PURTIMAN
FAMILY CHIROPRACTIC

Date: _____

Patient Demographics

Name (First, Middle, Last): _____

Date of birth: _____ Sex: ☐ M ☐ F Marital status: ☐ M ☐ D ☐ S ☐ W

Spouse's Name: _____ # of children: _____

Home Phone #: _____ Cell Phone #:_____

Home Address: _____ City/State/Zip: _____

Email Address: _____ Occupation: _____

Employer Name/Company: _____ Work Schedule: ☐ F/T ☐ P/T ☐ Per diem

Employer Address: _____ Work Phone #: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Primary Doctor's name: _____ Phone #:_____

How did you hear about us? _____

Primary Insurance Information

Name of Insurance Company: _____

ID or Policy #: _____ Group #: _____

Policy holder's name: _____Date of birth: _____

Relationship to patient: _____

Secondary Insurance Information

Name of Insurance Company: _____

ID or Policy #: _____ Group #: _____

Policy holder's name: _____Date of birth: _____

Relationship to patient: _____

425 W. Guadalupe Rd. #117, Gilbert, AZ 85233
Phone (480) 899-5753 Fax (480) 899-5754
www.purtimanchiropractic.com

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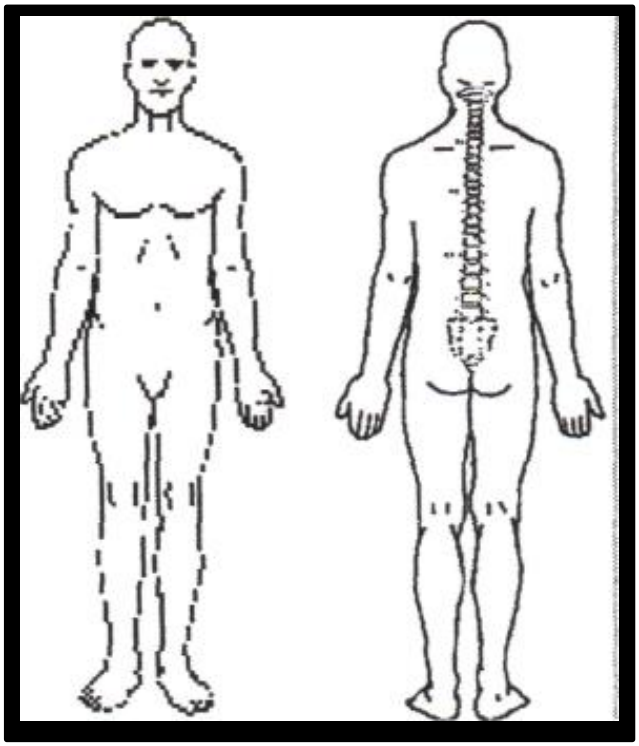
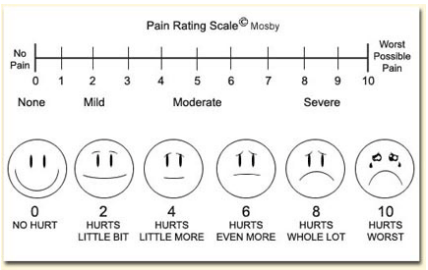
Please mark your areas of pain on the figures below:



Complaint 1:	**Type of Pain**	**Increases Pain**	**Relieves Pain**
_____ Began: _____ Have you had this in the past? ☐Yes ☐No Is it getting worse? ☐Yes ☐No ☐Constant How often do you experience pain? ☐ Occasionally (25% of the time) ☐ Intermittently (50% of the time) ☐ Frequently (75% of the time ☐ Constant (75%-100% of the time)	☐ Aching ☐ Burning ☐ Deep ☐ Dull ☐ Numb ☐ Sharp ☐ Stabbing ☐ Sore ☐ Shooting ☐ Throbbing ☐ Tingling ☐ Stiff ☐ Tight ☐ Other: _____	☐ Lying on back ☐ Lying on side ☐ Lying on stomach ☐ Turning over ☐ Getting in/out of car ☐ Dressing self ☐ Pushing ☐ Pulling ☐ Lifting ☐ Reaching ☐ Coughing ☐ Sneezing ☐ Climbing ☐ Walking ☐ Standing ☐ Sitting ☐ Twisting/Turning ☐ Bending ☐ Stooping ☐ Other:_____	_____ _____ _____ _____ **Severity** Please rate on a scale from 0 – 10 how severe your pain can get. 

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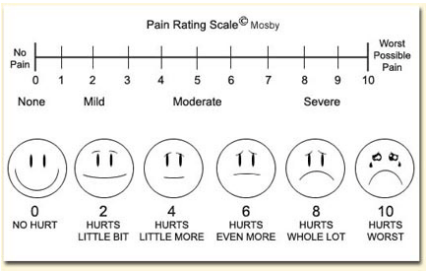
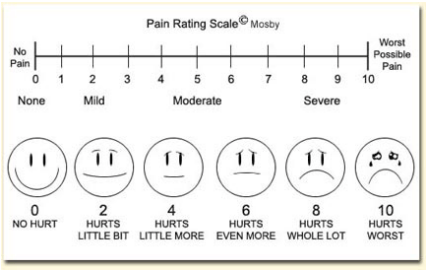
Complaint 2:	Type of Pain	Increases Pain	Relieves Pain
_____ Began: _____ Have you had this in the past? ☐Yes ☐No Is it getting worse? ☐Yes ☐No ☐Constant How often do you experience pain? ☐ Occasionally (25% of the time) ☐ Intermittently (50% of the time) ☐ Frequently (75% of the time ☐ Constant (75%-100% of the time)	☐ Aching ☐ Burning ☐ Deep ☐ Dull ☐ Numb ☐ Sharp ☐ Stabbing ☐ Sore ☐ Shooting ☐ Throbbing ☐ Tingling ☐ Stiff ☐ Tight ☐ Other: _____	☐ Lying on back ☐ Lying on side ☐ Lying on stomach ☐ Turning over ☐ Getting in/out of car ☐ Dressing self ☐ Pushing ☐ Pulling ☐ Lifting ☐ Reaching ☐ Coughing ☐ Sneezing ☐ Climbing ☐ Walking ☐ Standing ☐ Sitting ☐ Twisting/Turning ☐ Bending ☐ Stooping ☐Other:_____	_____ _____ _____ _____ **Severity** Please rate on a scale from 0 – 10 how severe your pain can get. 
Complaint 3:	**Type of Pain**	**Increases Pain**	**Relieves Pain**
_____ Began: _____ Have you had this in the past? ☐Yes ☐No Is it getting worse? ☐Yes ☐No ☐Constant How often do you experience pain? ☐ Occasionally (25% of the time) ☐ Intermittently (50% of the time) ☐ Frequently (75% of the time ☐ Constant (75%-100% of the time)	☐ Aching ☐ Burning ☐ Deep ☐ Dull ☐ Numb ☐ Sharp ☐ Stabbing ☐ Sore ☐ Shooting ☐ Throbbing ☐ Tingling ☐ Stiff ☐ Tight ☐ Other: _____	☐ Lying on back ☐ Lying on side ☐ Lying on stomach ☐ Turning over ☐ Getting in/out of car ☐ Dressing self ☐ Pushing ☐ Pulling ☐ Lifting ☐ Reaching ☐ Coughing ☐ Sneezing ☐ Climbing ☐ Walking ☐ Standing ☐ Sitting ☐ Twisting/Turning ☐ Bending ☐ Stooping ☐Other:_____	_____ _____ _____ _____ **Severity** Please rate on a scale from 0 – 10 how severe your pain can get. 

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PURTIMAN
FAMILY CHIROPRACTIC

Family History

	Stroke	Heart Disease	High blood Pressure	Cancer	Multiple Sclerosis	Arthritis	Osteoporosis	Scoliosis	Diabetes
Father									
Mother									
Brother									
Sister									
Child									
Child									
Child									

Condition history

Is this condition interfering with:

☐ Work ☐ School ☐ Sleep

☐ Daily routine

☐Other:_____

Have you received treatment for this?

☐ Yes ☐ No

If so, what types of treatment:

_____

Is this condition due to:

☐ Work injury ☐ Auto accident

☐ Other trauma: _____

☐ Does not apply

Social History

Habits

☐ Smoking

Packs/Day: ____

☐ Alcohol

Glasses/Day: ____

☐ Coffee

Cups/Day: ____

☐ Soft Drinks:

Glasses/Day: ____

☐ Water

Cups/Day: ____

☐ Vitamins

List:_____

Exercise

☐ 1-2 days/week

☐ 3-4 days/week

☐ 5 + days/week

Type:_____

Medications

List all medications you are currently taking now, including any over the counter medications:

_____

_____

_____

Do you have, or have you ever had, any diseases or medical problems not listed?

☐ Yes ☐ No

If so, please list: _____

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PURTIMAN
FAMILY CHIROPRACTIC

Never	Previously	Presently	General Symptoms/ Conditions
☐	☐	☐	Migraines
☐	☐	☐	Allergies

List: _____

_____

Never	Previously	Presently	General Symptoms/ Conditions
☐	☐	☐	Bronchitis
☐	☐	☐	Chills (constant)
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Headaches
☐	☐	☐	Loss of sleep
☐	☐	☐	Weight loss
☐	☐	☐	Nervousness
☐	☐	☐	Night sweats
☐	☐	☐	Numbness or pain in arms/legs/hands
☐	☐	☐	Wheezing
☐	☐	☐	Polio
☐	☐	☐	Alcoholism
☐	☐	☐	Anemia
☐	☐	☐	Chicken pox
☐	☐	☐	Rheumatic fever
☐	☐	☐	Pleurisy
☐	☐	☐	Arthritis
☐	☐	☐	Mumps
☐	☐	☐	Cancer
☐	☐	☐	Tuberculosis
☐	☐	☐	Venereal disease
☐	☐	☐	HIV positive
☐	☐	☐	Diabetes
☐	☐	☐	Measles
☐	☐	☐	Serious injury
☐	☐	☐	Other: _____

_____

Never	Previously	Presently	Gastro-Intestinal
☐	☐	☐	Belching or gas
☐	☐	☐	Acid reflux
☐	☐	☐	Heartburn
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Stomach pain
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting blood
☐	☐	☐	Bloody stool
☐	☐	☐	Irritable bowel
☐	☐	☐	Ulcers

Cardio-Vascular

Never	Previously	Presently	Cardio-Vascular
☐	☐	☐	High blood pressure
☐	☐	☐	Strokes
☐	☐	☐	Low blood pressure
☐	☐	☐	Chest pain
☐	☐	☐	Heart trouble
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart
☐	☐	☐	Slow heart
☐	☐	☐	Swollen ankles
☐	☐	☐	Varicose veins
☐	☐	☐	Pacemaker

Never	Previously	Presently	Eye/Ear/ Nose/Throat
☐	☐	☐	Sinusitis
☐	☐	☐	Asthma
☐	☐	☐	Deafness
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Thyroid problems
☐	☐	☐	Frequent colds
☐	☐	☐	Hay fever
☐	☐	☐	Nasal obstruction
☐	☐	☐	Nose bleeds
☐	☐	☐	Pain in eyes
☐	☐	☐	Poor vision
☐	☐	☐	Blurred vision
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

Muscles & Joints

Never	Previously	Presently	Muscles & Joints
☐	☐	☐	Backache
☐	☐	☐	Pain between shoulders
☐	☐	☐	Stiff neck
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Painful tail bone
☐	☐	☐	Spinal curvature
☐	☐	☐	Swollen joints
☐	☐	☐	Tremors
☐	☐	☐	Twitching
☐	☐	☐	Spinal disc disease
☐	☐	☐	Dislocated joints

Never	Previously	Presently	Respiratory
☐	☐	☐	Chronic cough
☐	☐	☐	Difficulty breathing
☐	☐	☐	Spitting blood
☐	☐	☐	Spitting phlegm

Genito-Urinary

Never	Previously	Presently	Genito-Urinary
☐	☐	☐	Bed wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control urine
☐	☐	☐	Kidney infections
☐	☐	☐	Kidney stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate problem

Neurological

Never	Previously	Presently	Neurological
☐	☐	☐	Anxiety
☐	☐	☐	Mood swings
☐	☐	☐	Phobias
☐	☐	☐	Mental disorders
☐	☐	☐	Multiple sclerosis
☐	☐	☐	Epilepsy
☐	☐	☐	Memory loss or impairment
☐	☐	☐	Depression

For females only

Never	Previously	Presently	For females only
☐	☐	☐	Irregular cycle
☐	☐	☐	Cramps
☐	☐	☐	Hot flashes
☐	☐	☐	Painful periods

Is there a possibility of pregnancy?

☐ Yes ☐ No

Last menstrual cycle:

_____

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FAMILY CHIROPRACTIC

Any additional information you would like the doctor to know about before beginning care at Purtiman Family Chiropractic?

_____

_____

Release of Medical Information

If you would like your medical information to be easily accessed by specific individuals for your convenience, please list below.

Last Name	First Name	Relationship	Phone Number

In the future, if you would like to change the individuals listed or revoke all together, please submit a request in writing and allow 48 hours for these changes to be applied to your account.

If none listed, under HIPPA regulation, we are **not** permitted to even acknowledge if you are patient. This means we **cannot** discuss your medical history or reschedule/cancel appointments under the direction of any individual other than yourself.

If you have read the above information, given medical information privileges to certain individuals or left blank and have no further questions, please sign below.

_____ _____

Signature Date

Treatment of Minor Consent

If the patient is a minor and the parent or guardian would like to have the ability to have him/her treated without parental supervision, please sign below.

I, _____ (parent/guardian), give permission to have _____ (patient) treated at Purtiman Family Chiropractic without adult supervision or a guardian present. This allows the doctor to perform any in office procedures that he deems necessary in the care of the patient.

_____ _____

Signature Date

PURTIMAN
FAMILY CHIROPRACTIC

Purtiman Family Chiropractic
1663 E. Ray Road Ste. 103
Gilbert, AZ 85296
Phone 480-899-5753 Fax 480-899-5754

Informed Consent

The nature of the chiropractic manipulation: I will use my hands, instruments, or table to move the joints of your body; this may result in an audible "pop" or "click".

The material risks inherent in an adjustment: As with any healthcare procedure, there are certain complications that may arise during a chiropractic manipulation. This may include: strains, dislocations, fractures, disc injuries and stroke. This list is not all inclusive.

The probability of those risks: Fractures are rare and can result from an underlying weakness in the bones. The other complications are considered rare. One source states that stroke is a possible occurrence in 1/1,000,000 cases or higher, even so we employ tests during our examination to identify if you may be susceptible to that kind of injury.

Ancillary treatments recommended: The risks in physiotherapy are minimal but could include: strains, dislocation, fractures, disc injuries and stroke. This list is not all inclusive.

Other treatment options for your condition include: Medical care with prescription drugs, self-management with over-the-counter medication, rest, and/or surgery. There are material risks inherent in each of these options including but not limited to: addiction to medication, side effects of medication, improper self dosages and surgical risks including complications from the procedure and the anesthesia.

Do Not Sign Until You Have Read and Understand the Above

I have read or have had read to me the above explanation of the chiropractic adjustment and the related treatment. I have discussed it with the doctor 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 I have decided that it was in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Patient Printed Name _____

Patient Signature_____ Date: _____

Parent/Guardian Signature_____ Date: _____

Doctor signature _____ Date: _____

PURTIMAN
FAMILY CHIROPRACTIC

Acknowledgement of Policies and Privacy Practices

Insurance Authorization

I hereby authorize Purtiman Family Chiropractic to furnish information to my insurance carriers, worker's compensation companies, attorneys, etc. concerning my illness and treatment.

Assignment of Benefits

I hereby assign to Purtiman Family Chiropractic all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

Treatment Authorization

I hereby authorize Purtiman Family Chiropractic to render health care to me during my visit.

Privacy Notice

I have been given the option to review Purtiman Family Chiropractic's' "Notice of Privacy Practices" that explains how my personal health information will be used. I am also aware that I may request a copy of the "Notice of Privacy Practices" at any time.

Signature of Patient _____Date_____

Signature of Parent or Guardian _____Date_____

Signature of Staff_____ Date _____

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