SIRUCEK CHIROPRACTIC NEUROLOGY CLINIC

Confidential Patient Information

Name				Date	Birthdate
Address		City/State/Zip		Home Phone	
Work Phone	Cell Phone			Social Security #	
Age	E-mail Address		Person Responsible for this account		

Referred by

Patient Name	Physician Name	Other: (TV, Radio, etc..)

Work Status

☐ Employed ☐ Retired ☐ Disabled ☐ Student

Employer	Occupation and Job Responsibilities
Employer Address	City/State/Zip

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow Spouse's Name____________

Females Only – In Reference To Radiographic Imaging

I, ____________________, to the best of my knowledge confirm that I am not pregnant, and waive all responsibility to the Doctor.

Signature: Date:

Minors Only – Consent For Treatment

I hereby authorize Dax Sirucek, D.C./ Maria Teresa Gomez, D.C, and whomever he/she may so designate as his/her assistant, to administer chiropractic care as he/she deems necessary to my son/daughter, __________________.

Signature: Date:

Dear New Patient,

I would like to take this opportunity to welcome you and thank you for choosing my clinic. My primary concern is to provide you with quality chiropractic care. My goal is to build a relationship with you of confidence and trust. I hope your experience with us will be pleasurable and will make you want to refer your family and friends for the benefits of Chiropractic care.

I would like to take a minute to explain some of our office policies at this time.

APPOINTMENTS

When appointments are made, that time has been reserve for you. As a courtesy we ask that if you will be unable to keep your scheduled appointment that you call 24 hours prior to your appointment to reschedule. If not, I reserve the right to charge you $25.00 for missed appointments.

*Initials*__________

SERVICES AND SUPPLIES

All orthopedic supplies and nutritional supplements must be paid for when received.

*Initials*__________

PAYMENTS

Payment is expected for all services when rendered unless prior arrangements have been made. Payment plans are available and my staff will be happy to discuss them with you. For those who have insurance, as a courtesy, we will verify your insurance coverage at the beginning of your care. However, *We Can Not Guarantee Benefits.* If you have a hand book you should refer to it or call to verify your benefits yourself. Your carrier does not guarantee the benefits they describe to us over the phone. Claims must be submitted and reviewed. *Please note.* Authorization by a utilization review board does not guarantee payment of those visits authorized. You are responsible for knowing your insurance limits, maximums, and restrictions. *Your care is not based on the number of visits your insurance carrier may authorize, but on the care most appropriated for your conditions.* We will also bill directly to your insurance carrier for you as a courtesy and will make every attempt to see your claims are paid. If problems occur, we will not enter into any dispute over unpaid claims with your insurance carrier. The contract is between you and your carrier and is your responsibility. All unpaid claims are your financial responsibility. All deductibles and co-payments are due at the time of your visit. Sirucek Chiropractic Neurology Clinic may accept the assignment of the benefits from your insurance coverage.

*Initials*_________

I welcome your referrals and offer free consultation to your family and friends as a courtesy. This consultation is designed to let them meet the doctor, discuss their concerns and see if chiropractic care is appropriate for them.

Please if you have any questions or concerns feel free to ask. My staff is always available to answer your questions and to help in any way they can.

Welcome To My Clinic!

Patient signature____ Date__________________

Please list your major complaints in order of severity (from most debilitating to least debilitating):

1.	**4.**
2.	**5.**
3.	**6.**

Complaint #1 ________________________

Location: ☐ Left ☐ Right ☐ Center
Severity: ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain) 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
How often do you experience these symptoms: ☐ Intermittent < 25% ☐ Occasional 25%-50% ☐ Frequent 50%-75% ☐ Constant >75%
Date when you first noticed this condition:
Better when: ☐ Lying down ☐ Medication ☐ Nothing ☐ Movement ☐ Sitting ☐ Stretching ☐ Chiropractic ☐ Heat ☐ Ice ☐ Rest ☐ Other ________________________
Worse when: ☐ Lifting ☐ Sitting ☐ Walking ☐ Coughing/Sneezing ☐ Bowel Movements ☐ Bright Lights ☐ Other ____________________________
Quality: ☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Electric ☐ Fiery ☐ Shooting ☐ Deep ☐ Superficial
Do your symptoms spread: ☐ No ☐ Yes Where?
When are your symptoms worse: ☐ Afternoon ☐ During Night ☐ Evening ☐ Light Activities ☐ Moderate Activities ☐ Morning
Side Effects: ☐ Decreased Range of Motion ☐ Increased Sensitivity ☐ Numbness ☐ Stiffness ☐ Tightness ☐ Tingling

Complaint #2 ________________________

Location: ☐ Left ☐ Right ☐ Center

Severity: ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe
☐ Severe

Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain)

1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

How often do you experience these symptoms:

☐ Intermittent < 25% ☐ Occasional 25%-50% ☐ Frequent 50%-75% ☐ Constant >75%

Date when you first noticed this condition:

Better when:

☐ Lying down ☐ Medication ☐ Nothing ☐ Movement ☐ Sitting
☐ Stretching ☐ Chiropractic ☐ Heat ☐ Ice ☐ Rest ☐ Other
____

Worse when:

☐ Lifting ☐ Sitting ☐ Walking ☐ Coughing/Sneezing ☐ Bowel Movements

☐ Bright Lights ☐ Other ________________________

Quality:

☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Electric ☐ Fiery

☐ Shooting ☐ Deep ☐ Superficial

Do your symptoms spread:

☐ No ☐ Yes Where?

When are your symptoms worse:

☐ Afternoon ☐ During Night ☐ Evening ☐ Light Activities ☐ Moderate Activities
☐ Morning

Side Effects:

☐ Decreased Range of Motion ☐ Increased Sensitivity ☐ Numbness ☐
Stiffness ☐ Tightness ☐ Tingling

Complaint #3 ________________________

Location: ☐ Left ☐ Right ☐ Center

Severity: ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe
☐ Severe

Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain)

1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

How often do you experience these symptoms:

☐ Intermittent < 25% ☐ Occasional 25%-50% ☐ Frequent 50%-75% ☐ Constant >75%

Date when you first noticed this condition:

Better when:

☐ Lying down ☐ Medication ☐ Nothing ☐ Movement ☐ Sitting
☐ Stretching ☐ Chiropractic ☐ Heat ☐ Ice ☐ Rest ☐ Other
____

Worse when:

☐ Lifting ☐ Sitting ☐ Walking ☐ Coughing/Sneezing ☐ Bowel Movements

☐ Bright Lights ☐ Other ____________________________________

Quality:

☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Electric ☐ Fiery

☐ Shooting ☐ Deep ☐ Superficial

Do your symptoms spread:

☐ No ☐ Yes Where?

When are your symptoms worse:

☐ Afternoon ☐ During Night ☐ Evening ☐ Light Activities ☐ Moderate Activities
☐ Morning

Side Effects:

☐ Decreased Range of Motion ☐ Increased Sensitivity ☐ Numbness ☐
Stiffness ☐ Tightness ☐ Tingling

If you have more than two complaints please ask the receptionist for more "complaint" description forms.

Please list any doctors that you have seen for these conditions. (Please include diagnoses, treatment received, and any changes in your condition).

Past Medical History

Please include any of your previous conditions.

If possible, include: dates, diagnosis, treatment received, and any residuals you still suffer.

General Health History: Have YOU had any of the following?

Injuries, Accidents, Falls or Traumas: ☐ No ☐ Yes Explain
Illnesses/Hospitalizations: ☐ No ☐ Yes Explain
Surgeries: ☐ No ☐ Yes Explain
Work Injuries: ☐ No ☐ Yes Explain
Motor Vehicle Accidents: ☐ No ☐ Yes Explain
Females only: Menopausal Symptoms ☐ No ☐ Yes Explain

Habits

Cigarettes/Cigars	☐ None ☐ Yes How much per week?
Alcohol	☐ None ☐ Yes How many drinks per week? What type of alcohol?
Coffee	☐ None ☐ Yes How many cups per week?
Exercise	☐ None ☐ Yes Hours/Days per week? Types?
Water	☐ None ☐ Yes Glasses per day?
Soft Drinks	☐ None ☐ Yes Amount per week? Types?
Sleep	☐ None ☐ Yes Average per night? Amount desires per night? Do you have difficulty staying or falling asleep?
Eating	Meals per day? Types of food? Do you consider your diet healthy? ☐ Yes ☐ No Explain

Personal Health History

Medications Please list your current medications and what you are taking them for.
Vitamins and Minerals Please list your current supplements and by whom prescribed

Check the left box for any condition YOU had in the PAST, and the right box for any condition that is CURRENT.

GENERAL HEALTH HISTORY

P C	**P C**	**P C**	**P C**
☐ ☐ Mental Disorders	☐ ☐ Diabetes	☐ ☐ Pneumonia	☐ ☐ Infective Disease
☐ ☐ Epilepsy	☐ ☐ Anemia	☐ ☐ Tuberculosis	☐ ☐ Fungal Infection
☐ ☐ Tumors	☐ ☐ Glaucoma	☐ ☐ Hepatitis	☐ ☐ Herpes
☐ ☐ Alcoholism	☐ ☐ Heart Disease	☐ ☐ Thyroid Disease	☐ ☐ Arthritis
☐ ☐ Drug Addiction	☐ ☐ Rheumatic Fever	☐ ☐ Parasites	☐ ☐ Autoimmune Disease
☐ ☐ Cancer	☐ ☐ Scarlet Fever	☐ ☐ Asthma	☐ ☐ Chicken Pox
CARDIOVASCULAR	**REPRODUCTIVE**	**GENITOURINARY**	**EYES/EARS/NOSE/THROAT**
☐ ☐ Chest Pain	☐ ☐ Erectile Difficulty	☐ ☐ Bladder Trouble	☐ ☐ Vision Problems
☐ ☐ Irregular Heartbeat	☐ ☐ Sexual Dysfunction	☐ ☐ Painful Urination	☐ ☐ Flashing Lights
☐ ☐ High Blood Pressure	☐ ☐ Menstrual Irregularity	☐ ☐ Incontinence	☐ ☐ Black Spots
☐ ☐ Shortness of Breath	☐ ☐ Menstrual Cramping	☐ ☐ Discolored Urine	☐ ☐ Blurriness
☐ ☐ Lung/Congestion Prob	☐ ☐ Venereal Infection		☐ ☐ Hearing Loss
☐ ☐ Varicose Veins			☐ ☐ Ringing in Ears
☐ ☐ Ankle Swelling			☐ ☐ Swallowing Difficulty

NERVOUS SYSTEM **GASTROINTESTINAL** **MUSCULOSKELETAL**

P C	P C	P C	
☐ ☐ Depression	☐ ☐ Poor/Excess Appetite	☐ ☐ Jaw Pain	
☐ ☐ Memory Loss	☐ ☐ Excessive Thirst	☐ ☐ Difficulty Chewing	
☐ ☐ Confusion	☐ ☐ Frequent Nausea	☐ ☐ Face Pain	
☐ ☐ Dizziness	☐ ☐ Hemorrhoids	☐ ☐ Neck Pain	
☐ ☐ Fainting	☐ ☐ Black/Bloody Stools	☐ ☐ Arm/Elbow Pain	
☐ ☐ Convulsions	☐ ☐ Digestive Problems	☐ ☐ Wrist/Hand Pain	
☐ ☐ Weakness	☐ ☐ Abdominal Cramping	☐ ☐ Mid Back Pain	
☐ ☐ Poor Balance	☐ ☐ Gas/Bloating	☐ ☐ Lower Back Pain	
☐ ☐ Twitches/Tremor	☐ ☐ Heartburn	☐ ☐ Thigh/Knee Pain	
☐ ☐ Cold Extremities	☐ ☐ Weight Problems	☐ ☐ Ankle/Foot Pain	
☐ ☐ Sleeping Difficulties	☐ ☐ Gall Bladder Problems	☐ ☐ Difficulty Walking	
☐ ☐ Headaches	☐ ☐ Liver Problems	☐ ☐ Leg/Arm Fatigue	

RELEASE OF MEDICAL INFORMATION

I give Sirucek Chiropractic Neurology Clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health operations like quality reviews.

I have been informed that I may review the clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this clinic has the right to change their privacy practices and that I may obtain any revised notices at the clinic.

I understand that I have the right to request a restriction of how my protected health information is used, However, I also understand that the clinic is not required to agree to the request. If the clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature
____Date_______________________

INFORMED CONSENT

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or the use of a machine. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to vertebral artery stroke is called the "extension-rotation-thrust atlas adjustment". We do not do this type of adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. Studies (Journal of the CCA, Vol. 37 No. 2, June, 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both neck and back. Yet occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. Rarely chiropractic adjustments may also cause a disc problem if the disc is in weakened condition. These problems occur so rarely that there is no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

________________________________ ________________________________

Patient's Name Printed Today's Date

________________________________ ________________________________

Patient's Signature Parent or Guardian Signature for Minor