joints have: ☐ morning stiffness lasting over 30 minutes ☐ joint pain or swelling ☐ Back Pain ☐ Gout

☐ Rheumatoid arthritis ☐ Osteoporosis ☐ prior fracture (which bone)__________ ☐ None of these

Have you had any of these symptoms? If no, mark None.

					NONE	YEAR
1)	**GI**	☐ Heartburn, ulcers	☐ Nausea, Vomiting	☐ Blood in Stool	☐	_____
		☐ Hepatitis	☐ Liver disease			
2)	**ENDO**	☐ Thyroid Disease	☐ Heat or Cold Intolerance		☐	_____
3)	**CON**	☐ Weight Loss	☐ Loss of Appetite		☐	_____
4)	**EYE**	☐ Blurred Vision	☐ Double Vision	☐ Vision Loss	☐	_____
5)	**ENT**	☐ Hearing Loss	☐ Hoarseness	☐ Trouble Swallowing	☐	_____
6)	**CV**	☐ Chest Pain	☐ Palpitations		☐	_____
7)	**RS**	☐ Chronic Cough	☐ Shortness of Breath		☐	_____
8)	**GU**	☐ Painful Urination	☐ Blood in Urine	☐ Kidney problems	☐	_____
9)	**SK**	☐ Frequent Rashes	☐ Skin Ulcers	☐ Lumps ☐ Psoriasis	☐	_____
10)	**NEU**	☐ Headaches	☐ Dizziness	☐ Seizures	☐	_____
11)	**PSY**	☐ Depression	☐ Drug/Alcohol Addiction	☐ Sleep disorder	☐	_____
12)	**HEM**	☐ Easy Bleeding	☐ Easy Bruising	☐ Anemia	☐	_____

Details/Comments

____

13) **ARE YOU HIV POSITIVE:** ☐ N ☐ Y

PAST MEDICAL HISTORY

Are you Diabetic? ☐ N ☐ Y If Yes, treatment: ☐ Insulin ☐ Oral Meds ☐ Diet ☐ None

Are you taking, or have you ever taken, blood thinners? ☐ N ☐ Y If yes, which one? ______________________

Past Surgical History: What operations have you had and when? Please list: ______________________

____

Have you or a family member ever had a reaction to anesthesia? ☐ N ☐ Y EXPLAIN:______________________

Past Hospitalizations: (Not for Surgery):______________________ ☐ None

Have you ever had: ☐ Heart attack (year_____) ☐ High Blood Pressure ☐ Blood Clots (year______) ☐ Stroke ☐ Heart Failure

☐ Ankle Swelling ☐ Kidney failure ☐ Cancer (location____________)

☐ Stomachache while taking anti-inflammatories (includes Advil/Aleve) What anti-inflammatories have you already had a problem with?

____

☐ **I do not have any of the above conditions.**

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?

☐ Diabetes____________ ☐ High Blood Pressure____________ ☐ Rheumatoid Arthritis____________ ☐ NONE

Do any direct relatives have the same condition you are being seen for today? ☐ Y ☐ N

SOCIAL HISTORY:

Do you use tobacco? ☐ N ☐ Y If Yes, packs per day____________ **Patient informed of Smoking Risk?** ☐ Y

Alcohol use? ☐ N ☐ Y If yes, how often ? ☐ Daily ☐ Other _____/week

Marital History: ☐ M ☐ S ☐ D ☐ W **How many people live with you**?________________________

Occupation:____________________________ ☐ Student

Employer: __________________________________

Do you plan to be working 6 months from now? ☐ Y ☐ N

PLEASE SIGN: The information on these this form is accurate to the best of my knowledge.

____

Signature Date

FOR OFFICE USE ONLY

Completed ____________ Date________________

Review #1 by ____________________ MD Date: ____________ Review #2 by __________________ MD Date:____________

Pain Diagram and Pain Rating

Name: ___________________________ **Date:** /_____/_____

INSTRUCTIONS: Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Use the key to indicate the type of symptoms.

KEY:

Pins and Needles	**= 000000**	**Stabbing**	**= / / / / / /**
Burning	**= xxxxxx**	**Deep Ache**	**= zzzzzz**

Please rate your current level of pain on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

GLENMONT CHIROPRACTIC OFFICE, PLLC
RIKER CHIROPRACTIC
DR. JEFFREY RIKER

DEMOGRAPHIC INFORMATION

NAME_____________________ DOB_______________ AGE_______

ADDRESS____

HOME PHONE_______________CELL_______________WORK__________

E-MAIL ADDRESS____________________________________

INSURANCE COMPANY______________________________

INSURED'S NAME____________________________________

INSURED'S DOB_________________________

IS TODAYS VISIT DUE TO A WORK-RELATED ACCIDENT? _______

IS TODAYS VISIT DUE TO A CAR ACCIDENT? _______

WERE YOU REFERRED TO OUR OFFICE? __________

Patient Financial Responsibility Contract

Please read, initial each blank and sign where indicated- this document describes your financial responsibilities. This is a legally binding contract between Riker Chiropractic and you. The words, I me, my, you and your all refer to the patient.

______ (initial) Current insurance cards must be presented at our request. I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt of a statement

______ (initial) I agree to give Riker Chiropractic Office my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment. I agree to pay Riker Chiropractic Office the balance on my account after my insurance claim has been processed.

______ (initial) I agree that if my insurance benefits require me to provide a referral and if the referral is not in place before my appointment, that I will pay in advance an estimate of charges for my office visit or reschedule my appointment.

______ (initial) I understand that there will be a $25.00 fee for all returned checks.

______ (initial) If I have a high deductible policy or do not currently have insurance benefits, I agree to pay and estimate of charges for my office visit in advance and understand that other charges may apply.

______ (initial) Riker Chiropractic Office has a contract with my insurance company. Riker Chiropractic Office will receive payments from my insurance company for covered services provided by my insurance benefits. I agree to pay co-payments and deductibles at the time of service. If co-payments are not made at the time of service, I understand that my appointment may be rescheduled.

______ (initial) I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must give Riker Chiropractic Office my current address and other contact information. I understand that if I fail to pay the balance on my account this may result in Riker Chiropractic Office pursuing any collection means possible.

______ (initial) If my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all cost of collection, including but not limited to interest, rebilling fees, court cost, attorney fees, and collection agency cost.

______ (initial) If the reason for my appointment is related to a work injury or auto accident, I agree to give Riker Chiropractic Office the case number of policy number, the workman's compensation or insurance carriers name, address or other contact information at the time of my appointment so that Riker Chiropractic Office can bill workman's compensation or the auto insurance carrier for my visit. If I do not provide this information at the time of the visit, I agree to pay all charges for my visit.

I have read and understand Riker Chiropractic Office financial policies and I accept responsibility for the payment of any fees associated with my care.

Patient Name (Printed) ____

Patient/Guardian Signature______________________________ **Dare**______________

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Glenmont Chiropractic Office, PLLC Notice of Privacy Practices. By signing below I am “only” giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

______________________________	______________
Patient Name (Type or Print)	Date

____

Signature

INFORMED CONSENT FORM

PATIENT NAME: _____________________________ DATE: ___________________

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

The nature of the chiropractic adjustment

One 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 chiropractic procedures.

The material risks inherent in chiropractic treatment

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. Symptoms may increase and 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 had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Riker 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: ______________**

Patient’s Name **Doctor’s Name**

______________________________ ________________________________

Signature **Signature**

______________________________ ______________________________

Signature of Parent or Guardian

(if a minor)