New Patient Health History Form

Please fill out all areas accurately

Patient Data

First Name_______________ Last Name_______________

Date_______ Referred by, or heard about Standridge Clinic_______________
Email_______________

Your email with NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions and appointment reminders

Mailing Address

Address_______________

City_______________ State_______ Zip_______

Phone Cell _______ Phone Home_______ Phone work_______

Age____ Birth Date______ Social Security # _______ Number of Children ____

Occupation_______ Describe your daily activities at work_______________

Employer_______ Marital Status ___M ___W ___S ___D Spouse's Name_______

Spouse's Phone #_______ Spouse's Employer_______ Spouse's Work #_______

Spouse's Health Status _______________

Current Complaints

Area (s) of Injury/Illness/Condition_______________

Please Describe: (aching, throbbing, numbness, etc)_______________

Date of onset of symptoms_______ If injury, date_______ Have you ever had similar condition? _______

If yes, When?_______ Have you ever been under Chiropractic care?_____, If yes, When_______

Who did you see?_______ Explain treatment received_______________

Have you been under care with any other practitioners for the condition you are presenting with today ?_______

If yes, Where?_______, Explain treatment received_______________

Insurance Information

Name of Party Responsible for Payment_______ Phone #_______ Do you have health insurance_______

Name of Insurance Company_______ ID#_______ Group#_______

Signatures

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the Chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Chiropractic care to third party payers and/or health practitioners. I authorize and request request my insurance company to pay directly to the Chiropractor or Chiropractic group insurance benefits otherwise payable to me. I understand that my Chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Name of the Insured ___________________DOB___________SS#______________________

Patient/Guardian Signature___________________________ Date______________________

Medical History

Have you been treated for any conditions in the last year? ____Yes ____No

If yes, Please Describe____

Date of Last Physical Exam ______/______/______ Is there a chance that you are pregnant?____Yes _____No

Have you had x-rays taken?_____Yes _____No If Yes, Where?____

What medications are you taking and for what conditions (**Please list dosages and amounts, etc)**

____

____

What vitamins, minerals, or herbs do you currently take? **(Please list for what conditions, dosage, and frequency)**

____

____

Have you ever:

Broken Bones? _____Yes _____No, Please Briefly Explain____

Been hospitalized? _____Yes _____No, Please Briefly Explain____

Been in an auto accident?_____Yes _____No, Please Briefly Explain______________________________________

Had Sprains/Strains?_____Yes _____No, Please Briefly Explain____

Been struck unconscious? ____Yes _____No, Please Briefly Explain______________________________________

Had surgery? ____Yes ____No, Please Briefly Explain____

Under pain management at this time or in the past? ____Yes ____No, If so, Where?____________________When?______________

Family History

Family Members – Present and past health conditions: (Example: heart disease, cancer, diabetes, arthritis, etc.):

____

____

Please explain what activities aggravate your symptoms, be detailed, when, how, etc___________

____
____
____
____
____
____

Do you experience pain every day? ☐ Yes ☐ No
Do your symptoms interfere with daily life? ☐ Yes ☐ No
Does pain wake you up at night? ☐ Yes ☐ No
Are your symptoms worse during certain times of the day? ☐ Yes ☐ No
Do changes in weather affect your symptoms? ☐ Yes ☐ No
Do you wear orthotics? ☐ Yes ☐ No
Do you take vitamin supplements? ☐ Yes ☐ No

Habits

Alcohol	☐ None	☐ Light	☐ Moderate	☐ Heavy
Coffee	☐ None	☐ Light	☐ Moderate	☐ Heavy
Tobacco	☐ None	☐ Light	☐ Moderate	☐ Heavy
Drugs	☐ None	☐ Light	☐ Moderate	☐ Heavy
Exercise	☐ None	☐ Light	☐ Moderate	☐ Heavy
Sleep	☐ None	☐ Light	☐ Moderate	☐ Heavy
Appetite	☐ None	☐ Light	☐ Moderate	☐ Heavy
Soft Drinks	☐ None	☐ Light	☐ Moderate	☐ Heavy
Water	☐ None	☐ Light	☐ Moderate	☐ Heavy
Salty Foods	☐ None	☐ Light	☐ Moderate	☐ Heavy
Sugary Foods	☐ None	☐ Light	☐ Moderate	☐ Heavy
Artificial Sweeteners	☐ None	☐ Light	☐ Moderate	☐ Heavy

Have you ever suffered from:

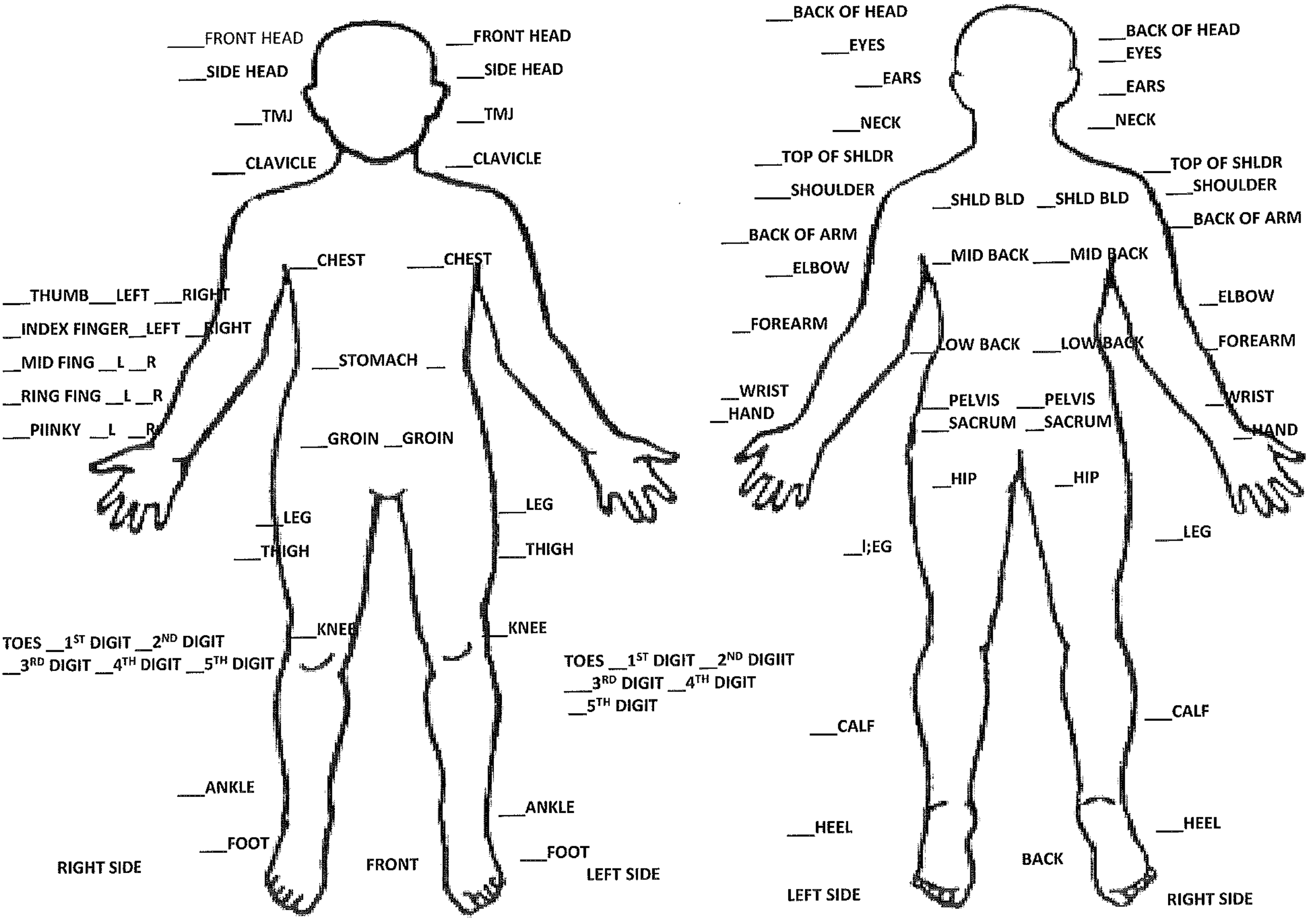
☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Arteriosclerosis
☐ Arthritis
☐ Asthma
☐ Back Pain
☐ Breast Lump
☐ Bronchitis
☐ Bruise Easily
☐ Cancer
☐ Chest Pain/Conditions
☐ Cold Extremities
☐ Constipation
☐ Cramps
☐ Depression
☐ Diabetes
☐ Digestion Problems
☐ Dizziness

☐ Ears Ring
☐ Excessive Menstruation
☐ Eye Pain or Difficulties
☐ Fatigue
☐ Frequent Urination
☐ Headache
☐ Hemorrhoids
☐ High Blood Pressure
☐ Hot Flashes
☐ Irregular Heart Beat
☐ Irregular Cycle
☐ Kidney Infection
☐ Kidney Stones
☐ Loss of memory
☐ Loss of balance
☐ Loss of smell
☐ Loss of taste
☐ Lumps In Breast
☐ Neck Pain or Stiffness

☐ Nervousness
☐ Nosebleeds
☐ Pacemaker
☐ Polio
☐ Poor Posture
☐ Prostate Trouble
☐ Sciatica
☐ Shortness of breath
☐ Sinus Infection
☐ Sleep problems or Insomnia
☐ Spinal Curvatures
☐ Stroke
☐ Swelling of ankles
☐ Swollen Joints
☐ Thyroid Condition
☐ Tuberculosis
☐ Ulcers
☐ Varicose Veins

PATIENT NAME:______________________ DATE:___________ ACCOUNT # ____________

Put a X by the area that you have experienced symptoms in the last 30 days.



Patient Name________________________________ Date__________________ Account Number____________________

This must be filled out completely, it is to get an idea of the health issues you are suffering from, the nature of those issues, and how severe the symptoms are. It also helps us to describe for your insurance why you need the services you will be receiving. Please be as thorough and detailed as you can.

Steps for filling out this form – list the worst area first, then continue down with the next, then the next until you have completed your concerns. Use the back page if necessary.

Describe – Example, Area - Neck, Describe - sharp, stabbing, with numbness down left arm to the hand. Activities affected – I can not turn my head to the left to look over my shoulder, Present 100% of the day with a severity level out of 0-10 at 5.

1. Area of concern__________________________________

Describe the symptoms____

What activities can you not do as a result of this concern____

____

What activities are you doing but with pain or symptoms____

____

Present ___100% ____75% ____50% ____25%

Pain scale (X) __1(itch) __2(need bandage) __3(annoying) __4(concerning but not limiting)
__5(bees?)__6(bees!!)__7(crying) __8(move with pain)__9(a fire breathing dragon attack)__10(unconscious)

2. Area of concern__________________________________

Describe the symptoms____

What activities can you not do as a result of this concern____

____

What activities are you doing but with pain or symptoms____

____

Present ___100% ____75% ____50% ____25%

Pain scale (X) __1(itch) __2(need bandage) __3(annoying) __4(concerning but not limiting)
__5(bees?)__6(bees!!)__7(crying) __8(move with pain)__9(a fire breathing dragon attack)__10(unconscious

3. Area of concern__________________________________

Describe the symptoms____

What activities can you not do as a result of this concern____

____

What activities are you doing but with pain or symptoms____

____

Present ___100% ____75% ____50% ____25%

Pain scale (X) __1(itch) __2(need bandage) __3(annoying) __4(concerning but not limiting)
__5(bees?)__6(bees!!)__7(crying) __8(move with pain)__9(a fire breathing dragon attack)__10(unconscious

Date ______________

Our office is now able to send email and text messages to patients to confirm appointments! This is a great tool for our patients to utilize when a phone call isn't possible. However, we understand some patients prefer to simply be called.

Please indicate below if you would like to receive email and text message appointment confirmation and reminders from our office. If so, please provide your cell phone number and/or email address. As always, we will never share your cell phone and email information with any 3rd party companies.

- ☐ Yes, I would like to receive a text message confirmation.
- ☐ No, please do not text me regarding my appointments.

Cell phone number ______________________________

- ☐ Yes, I would like to receive email appointment confirmations.
- ☐ No, please do not email me regarding my appointments.

Email address ___________________________________

Printed Name ____

Signature ____

Parent/Guardian ____

Patient Name______________________________ **Date**____________________ **Account Number**____________

I__________________________**understand that Standridge Clinic is in network with my insurance plan. I also understand that my plan may deem some of the service not allowable because of guidelines the insurance plan has established internally which has no relationship to my need to treat and resolve my condition. However, Standridge Clinic will attempt in good faith to advise me of those services not covered prior to the day I will be receiving them so that I can opt to decline the service, or in the event, that Standridge Clinic had no way of knowing it would not be covered and they were unable to advise me of the status of non coverage from my insurance plan, I do understand I am still responsible for the services but they will discount the charge at their lowest fee schedule in the office.**

______________________________ ________________________

Patient Name **Date**

INFORMED CONSENT FOR TREATMENT

PATIENT NAME______________________ DATE_____________ACCOUNT#__________

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions of the doctor before you sign if there is anything that is unclear or of a concern.

The Nature of the Chiropractic Adjustments

The primary treatment I use as a Doctor of Chiropractic is spinal manipulation 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.

You will receive an analysis, examination, and then a plan of care with treatment recommended for resolution of your health concerns. As a part of the analysis, examination and treatment, you are consenting to the following procedures being performed:

X Spinal manipulative therapy
X Palpation
X Vital signs
X Range of motion testing
X Orthopedic testing
X Basic neurological testing
X Muscle strength testing
X Postural analysis
X EMS
X Radiographic studies
X Hot/cold therapy
X Mechanical traction
X Active therapy and rehab
X Myofascial release

The Material Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during treatment, this is a list of rare but reported complications following an adjustment. 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 that could cause such injury such as previous stroke or osteoporosis, it is your responsibility to inform me. Of note: In my career I have not had any of these reported in my office following an adjustment I have performed.

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 n 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 and surgery is an option. If you choose any 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 to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficulty 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 the staff and or doctor and I have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided it is my best interest to undergo the treatment recommended.

Having been informed of the risks, I hereby give my consent to the treatment recommended. Date_____Signature of Patient_____________

Standridge Clinic and or Structural Rehab

12707 E. 86th Street North

Owasso, Oklahoma 74055

918-272-7432

CONSENT TO USE PHI

Use and Disclosure of your Protected Health Information

Your protected health information will be used by Standridge Clinic and or Structural Rehab or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy.
_____Patient Initials

Requesting a Restriction on the Use of Disclosure of Your Information

- You may request a restriction on the use of disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use of disclosure of your Protected Health Information
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.
- **Notice of Treatment in Open or Common Areas**
- Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

____ ____________

Patient or Legally Authorized Individual Signature **Date**

____ ____________

Print Patient's Full Name **Time**

____ ____________

Witness Signature **Date**

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Patient or Legally Authorized Individual Signature **Date**

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Print Patient's Full Name **Time**

____ ____________

Witness Signature **Date**