

ABOUT THE PATIENT



Name _____ Today's Date _____ Birthdate _____ Age _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Gender M F
Significant Other's Name _____ Kid's Names and Ages _____
Your Employer _____ Type of Work _____
E-Mail Address _____ Have you been to a chiropractor before? Y N
Emergency Contact _____ Phone Number _____
Name of Medical Doctors _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Oshkosh Spine Wellness Center to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is : Cash Check Credit Card Car/Work Insurance

Patient/Parent Signature _____ Date _____

REASONS FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
2. _____ How long has this been an issue? _____
Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
3. _____ How long has this been an issue? _____
Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
4. _____ How long has this been an issue? _____
Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____

5. Does your condition affect: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving

6. What makes it better? _____

7. What makes it worse? _____

8. What Doctor's have you seen for this? _____

9. Type of treatment: _____

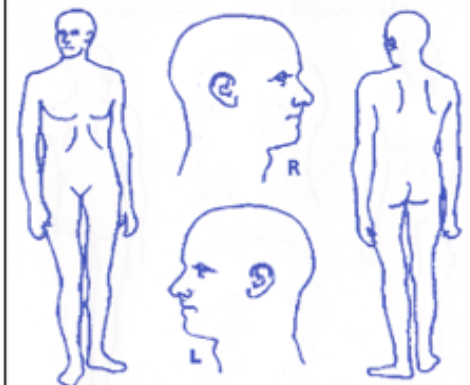
10. Results: _____

NOTES: _____

Are you pregnant?

☐ Yes ☐ No

Please mark All areas of concern.



INFORMED CONSENT

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication.

Printed Name

Date _____

Signature or (Parent or Legal Guardian)

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Name _____
Print Patient's Name

Date _____

By _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By _____
Signature of Parent/Guardian (circle one)

OSHKOSH SPINE WELLNESS CENTER

David Augustine, DC
314 N Koeller St Oshkosh, WI 54902 (920) 235-0000

REVIEW OF SYSTEMS

Name _____

Date _____

Please write in a number:

1. Presently have **2. Previously had** **3. Related to an accident (date _____)**

GENERAL

1. ____ Allergy
2. ____ Chills
3. ____ Convulsions
4. ____ Dizziness
5. ____ Fainting
6. ____ Fatigue
7. ____ Fever
8. ____ Headache
9. ____ Sleep loss
10. ____ Weight loss
11. ____ Nervous/Depress
12. ____ Neuralgia
13. ____ Numbness
14. ____ Sweats
15. ____ Tremors

EYES, EARS, NOSE THROAT

16. ____ Asthma
17. ____ Colds
18. ____ Sore throat
19. ____ Deafness
20. ____ Dental Decay
21. ____ Earache/noises
22. ____ Ear Discharge
23. ____ Sinus Infection
24. ____ Enlarged glands
25. ____ Enlarged thyroid
26. ____ Nose bleeds
27. ____ Failing vision
28. ____ Far sighted
29. ____ Gum trouble
30. ____ Hay fever
31. ____ Hoarseness
32. ____ Nasal obstruction
33. ____ Near sighted

MUSCULOSKELETAL

34. ____ Arthritis
35. ____ Bursitis
36. ____ Foot Trouble
37. ____ Hernia
38. ____ Low Back Pain
39. ____ Lumbago
40. ____ Neck pain/stiff
41. ____ Shoulder blade pain

PAIN OR NUMBNESS IN:

42. ____ Shoulders
43. ____ Arms
44. ____ Elbows
45. ____ Hands
46. ____ Hips
47. ____ Legs
48. ____ Knees
49. ____ Feet
50. ____ Painful tailbone
51. ____ Poor Posture
52. ____ Sciatica
53. ____ Spinal curvature

GENITO-URINARY

54. ____ Bedwetting
55. ____ Blood in urine
56. ____ Freq urination
57. ____ Inability to control bladder
58. ____ Kidney infection
59. ____ Painful urination
60. ____ Prostate trouble
61. ____ Pus in urine
62. ____ Painful menstruation
63. ____ Hot Flashes
64. ____ Irregular cycle
65. ____ Lumps in breasts
66. ____ Bladder infection

CARDIOVASCULAR

67. ____ Hardening of arteries
68. ____ High Blood pressure
69. ____ Low Blood pressure
70. ____ Pain over heart
71. ____ Poor circulation
72. ____ Rapid heart beat
73. ____ Slow heart beat
74. ____ Swelling of ankles

RESPIRATORY

75. ____ Chest pain
76. ____ Chronic cough
77. ____ Difficult breathing
78. ____ Spitting up blood
79. ____ Spitting up phlegm
80. ____ Wheezing

GASTROINTESTINAL

81. ____ Belching or gas
82. ____ Colitis
83. ____ Colon trouble
84. ____ Constipation
85. ____ Diarrhea
86. ____ Difficult digestion
87. ____ Distention of abdomen
88. ____ Excessive hunger
89. ____ Gall Bladder trouble
90. ____ Hemorrhoids
91. ____ Intestinal worms
92. ____ Jaundice
93. ____ Liver trouble
94. ____ Nausea
95. ____ Pain over stomach
96. ____ Poor appetite
97. ____ Vomiting
98. ____ Vomiting blood

OTHER: