Laura Freeman D.C. Chris Freeman D.C. Emmaline Miller D.C.
7399 SR 366 Huntsville, OH 43324
P: 937-842-2220 F: 937-842-2227 www.indianmeadowschiro.com

Name____**Date** _______________________
Address______________________**City**_________________**State**____ **Zip code**________**Male / Female**
Phone: (Home)______________________**(Cell)**___________________**(Work)** ___________________
Date of Birth_____/_____/_____**Age** ______
Occupation______________________________**Employer** _______________________________________
E-mail Address ____

Marital status S / M / W / D Name of spouse _______________________________________
Emergency Contact (nearest relative, not spouse)_________________________**Phone** _____________
Have you had chiropractic care before?__________**When?** ____________________________________

Previous Surgeries (dates) ____
Previous Fractures (dates) ____
Serious Illnesses (dates) ____
Worker's Comp./Personal Injuries (date, treatment) ____

Injuries to head, neck or back ____

Known medication allergies ____
Known food/environmental allergies ____
Current over the counter medications/supplements ____

Social Habits ☐Tobacco ☐Previous Smoker ☐Alcohol (___drinks/day/wk/mo) ☐Coffee (___cup/day)
Have you gained or lost any weight in the past year? Yes / No If yes, explain _________________

Other Doctors seen for this condition:
Dr ____________________ Specialty ____________________ Tests Done ____________________

Do you currently see this doctor? Yes / No Did treatment help? Yes / No

Whom may we thank for referring you? ____
May we send them a personal "thank you" for telling someone about our office? **Yes / No**

Signature (for the referral thank you*)

____
*Health information will not be released in the 'thank you' referral letter.

INDIAN MEADOWS CHIROPRACTIC CENTER

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Patient Name: ______________________________ Date: ______________________

What is your present complaint: ____

When did your problem begin? ____

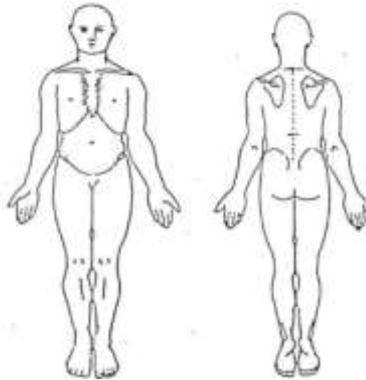
Is this condition due to: ☐ Auto accident ☐ Work injury ☐ Other accident ☐ Illness ☐ Unknown cause

How did your problem begin?____

Have you experienced this before: Yes / No (outcome): ______________________________

Did it start: ( ) Gradually ( ) Immediately

Indicate the location of the Pain:



What is your current pain level? (no pain) 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (worst pain imaginable)

Is the pain: Getting Better Worse Staying the Same

What is Your Pain Intensity? Minimal Slight Mild Moderate Severe None

How often do you feel the pain? Constantly (76-100%) Frequently (51-75%) Occasionally (26-50%) Intermittently (0-25%)

Can you describe the pain? ( ) Dull ( ) Sharp ( ) Aching ( ) Shooting ( ) Spasm
( ) Throbbing ( ) Burning ( ) Numbing ( ) Tingling ( ) Tightness
( ) Radiating

What makes the pain better? Acupuncture Chiropractic Heat Ice Massage Nothing
Medication Stretching Physical Therapy Other: __________________

What makes the pain worse? Sitting Standing Riding in a car Bending Walking
Twisting Lying down Lifting Other: ______________

Have you noticed any changes in bowel or bladder function? Yes / N o

Any fever, chills, dizziness associated with the symptoms? Yes / No

Do you take any prescription drugs? Yes / No
( ) Anti-inflammatory ( ) Muscle relaxers ( ) BP Meds ( ) Pain Meds
( ) Cholesterol Meds ( ) Birth control ( ) Allergy Meds ( ) Thyroid Meds
( ) Headache Meds ( ) ADD/ADHD Meds ( ) Nerve Pills ( ) Diabetes Meds
( ) Osteoporosis Meds ( ) Depression Meds ( ) Other: ________________

Do you have Any Other Health Concerns: ______________________________________

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Acknowledgment of Receipt

The federal government recently published regulations designed to protect the privacy of your health information. This "privacy rule" protects the health information that is maintained in this office. We take precautions in our office to safeguard this health information. We will not sell, trade, lend or otherwise covey any personal information about you to anyone or any organization without your consent.

Our Notice of Private Practices explains our privacy practices more fully. It contains very important information about how your confidential health information is protected, I acknowledge that I have been provided a copy of the Notice of Privacy Practices of Indian Meadows Chiropractic Center. I further acknowledge that I have had an opportunity to ask questions about this privacy.

________________________________ _________________________

Signature Date

________________________________ _________________________

Name of Patient Relationship to Patient

Financial Policy

We are committed to providing you with the best possible care. If you have medical or accident Insurance we will be happy to assist you. In order to do this, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered, unless payment arrangements have been approved in advance by our staff. We accept most major insurances, cash, checks and credit cards. We will be happy to provide you a receipt for your records.

Returned checks and balances older than 30 days may be subject to additional collection.

Your insurance is a contract between you, your employer and the insurance company. Our doctors also have contracts with many insurance companies as well and will honor the fee schedule agreed upon in those contracts. Some services may not be covered by your insurance contract, if this is the case the doctor will inform you of this ahead of time if at all possible. Those services that are not covered will be patient responsibility to pay. We make every effort to make your care affordable. Simply ask if you need assistance in any way.

NO SHOW/NO CALL POLICY: 24 hour notice is required for cancelled/rescheduled appointments or the account will be charged 50% of scheduled service. This will be payable prior to rescheduling your next appointment.

We value our relationship with you. If you have any questions about the above information, please don't hesitate to ask.

We are here to help you.

I understand and agree that all services rendered to me are billed to my insurance company or directly to me and that I am ultimately responsible for payment. In case of coverage by Health Insurance, Workmen's Compensations, or Auto Insurance I agree to pay my portion or too pay according to my insurance contract. Payments for service rendered on a fee for service basis are due at the time of service unless other payment arrangements have been made.

________________________________ _________________________

Signature Date

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Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatments. In particular you should note:

a) While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments;
b) There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasio9n result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote;
c) There have been rare reported cases of injury of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes t your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms.

I acknowledge I have discussed, or have the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this ______ day of ______________, 20____

____ ____________________________________

Patient Signature (Legal Guardian) Witness of Signature

Name ____ Name _________________________________
(Please Print) (Please Print)