Givens Chiropractic, LLC
2917 Independence St. Suite 400
Cape Girardeau, MO 63703
(573) 651-8686 (573) 651-6633

NEW PATIENT HEALTH HISTORY FORM

In order to provide the best possible wellness care, please complete this form and bring it to your first appointment. ALL information is strictly CONFIDENTIAL!

PATIENT DATA

Name_____Date_____Email_____

Do we have permission to email you your invoice(s), or appointment reminders, news, etc.? _____Yes _____No

GENERAL INFORMATION

Address_____City_____State_____Zip _____
Home Phone_____ _____Work Phone _____ Cell Phone _____
Birthdate _____Social Security #_____Referred by _____
Occupation_____Employer_____Marital Status_____ # of children _____
Spouse's Name_____ Spouse's Occupation_____
Spouse's Employer_____ Spouse's Health Status_____
Emergency Contact_____ Emergency Phone_____

CURRENT COMPLAINTS

Nature of Injury: Automobile* [ ] Work [ ] Other [ ]
Please describe:

_____
_____
_____

Date of injury _____ Date symptoms appeared _____
Have you had this condition before? [ ] No [ ] Yes
If yes, describe _____
***If auto accident, we MUST have a police report on file!!!

INSURANCE INFORMATION

NOTE: Estimated coverage is provided as a courtesy to our patients, but does NOT release them from total responsibility for their balance. I authorize the release of any medical or other information necessary to process insurance claim(s). I also request payment of government benefits either to myself or to the party who accepts assignment below. I also authorize payment of medical benefits to the undersigned physician or supplier for services described in said claims.

Primary Insured Name:_____SS#_____ Date of Birth _____

Signature:_____Date:_____

RESPONSIBLE PARTY

Name of party responsible for payment _____Social security number: _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. Finance charges are computed at the rate of 1.5% per month (18% annually) for unpaid balances greater than 60 days old.

The above does not apply for those patients that are considered Workers' Compensation or Personal Injury. However, be advised if you claim Workers' Compensation or Personal Injury and are subsequently denied such benefits, you may be held responsible for the amount of charges for the services rendered to you.

Patient's Signature_____ Date_____

Parent/Guardian's Signature_____ Date_____

MEDICAL HISTORY

Have you been treated for any conditions in the last year? [ ] No [ ] Yes _____
Date of last physical exam _____ Is there a chance that you may be pregnant? [ ] No [ ] Yes
Have you had X-rays taken? [ ] No [ ] Yes If yes, where? _____
What medications are you taking (Please list for what condition, dosage, and frequency)?

_____

_____

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

_____

_____

HAVE YOU EVER:	NO	YES	BRIEFLY EXPLAIN
Broken Bones	[ ]	[ ]	_____
Been Hospitalized	[ ]	[ ]	_____
Auto Accident	[ ]	[ ]	_____
Sprain/Strain	[ ]	[ ]	_____
Been Unconscious	[ ]	[ ]	_____
Had Surgery	[ ]	[ ]	_____
Joint Replaced	[ ]	[ ]	_____
Wear Orthodics	[ ]	[ ]	_____

FAMILY HISTORY	NO	YES	FAMILY MEMBER
Heart Disease	[ ]	[ ]	[ ] Self [ ] Mother [ ] Father [ ] Sibling
Cancer	[ ]	[ ]	[ ] Self [ ] Mother [ ] Father [ ] Sibling
Diabetes	[ ]	[ ]	[ ] Self [ ] Mother [ ] Father [ ] Sibling
Stroke	[ ]	[ ]	[ ] Self [ ] Mother [ ] Father [ ] Sibling

HABITS	NONE	LIGHT	MODERATE	HEAVY
Alcohol	[ ]	[ ]	[ ]	[ ]
Tobacco	[ ]	[ ]	[ ]	[ ]
Soft Drinks	[ ]	[ ]	[ ]	[ ]
Coffee	[ ]	[ ]	[ ]	[ ]
Drugs	[ ]	[ ]	[ ]	[ ]
Exercise	[ ]	[ ]	[ ]	[ ]
Sleep	[ ]	[ ]	[ ]	[ ]
Water	[ ]	[ ]	[ ]	[ ]

ABOUT YOUR PAIN DOES IT:	NO	YES	BRIEFLY EXPLAIN
Occur Every Day	[ ]	[ ]	_____
Interfere With Daily Life	[ ]	[ ]	_____
Wake You At Night	[ ]	[ ]	_____
Worse At Certain Times Of The Day	[ ]	[ ]	_____
Do Activities Aggravate	[ ]	[ ]	_____

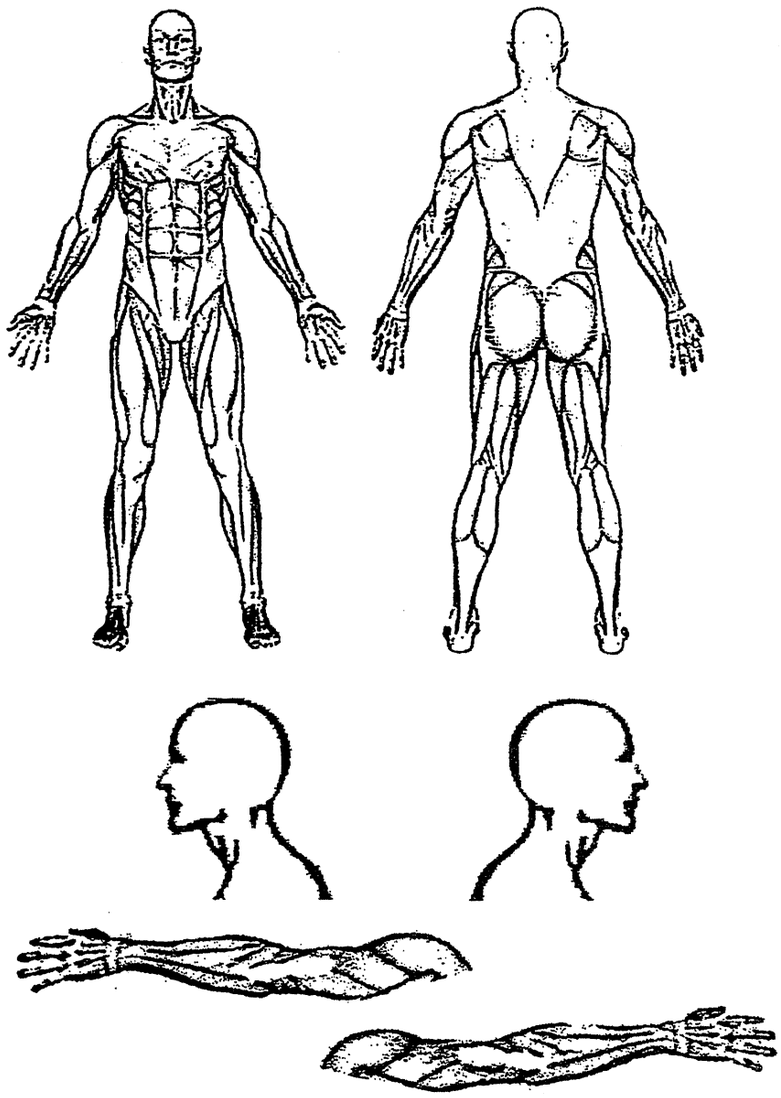
HAVE YOU EVER SUFFERED FROM:

Allergies	[ ]
Anemia	[ ]
Arthritis	[ ]
Asthma	[ ]
Back & Neck Pain	[ ]
Bronchitis	[ ]
Chest Pain	[ ]
Cholesterol	[ ]
Cold Extremities	[ ]
Constipation	[ ]
Depression	[ ]
Dizziness	[ ]
Ears Ring	[ ]
Fatigue	[ ]
High Blood Pressure	[ ]
Irregular Heart Beat	[ ]
Loss of Memory, Balance	[ ]
Night-time Cramps	[ ]
Poor Posture	[ ]
Sciatica	[ ]
Shortness of Breath	[ ]
Sleep Problems/Insomnia	[ ]
Spinal Curvatures	[ ]
Swelling of Ankles	[ ]
Swollen Joints	[ ]
Thyroid Condition	[ ]
Diabetes	[ ]

CURRENT COMPLAINTS

Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing.

A=Ache S=Stabbing B=Burning N=Numbness P=Pins & Needles O=Other



PAIN SCALE

Right now, how severe is the pain (1-10)? _____

On average, how severe is the pain (1-10)? _____

What is the worst your pain has been (1-10)? _____

Is the pain constant, or does it come and go? _____

Dr. Michael Givens, DC

INFORMED CONSENT FORM

PRINT PATIENT NAME: _____

DATE: _____

To the patient: Please read this entire document prior to signing it. It is very important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

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 and 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 necessary procedures:

__Spinal manipulative therapy	__Palpation	__Vital signs
__Range of motion testing	__Orthopedic testing	__Basic neurological
__Muscle strength testing	__Postural analysis	__Ultra sound
__Hot/cold therapy	__Electrical Stim	__X-rays
__Mechanical Traction	__Acupuncture	__Other (please explain)

_____
_____
_____

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complication 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, ad 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 the examination and any necessary X-rays. Stoke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur

Acknowledgement of Privacy Policies

By signing below, I acknowledge that I have received a copy of the privacy policies for Givens Chiropractic, LLC. I understand that if I have any issues or questions concerning this policy it is my responsibility to submit them in writing to:

Dr. Michael Givens, DC
Attn: Privacy Officer
2917 Independence Ste 400
Cape Girardeau, MO 63703

Signature:_____ Date:_____

RECORDS RELEASE AUTHORIZATION

My signature below authorizes the release of my x-rays, laboratory tests, and health records directly to:

Dr. Michael Givens, DC
2917 Independence, Ste. 400
Cape Girardeau, MO 63703
573-651-8686 Fax 573-651-6633

Printed Name: _____ Date: _____

Signature: _____Birthdate: _____

Mechanical copies of this authorization shall be as valid as the original.

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-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose 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 process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UTIL 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 explaination of the chiropractic adjustment and related treatment. I have discussed it with Dr. Michael Givens, DC 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.

Dated:_____ **Dated:**_____

_____ **Dr. Michael Givens, DC**

Print Patient's Name **Print Doctor's Name**

_____ _____

Patient's Signature **Doctor's Signature**

_____

Signature of Parent or Guardian (if a minor)