PEARSON
CHIROPRACTIC & REHABILITATION

pearsonchiropractic.com

WELCOME

The doctors and staff of Pearson Chiropractic & Rehabilitation welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical exam to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient, but will refer you to another health care provider, if appropriate. PLEASE PRINT CLEARLY!

PATIENT INFORMATION (PLEASE PRINT)

Name (First, Middle, Last) _____ Name you like to be called _____ Date of Birth _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Race:_____

Address _____ City _____ State _____ ZIP _____

Social Security Number **(REQUIRED)** _____ Home Phone _____ Mobile Phone _____ Work Phone _____

Emial Address **(REQUIRED)** _____

EMPLOYMENT INFORMATION

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Part Time Student ☐ Full Time Student ☐ Other_____

Employer _____ Occupation _____

RESPONSIBLE PARTY INFORMATION - If you are over age 18, please indicate self as responsible party

Name (if other than self) _____ Relationship to Patient _____ Responsible Party Phone _____

Responsible Party Address _____ City _____ State _____ ZIP _____

EMERGENCY CONTACT

Emergency Contact Name _____ Relationship to Patient _____ Emergency Contact Phone _____

INFORMATION ABOUT YOUR INJURY OR ILLNESS

Is your illness/injury related to any of the following?

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident—state accident date _____

If employment related, has your employer been notified? ☐ Yes ☐ No

REFERRAL INFORMATION

How were you referred to our office? ☐ By an Attorney ☐ By a Doctor ☐ By a Patient ☐ On Social Media

☐ Google ☐ Pearson Website ☐ Office Location ☐ Other _____

Name of Referral Source _____

ACCEPTANCE AS A PATIENT

I understand and agree that the doctors of Pearson Chiropractic & Rehabilitation have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient. By submitting your phone number, you are authorizing us (opting in) to send you text messages and notifications. Message/data rates apply. Reply STOP2END to unsubscribe to a message sent from us.

Signature _____ Date _____

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PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient _____ Date _____

Signature _____

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FINANCIAL POLICY

The following is an explanation of our clinic policy. We believe that a clear definition of our policy will allow us both to concentrate on the big issue: re-establishing, retaining and maintaining your health. We will be happy to answer any questions you have regarding our policy, your account and your insurance coverage.

Payments
At Pearson Chiropractic your health care needs are our primary concern. We do not want finances to get in the way of you getting the health care that you need. Policies are in place in an attempt to assist you in meeting your financial obligations without increasing stress in your life.

- **If you do not have insurance ALL payments are expected at the time of service. Prepayments are also allowed.**
- **If you have insurance ALL COPAYS & CO-INSURANCE are due at time of service. By taking care of this while you are in the office the need for an invoice is minimized.**
- **There will be a 1% finance charge added to all balances after 60 days. Maximum charge is 12% per year.**
- **There will be a $25.00 charge on all returned checks.**
- **If you need any additional documentation other than a receipt please feel free to ask the front desk as we are able to provide that to you at no additional charge.**

Insurance Coverage
Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment. If claims denial is received after the insurance has processed, the balance will be Patient Responsibility.

Statements are sent via text or e-mail. We will not bill your health insurance for personal injury claims unless it is specified on the Motor Vehicle Accident authorization paperwork.

X-rays
We will release your X-rays to another doctor only after you sign a release/transfer form & your account has been paid in full, unless you have been referred for a consultation. We need 48 hours notice to enable us to mail X-rays in time for your appointment.

Appointment/Treatment
Pearson Chiropractic is a very busy clinic and when an appointment is scheduled for you we reserve that time for you only. There will not be a fee for rescheduling or canceling an Adjustment. ***However, for Massage Therapy, there is a $100 fee, for Rehab there is a $50 fee and for Acupuncture there is a $100 fee, if an appointment is not cancelled more than 24 hours in advance. A credit card must be on file for ALL PATIENTS, no exceptions. The credit card will be on file and charged automatically if there is a no-show or cancellation less than 24 hours in advance.***

Release and Wellness
If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

I have read and understand Pearson Chiropractic's office policies and I will honor them.

Patient's Printed Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Credit card on file with us:

Card# _____ Exp Date: _____

Name as it Appears on Card: _____

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WORK INJURY INFORMATION

Patient Name _____ Today's Date _____

General Information

DATE OF INJURY	Employer at time of injury	Job Title
____ / ____ / ____	Duties	

Did you notify employer of your injury? ☐ Yes ☐ No Are you currently working? ☐ Yes ☐ No

If no, what as the last day you worked? _____

How were you injured? (mark one)

- ☐ **Overexertion:** This includes injuries related to pulling, lifting, pushing, holding, carrying and throwing activities at work.
- ☐ **Fall on Same Level Surfaces:** This pertains to falls on work site and office floors.
- ☐ **Fall to Lower Level:** This type of fall happens from an elevated area such as a roof, ladder or stairway.
- ☐ **Bodily Reaction:** These are injuries caused by slipping or tripping without falling.
- ☐ **Struck by an Object:** Objects that fall from shelves or are dropped by another person.
- ☐ **Struck Against an Object:** This happens when a person accidentally runs into immovable objects such as walls, doors, cabinets, windows or furniture.
- ☐ **Driving Incident:** An injury that occurs while driving for work.
- ☐ **Caught In/Compressed By:** This type of injury usually occurs when large moving machinery catches a limb or clothing and pulls you in.
- ☐ **Repetitive Motion:** Repetitive motions such as typing or using the computer can strain muscles and tendons, causing pain.
- ☐ **Assaults and Violent Acts:** Attacks by co-workers or others.

Specifically describe how the injury occurred (include weights, measures, distances, etc)

_____

_____

_____

_____

_____

After Accident Information

Did you fill out an accident report? ☐ Yes ☐ No *If yes, please provide us with a copy.* Have you hired an attorney? ☐ Yes ☐ No

Attorney's Name _____ Phone _____

Office Address _____

Immediately after the accident, how did you feel? ☐ Dizzy/dazed ☐ Upset ☐ Weak ☐ Nervous ☐ Headache ☐ Disoriented ☐ Unconscious ☐ Other _____

Medical Care After Injury

Admitted to the hospital?	☐ Yes ☐ No	Which hospital?	
Did you see a doctor?	☐ Yes ☐ No	Dr.'s Name	Ph:
Physical Therapy?	☐ Yes ☐ No	Name	Ph
Chiropractor?	☐ Yes ☐ No	Dr.'s Name	Ph:
X-rays taken?	☐ Yes ☐ No	Location	Ph:
Did you get an MRI?	☐ Yes ☐ No	Location	Ph:
Other Medical Care?	☐ Yes ☐ No	Describe	

continue next page

Previous Injuries

Have you suffered previous accidents or injuries? ☐ Yes ☐ No

If yes, please specify: _____

Do you have residual pain from previous accidents or injuries? ☐ Yes ☐ No

If yes, please specify: _____

Later Symptoms (Please note any symptoms that started AFTER the injury occurred)

HEAD

☐ Headache ☐ Memory Loss ☐ Light-headedness ☐ Bump, Bruise, Laceration
☐ Fainting ☐ Blurred Vision ☐ Double Vision ☐ Other _____
☐ Dizziness ☐ Ear Pain ☐ Loss of Vision _____

NECK

☐ Radiating Pain in Shoulders or Arms ☐ Popping in Neck
☐ Neck Pain ☐ Other _____
☐ Muscle Spasms

SHOULDERS

☐ Shoulder joint pain ☐ Muscle spasms in shoulder ☐ Other _____
☐ Pain across shoulder ☐ Can't raise arms above shoulder level _____
☐ Tension in shoulders ☐ Can't raise arms over head

ARMS AND HANDS

☐ Pain in arms ☐ Loss of grip strength ☐ Swollen joints in fingers ☐ Other _____
☐ Pain in fingers ☐ Pins & needles in hands ☐ Numbness in left arm _____
☐ Cold hands ☐ Pins & needles in fingers ☐ Numbness in right arm

CHEST

☐ Chest pain ☐ Pain around ribs ☐ Other _____
☐ Breast pain ☐ Shortness of breath

ABDOMEN

☐ Nervous stomach ☐ Diarrhea ☐ Abdominal Pain ☐ Other _____
☐ Nausea ☐ Constipation

MID BACK

☐ Sharp stabbing ☐ Muscle spasms ☐ Pain between shoulders ☐ Other _____
☐ Pain ☐ Pain from front to back

LOWER BACK

☐ Sharp stabbing
☐ Pain
☐ Muscle spasms

Low back pain is worse when:

☐ Working ☐ Sitting ☐ Lifting ☐ Bending
☐ Stooping ☐ Coughing ☐ Standing ☐ Lying down

☐ Other _____
_____

HIPS, LEGS AND FEET

☐ Pain in buttocks ☐ Leg cramps ☐ Numbness in leg ☐ Other _____
☐ Pain in hip joint ☐ Pins & needles in legs ☐ Pain down leg _____
☐ Numbness in toes ☐ Feet feel cold ☐ Knee pain

GENERAL

☐ Nervousness ☐ Depression ☐ Sleep loss: _____ hours per night
☐ Irritability ☐ Cramping
☐ Fatigue ☐ Generally feeling run down ☐ Other: _____

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HISTORY CHECKLIST

Patient Name _____ No. _____

Doctor _____ Date _____

Date of Birth _____ Claim No. _____

System Review (Have you had any problems with or treatment of any of the following? If yes, please describe.)

ALL PATIENTS		
Do you get dizzy when you turn your head and look back?	☐ Yes ☐ No	
Thyroid	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Head/Brain	☐ Yes ☐ No	
Eyes/Ears/Nose/Throat	☐ Yes ☐ No	
Lungs	☐ Yes ☐ No	
Heart/Blood Pressure	☐ Yes ☐ No	
Stomach/Bowel	☐ Yes ☐ No	
Bladder/Kidney	☐ Yes ☐ No	
Prostate	☐ Yes ☐ No	
Skin	☐ Yes ☐ No	
Nerves	☐ Yes ☐ No	
Medications	☐ Yes ☐ No	
Psychiatric	☐ Yes ☐ No	
Blood/Lymph/Immune System	☐ Yes ☐ No	

FEMALE PATIENTS ONLY		
Are your pregnant?	☐ Yes ☐ No	Date of last menses:
Are you taking birth control pills or shots?	☐ Yes ☐ No	
Thickening of the breast or breast pain?	☐ Yes ☐ No	
Vaginal bleeding or discharge?	☐ Yes ☐ No	

Past Medical History (Have you had any of any of the following? If yes, please describe.)

Cancer	☐ Yes ☐ No	
On the job injuries	☐ Yes ☐ No	When? Which body part?
Motor vehicle accident	☐ Yes ☐ No	When?
Other injuries	☐ Yes ☐ No	
Illnesses	☐ Yes ☐ No	
Hospitalizations	☐ Yes ☐ No	
Surgeries	☐ Yes ☐ No	
Allergies	☐ Yes ☐ No	
Implants or Joint Replacements	☐ Breast ☐ Knee ☐ Hip ☐ Other (specify)	

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Family History (Did your mother or father have any of the following? Put an **M** for mother, **F** for father, **B** for both)

_____ High Blood Pressure
_____ Heart Attack
_____ Emphysema
_____ Seizures/Convulsions
_____ HIV Positive
_____ Asthma
_____ Diabetes
_____ Kidney Disease
_____ Pacemaker
_____ Ulcer or Stomach Problems
_____ Stroke
_____ Arthritis-Rheumatism
_____ Mental Illness
_____ Thyroid Disease
_____ Circulation Problems
_____ Cancer
_____ Osteoporosis

Social History

What level of education have you completed? ☐ Elementary ☐ Jr. High ☐ High School ☐ College (2 year) ☐ College (4 year)

Have you served in the military? ☐ Yes ☐ No Where?_____

What is your occupation?_____ Are you retired? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No How much per week?_____

Do you use alcohol? ☐ Yes ☐ No How much per week?_____

What are your hobbies?_____

Other Medical Information

Do you have chest pain? ☐ Yes ☐ No
Do you have a sore on your skin that does not heal? ☐ Yes ☐ No
Do you have a nagging cough or hoarseness? ☐ Yes ☐ No
Do you have night sweats? ☐ Yes ☐ No
Do you have pain in or numbness your jaw or face? ☐ Yes ☐ No
Do you have a drooping eyelid or and change in your pupils? ☐ Yes ☐ No
Do you have any nausea or vomiting? ☐ Yes ☐ No
Do you have any slurred speech? ☐ Yes ☐ No
Have you noticed changes in your balance? ☐ Yes ☐ No

Have you noticed changes in your memory? ☐ Yes ☐ No
Do you have any ringing in your ears? ☐ Yes ☐ No
Does your pain ever wake you from a sound sleep? ☐ Yes ☐ No
Are you losing weight now without trying? ☐ Yes ☐ No
Are you coughing up blood or noticing it in your stools or urine? ☐ Yes ☐ No
Have you lost consciousness recently? ☐ Yes ☐ No
Are you seeing any other doctor for any other reason? ☐ Yes ☐ No

Note:_____

Comments

I certify that the information I give is correct to the best of my knowledge. I will not hold the doctors or staff responsible for any errors or omissions that I may have made and I authorize this office to provide chiropractic care.

Print Patient Name _____ Date _____

Patient Signature _____

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SUBJECTIVE REPORT

Date _____

Name _____

WHEN did the pain start? _____

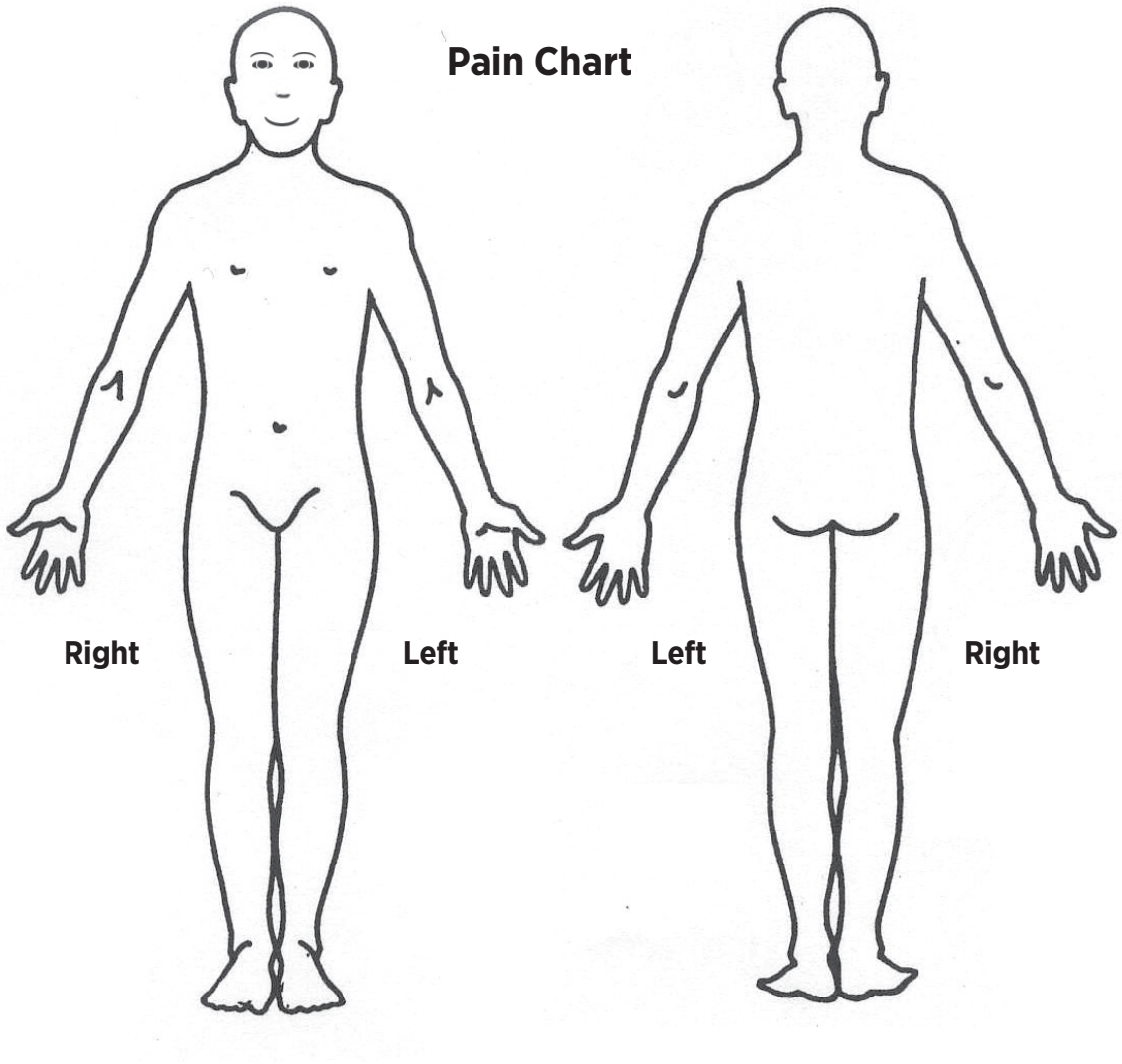
HOW did the pain start? _____

_____

_____

_____

On the body diagrams below, please circle all areas in which you have pain.
Then place a number for your level of pain inside the circle. **1** is good and **10** is your worst pain ever.



Date _____ Signature _____

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INFORMED CONSENT

Patient Name

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 before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

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

Analysis/Examination/Treatment

As a part of the analysis, examination and treatment, you are consenting to the following procedures:

Spinal manipulative therapy	Postural analysis
Range of motion testing	Hot/cold therapy
Muscle strength testing	Vital signs
Radiographic studies	Palpation
Basic neurological testing	Myofascial Release Therapy
Orthopedic testing	Mechanical Traction

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. 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, it is your responsibility to inform me.

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 in 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-inflammatories, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you choose to use 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 attendant 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 growth may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BOX 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 _____and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date

Patient's Name (Printed)

Patient's Signature

Signature of Parent or Guardian (if a minor)

Date

Doctor's Name (Printed)

Doctor's Signature

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