BRENNER
CHIROPRACTIC

New Patient Information / Worker's Compensation

Patient's Name: _____ Initial Visit Date _____

Address _____ City _____ Zip_____

Date of Birth _____ SS# _____ Marital Status M S W D Sex M F

Telephone _____ Cell _____ Email Address _____

How did you hear about our office? _____

Insurance Information

Insurance Co Name: _____ Phone _____

Address _____ City _____ State_____ Zip _____

WCB# _____ Carrier Case # _____

Adjuster's Name _____ Phone # _____

Employment Information

Employer's Name _____ Phone _____

Address _____ City _____ State ____ Zip _____

Date of Injury _____ Approximate Time of Injury _____

Did you report your injury? Y N To whom? _____

Attorney Information

Firm Name _____

Attorney Name _____

Address _____ City _____ State _____ Zip_____

Telephone # _____ Fax # _____

Verified By _____ Date _____

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Medical History Form

Name: _____ DOB: _____ Date:_____

Place an 'X' in the box to indicate if you have or have had any of the following:

□ Anemia
□ Arthritis
□ Asthma
□ Cancer
Specify: _____
□ Concussion
□ Diabetes
□ Emphysema
□ Epilepsy
□ Fractures
□ Goiter
□ Headache
□ Heart Disease
□ Hepatitis
□ Hernia
□ Herniated Disc
□ HIV / AIDS
□ High Blood Pressure
□ High Cholesterol
□ Kidney Disease
□ Liver Disease
□ Migraines
□ Multiple Sclerosis
□ Osteoporosis
□ Pacemaker
□ Parkinson's Disease
□ Polio
□ Prostate Problems
□ Psychiatric Care
Specify:_____
□ Stroke
□ Thyroid Problems
□ Tuberculosis
□ Ulcers
□ Venereal Disease
Other:
_____

MEDICATIONS

_____
_____
_____

ALLERGIES

_____
_____
_____

VITAMINS/HOLISTIC THERAPY

_____
_____
_____

Are you pregnant? □Yes □No If Yes, due date: _____

Injuries / Surgeries you have had: Description Date

Falls: _____ _____
Broken Bones: _____ _____
Dislocations: _____ _____
Surgeries: _____ _____

EXERCISE

□None
□Moderate
□Daily
□Heavy

WORK ACTIVITY

□Sitting
□Standing
□Light Labor
□Heavy Labor

HABITS

□Smoking Packs/Day _____
□Alcohol Drinks/Wk _____
□Coffee / Caffeine Cups/Day _____
□High Stress Levels Reason _____

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Current Condition

Please complete ALL parts to this questionnaire.
This confidential history will be part of your permanent record. Thank you.

Name: _____ DOB: _____ Date:_____

Present Condition:

Reason for THIS visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Y N

Any other healthcare providers treating you for this? _____

If yes, whom:_____

What treatment(s) have you already received for your condition?

□ Physical Therapy □ Chiropractor □ Medication □ Surgery □ Injection(s)

□ Other _____

What tests have been done to you for this condition? If yes, please include date and results.

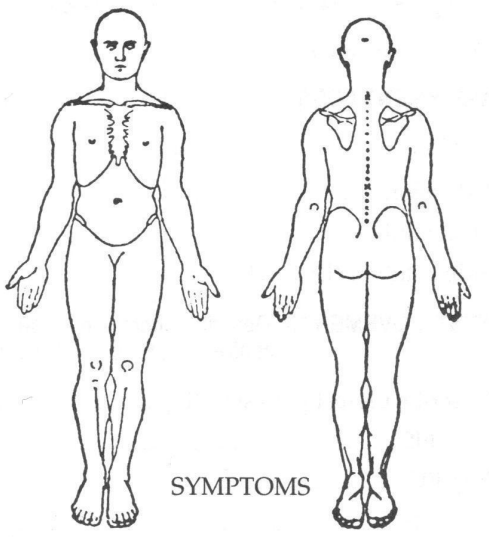
MRI: _____ X-Ray: _____

EMG / NCV: _____ Other: _____

Rate the severity of your pain from 1 (least pain) to 10 (severe pain): _____

Type of symptoms: □ Sharp □ Shooting □ Burning □ Dull □ Throbbing □ Aching
□ Cramping □ Stiffness □ Swelling □ Numbness □ Tingling
□ Other: _____

Please mark your symptoms on the picture on the right:
"X" = Pain / Tightness / Stiffness **"O"** = Numbness / Tingling



How often do you have this pain? (Please mark all that apply)

□ Constant □ Come and go □ Daily
□ Weekly □ Mornings □ End of day

Does it interfere with your:

□ Work □ Sleep □ Daily Routine □ Recreation

Activities that are painful to perform:

□ Sitting □ Standing □ Walking □ Bending □ Lying down

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Patient Questionnaire – Work-Accident

Patient Name:_____ DOB: _____ Today's Date: ____/____/____

Date of Exam: ____/____/____ Provider: _____ New Patient □ Yes □ No

Basic Information about the Accident:

Date Accident Occurred or Started: ____/____/____
Time of Day when Accident Occurred or Started: ___:_____ AM / PM

Describe how the Accident took place: _____
_____
_____
_____

Describe the condition or symptoms caused by the Accident: _____
_____
_____
_____

Work-Accident Specific Information:

Check all that apply:

□ Did the accident occur on the premises of the facility where you normally work (i.e., your local work address)?

□ Did the accident occur during your normal working hours?

□ Did you report the accident to your Employer?

□ Is your Employer covered by Workers' Compensation Insurance under state law?

□ Has your Employer prepared an initial written report?

□ Does the Employer's Report describe the condition or symptoms you are experiencing?

□ Has a claim number been issued for this accident?

□ Have you received any written denial of liability from either your Employer or Worker's Insurance Comp Payer?

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Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, muscle manipulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- ***Over-the-counter analgesics.*** The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- ***Medical care,*** typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- ***Hospitalization*** in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- ***Surgery*** in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____	_____	_____
Printed Name	**Signature**	**Date**

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BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign medical benefits to which I am entitled, including Medicare, private insurance and third-party payers, to Brenner Chiropractic, P.C. A photocopy of this assignment, including medical records, is information necessary to secure payment.

_____ _____
Signature of Patient/Guardian Date

PATIENT AGREEMENT

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

_____ _____
Signature of Patient/Guardian Date

ACKNOWLEDGEMENT FORM

I acknowledge that I have been given a copy of the practice's "HIPAA Privacy Policy Notice", which describes the practice obligations to ensure the privacy of my health information. The HIPAA Privacy Policy Notice also describes how the practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the practice's HIPAA Privacy Policy Notice and to ask questions about it. I understand that the practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Policy Notice.

I further acknowledge that the practice can change its HIPAA Privacy Policy Notice in the future and that I can receive a copy of the practice's current Privacy Notice at any time.

I understand that I have the right to request that the practice restrict its use and disclosure of my health information for treatment, payment or health care operations. If my restrictions are accepted by the practice, these restrictions will be binding on the practice. I also understand that the practice is not required to agree to my requested restrictions.

I do not request any restrictions on the practice's use and disclosure of my health information for treatment, payment, or health care operations. _____ (Initial)

By signing this form, I consent to the practice's use and disclosure of my health information for treatment, payment and health care operations. I understand that I have the right to revoke this consent at any time in writing, and if I do, my revocation will not affect any actions the practice has already taken in reliance of this consent.

_____ _____
Signature of Patient/Guardian Date

BRENNER
CHIROPRACTIC

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize Brenner Chiropractic, P.C to obtain any and all medical records concerning my care from any physician, hospital or healthcare professional that has provided medical care to me in the past. I also authorize Brenner Chiropractic, P.C to release any and all medical records concerning my care to any physician, hospital or other healthcare professional providing care to myself and/or child at any time.

_____ _____

Signature of Patient/Guardian Date