Neurologic Relief Centers

ARFoote Chiropractic

2080 W. Southern Ave. Ste A-2, Apache Junction, AZ, 85120

NEW PATIENT REGISTRATION

EMAIL:________________________________

Name:________________________________ ❑MALE ❑FEMALE

Address:________________________________ ________________________________
Street City, State, Zip Code

Birth Date:________________ Age:__________ SSN:________________

Home Ph Number:________________ Cell Ph Number:________________

Employment Status: ❑Employed ❑Student ❑Homemaker

Occupation:________________ Employer:________________

RESPONSIBLE PARTY INFORMATION

(not required if insurance card has been copied by the front desk)

Name (Guarantor):________________________________

Relationship to Patient:________________________________

Insurance Co:________________________________

Policy Number:________________ Group Number:________________

Insurance Address/Phone:________________________________

As a service we can provide diagnosis and treatment info to your primary care physician (PCP). If you would like us to provide this info please check the YES box and initial. ❑YES / ____ (initials) / PCP NAME:________________

PATIENT AGREEMENT AND ASSIGNMENT OF BENEFITS

I, the undersigned, authorize the release of any information including diagnosis and the records of any treatment rendered to me or those I am responsible for during the period of such care to third party payers, other health practicioners, and/or legal representation. I authorize and request my insurance company and/or legal representation to pay directly to ARFoote Chiropractic, LLC all medical benefits payable for service rendered. I authorize the use of this signature on all my insurance submissions and to obtain records. I agree to pay all charges for medical and health care services not covered by my insurance company. **By signing below I certify that I have read this form & Patient Agreement / Assignment of Benfits and understand its content.**

________________________________ ________________
Signature of Patient or Other Legally Authorized Person Date Signed

Office: (480) 982-6568 Fax: (888) 849-4389

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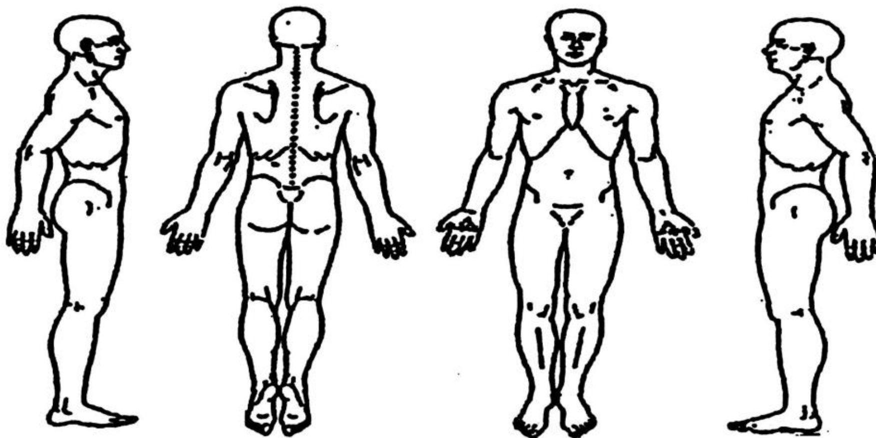
REASON FOR SEEKING CARE (part 2 of Patient Information Form)

☐ I have symptoms. If so, when did you first notice the symptoms? ________________ ☐ Optimizing/Maintaining My Health

What and Where specifically are your symptoms located? ____

Indicate on the drawings below where you have pain/symptoms



1. Is today's problem caused by: ☐ Auto Accident ☐ Other Traumatic event (physical or emotional?)

____

2. How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)
☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

3. How would you describe the type of pain?

☐ Sharp ☐ Numb
☐ Dull ☐ Tingly
☐ Diffuse ☐ Sharp with motion
☐ Achy ☐ Shooting with motion
☐ Burning ☐ Stabbing with motion
☐ Shooting ☐ Electric like with motion
☐ Stiff ☐ Other:___________________

4. How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

6. How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

7. How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately Quite a bit ☐ Extremely

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8. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____________
□ Massage Therapist □ Physical Therapist □ No one

9. How long have you had this problem? ___________

10. How do you think your problem began?

____

11. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

12. What aggravates your problem?

____

13. What alleviates your problem?

____

14. What concerns you the most about your problem; what does it prevent you from doing?

____

15. What is your: Height___________ **Weight** _____________ **Date of Birth** ___________
Occupation ____

16. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?

□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Parkinson's Disease □ Fibromyalgia
□ Heart Problems □ Cancer □ ALS □ RSD/CRPS □ Multiple Sclerosis

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Epilepsy
□	□ Hand Pain	□	□ Painful Urination	□	□ Dermatitis/Eczema/Rash
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ HIV/AIDS
□	□ Upper Leg Pain	□	□ Prostate Problems	**Chronic Pain / Neurological DX**	
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss	□	□ Parkinson's Disease
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	□	□ Fibromyalgia
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Multiple Sclerosois
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ RSD/CRPS
□	□ Arthritis	□	□ Hepatitis	□	□ Debilitating Migraines
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination	**For Females Only**	
□	□ Asthma	□	□ Visual Disturbances	□	□ Birth Control Pills
□	□ Chronic Sinusitis	□	□ Dizziness	□	□ Hormonal Replacement
□	□ Other:___________________________			□	□ Pregnancy X ______

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20. List all prescription medications you are currently taking:

____

21. List all of the over-the-counter medications you are currently taking:

____

22. List all surgical procedures you have had:

____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?

____

25. Have you ever been hospitalized? □ No □ Yes

if yes, why ____

26. Anything else pertinent to your visit today? ___________________________________

27. How committed are you to getting well? _______________________________________

28. What do want to achieve? ____

29. In what time frame would you expect to see a recovery of your symptoms? _____________

30. Once your symptoms "Go Away", where else do you see this benefitting and positively affecting your life. ____

31. If you do the same thing you doing now the same result will be happen. Are you willing to do something different and give 100% effort in doing so to get well ?___________________

AUTHORIZATION

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 agree to be responsible for payment of all services rendered on my behalf, or my dependents.

X _________________________________ **Date:** _______________
SIGNATURE OF PATIENT (or parent if a minor)

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INFORMED CONSENT TO MEDICAL TREATMENT

I hearby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctors of chiropractic that are associated with ARFoote Chiropractic.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment or treatment. Those complications include but are not limited to: soreness, fractures, disc injuries, dislocations, and strain/sprains. 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. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with a doctor at ARFoote Chiropractic the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I also understand that there is no guarantee or warranty for a specific cure or result.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have, myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

______________________________________ ________________

PATIENT SIGNATURE OR LEGAL GUARDIAN DATE

____

PRINTED NAME OF PATIENT

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PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO
CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

____________________hereby states that by signing this Consent, I acknowledge and agree as follows:

1. ARFoote Chiropractic's (ARFC) Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/ or disclosures of my protected health information ("PHI") necessary for ARFC to obtain payment for that treatment and to carry out its health care operations. ARFC explained to me that the Privacy Notice will be available to me in the future at my request. ARFC has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. ARFC reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by ARFC: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone, or by e-mail.
4. ARFC may use/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for ARFC to treat me and obtain payment for that treatment, and as necessary for ARFC to conduct its specific health care operations.
5. I understand that I have a right to request that ARFC restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, ARFC is not required to agree to any restrictions that I have requested. If ARFC agrees to a requested restriction, then the restriction is binding on ARFC.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that ARFC has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, ARFC has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then ARFC will not treat me

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

______________________________ ______________________________
Name of Patient/Individual (Please print) Signature of Patient/Individual

______________________________ ______________________________
Signature of Legal Representative Relationship to Patient
(e.g.,Attorney-In-Fact, Guardian, Parent if a minor)

______________________________ ______________________________
Date Signed Witness

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