Pearson & Weary
CHIROPRACTIC ORTHOPEDICS AND REHABILITATION

Pain Relief Clinics

Please Complete All Sections

Full Name: Preferred Name (if different): Gender: ☐ M ☐ F ☐ Other:

Date of Birth: / / Age: Race: (optional)

Family Status: ☐ Single ☐ Married ☐ Widow(ed) ☐ Divorced ☐ Separated ☐ Partner No. of Children:

Full Address: City: State: Zip:

Primary Phone: ( ) Email: Permission to contact via email: ☐ Yes ☐ No

Employer: Occupation: Who referred you to the clinic? Full Name:

Emergency Contact: Relationship: Phone: ( )

Do you have a primary care provider? ☐ Yes ☐ No Name of your Doctor / Facility:

Do you have health insurance? ☐ Yes ☐ No Insurance company:

Are you the primary subscriber? ☐ Yes ☐ No Name of primary subscriber? Date of birth / primary:

What is your relationship to the primary subscriber?

Who is financially responsible for your care? Name:

Legal Guardian (if applicable):

CHIEF COMPLAINT INFORMATION:

Describe the location of your chief complaint:

NOTE: A date of onset is REQUIRED **Date of onset: / /**

How did your pain begin? (note the date in the next line)

What is the severity of your complaint: 0 - no pain / 10 - severe pain:

Is your complaint getting progressively worse?

Is your complaint better at certain times of the day?

Is your complaint worse at certain times of the day?

What makes your complaint better?

What makes your complaint worse?

Circle any of the associated symptoms you experience: Numbness Tingling Weakness Headaches Feeling a catch / locking up

How frequently do you experience the symptoms you circled above?

Previous treatment including current providers you are seeing: ☐ NA

PLEASE COMPLETE THE FOLLOWING TWO PAGES!

What have they recommended and what has been the outcome? ☐ NA

Please list other concerns you have in the order of their importance: ☐ NA

Have you had chiropractic care before? ☐ Yes ☐ No Date of last treatment if applies: Name of DC:

Have you had X-rays or MRI or any other imaging performed? ☐ Yes ☐ No What body part?

Which imaging center performed the testing? ☐ NA Estimated date of most recent imaging?

PAST MEDICAL HISTORY

Have you been treated by a physician for any health condition in the past 6 months? ☐ Yes ☐ No

Please describe:

Please list your medications: ☐ NA

Please list your allergies: ☐ NA

Please list any supplements / vitamins you take on regular basis: ☐ NA

SOCIAL HISTORY

Tobacco/Vaping	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of packs/usages per day:
Alcohol	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of drinks per week:
Water	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of cups per day:
Coffee/Caffeine	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of cups per day:
Exercise	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of times per week:

Please describe your exercise:

PAST FAMILY HISTORY - Please list any incidence and familial relationship of the following conditions.

☐ Heart Disease ☐ Cancer ☐ Stroke ☐ Diabetes ☐ Arthritis ☐ Back or Disc Problems

☐ Other Describe:

YOUR GOALS AND ASPIRATIONS

Are there certain activities that you have been unable to perform that you would like to return to or begin? *(Please list)*

Patients Signature: _____ Date: _____

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Financial Policies

I agree to pay for services rendered as the charge is incurred. I understand that health care and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments, co-insurances, deductible and non-covered services. I also agree to pay for all copays and non-covered services after seeing the doctor. I authorize the doctor and his/her staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjustor, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of the professional services rendered and hereby release him/her of any consequences thereof. I hereby authorize and direct payment of any and all medical /chiropractic expense benefits allowable to the doctor as payment toward the total charges for the professional services rendered.

If required by my health insurance policy, it is my responsibility to obtain a referral for my primary care physician prior to treatment at PWC. I also understand that if I do not have prior authorization and it is denied, I am responsible for any charges not covered by my insurance company. I understand benefits are sometimes misquoted by the insurance company.

Time of Service (TOS) Discount

Certain services provided may not be covered by your health plan. Those services are deemed important to your recovery. Because you are responsible for paying for those services on the date the service is rendered, we offer a time of service discount of $25.00 off the total of all non-billed charges for that day. (This will not include supplements or supplies.) Examples of non- covered services may include (but are not limited to) the examples noted below:

Active release / Advanced Muscle Integration:	$48 fee: With the TOS discount, the fee is $23
Extremity and Active release:	$78 fee: With the TOS discount, the fee is $53
Initial examination (Medicare)	$136 - $241 fee: With the TOS discount, the fee is $111 - $216
Re-examination (Medicare)	$90 - $142 fee: With the TOS discount, the fee is $65 - $117
Laser	$54 fee: With the TOS discount, the fee is $29

Cancellation Policy

We realize that emergencies come up, but if you need to cancel an appointment for any reason we do require 24 hours notice. We do have a waiting list of other patients who are in pain and would like to be seen as soon as possible.
Clinic Policy: If you do not contact our office 24 hours prior to your scheduled appointment on more than (2) two occasions, you will be billed for the 3rd missed appointment for a fee of $25.00, whether it be for chiropractic or movement. If you do not contact the office 24 hours prior to your scheduled massage appointment, you will be billed $35.00 for each missed massage.

X_____	**X**_____	**X**_____
Patient's or Guardian Printed Name	Patient's or Guardian Signature	Date

HIPAA Privacy

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI) The patient is also provided the right to request confidential communication and can be provided in the manner they choose.

☐ It is okay to leave a message with detailed information ☐ Leave call back number only

I prefer to be contacted for appointments in the following manner: ☐ Text ☐ Call ☐ Email

In the event I cannot be reached, I give permission for Pearson & Weary Clinic to discuss my patient information and billing account with:

Name _____ Relationship _____

X_____	**X**_____	**X**_____
Patient's or Guardian Printed Name	Patient's or Guardian Signature	Date

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Patient name: Date:

DESCRIBE YOUR CHIEF COMPLAINT TODAY:

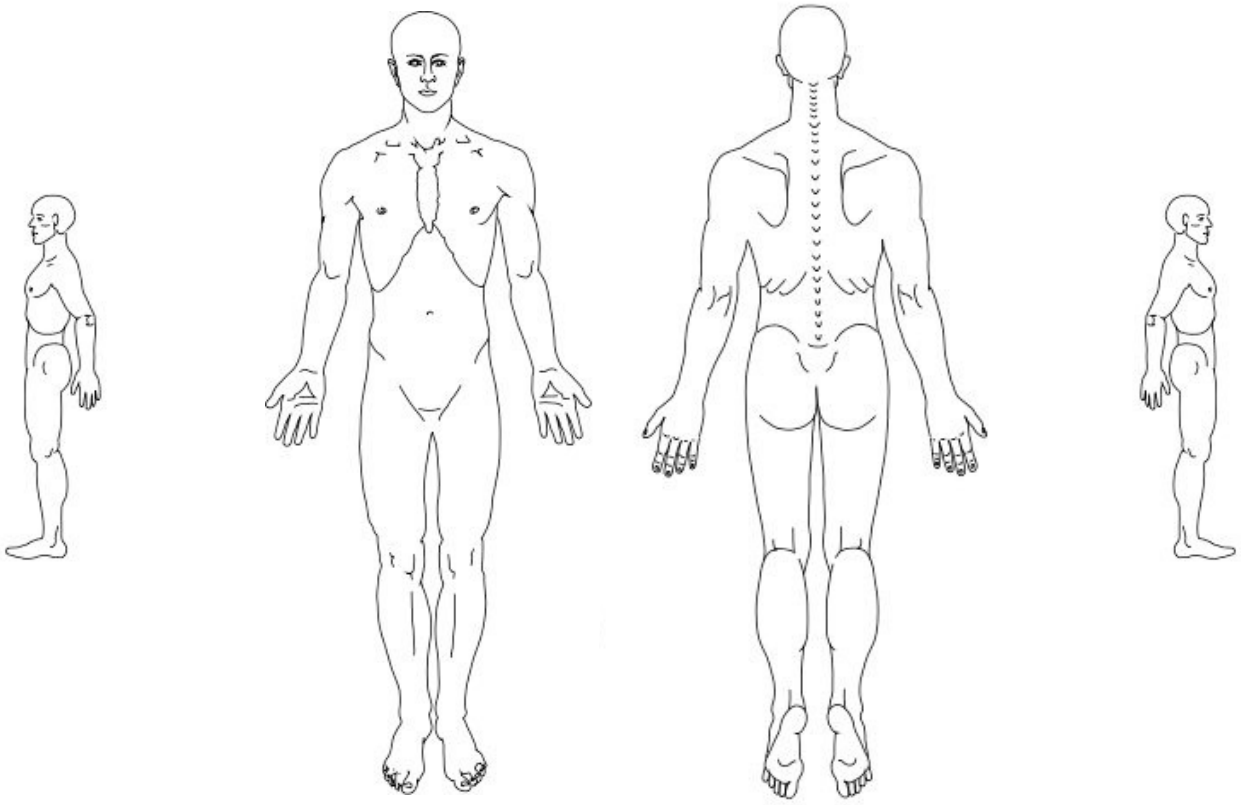
_____

_____

_____

Mark or circle the area of your symptoms on the drawing and indicate if possible:

Pain (P) **Numbness (N)** **Tingling (T)** **Achey (A)** **Sharp (S)**



VISUAL ANALOGUE SCALE

Please rate your pain regarding your chief complaint.

0 1 2 3 4 5 6 7 8 9 10

No Pain **Severe Pain**

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Functional Rating Index

For use with Neck and/or Back Problems

In order to assess your condition we must understand how much your body pain / problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

CIRCLE the number which most closely describes your condition right now.

PAIN INTENSITY

0	1	2	3	4
no pain	mild pain	mod pain	severe pain	worst pain

ABILITY TO DO RECREATION

0	1	2	3	4
can do all activity	most activity	some activity	a few activities	cannot do any

SLEEP DISTURBANCE

0	1	2	3	4
perfect	mildly	moderate	greatly	totally

FREQUENCY OF PAIN

0	1	2	3	4
no pain	25% of day	50% of day	75% of day	constant pain

PERSONAL CARE RESTRICTIONS

0	1	2	3	4
none	mild	moderate	severe	needs help

PAIN WITH LIFTING WEIGHT

0	1	2	3	4
no pain heavy wt	some w/ heavy wt	worse w/ mod wt	worse w/ light wt	worse w/ any wt

PAIN WITH TRAVEL (DRIVING)

0	1	2	3	4
no pain	mild long trip	moderate long trip	moderate short trip	severe short trip

WALKING

0	1	2	3	4
no pain any distance	pain after 1 mile	pain after 1/2 mile	pain after 1/4 mile	pain with all walking

ABILITY TO DO WORK

0	1	2	3	4
can do extra work	can do only usual	can do 50% of usual	can do 25% of usual	unable to work at all

ABILITY TO STAND

0	1	2	3	4
no pain several hours	increased pain after 2 hours	increased pain after 1 hour	increased pain after 1/2 hour	increased pain with any stand

Please circle the average level of pain in the last week. (No pain 0 - Worst pain 10)

0 1 2 3 4 5 6 7 8 9 10

Name: _____ Date: _____ Score: _____

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Full Name _____ Date: _____

Review of Systems: In order to provide the best care possible, please check those health concerns that apply to you. Please check **C** for **Current** and **P** for **Past** history in the box to the left of the condition.

P	C	
		CONSTITUTIONAL
		Unexplained weight change
		Fever
		Weakness
		Undue fatigue
		CARDIOVASCULAR
		High BP
		Faintness
		Vertigo
		Chest pains
		Heart palpitations
		GENITOURINARY
		Hernia
		Frequent urination
		Painful urination
		Rashes
		Skin lesions
		JOINT REPLACED
Describe:		
		HERNIATED DISC
Describe:		
		SURGERY
Describe:		

P	C	
		IMMUNOLOGIC
		Allergies to food
		Hepatitis
		Rheumatoid
		Lupus
		Psoriasis
		Diabetes
		Other:
		RHEUMATOLOGIC
		Chest pain
		Cough
		Asthma
		Bronchitis
		PSYCHIATRIC
		Anxiety
		Depression
		Insomnia
		Energy Loss
		FRACTURE
Describe:		
		TRAUMA (accidents)
Describe:		

P	C	
		EAR/NOSE/THROAT
		Dizziness
		Tinnitus
		Hearing Loss
		Nose Bleeds
		Hoarseness
		Swallowing difficulty
		GASTROINTESTINAL
		Appetite change
		Nausea
		Diarrhea
		Constipation
		HEMATOLOGIC
		Anemia
		Bruise easily
		ENDOCRINE
		Hot /cold intolerance
		Excessive sweating
		Thyroid problems
		OTHER
		Loss of bowel control
		Osteporosis
		Stroke / TIA (yr)
		Heart attack (yr)

If none of these conditions apply: Please check ☐ NA

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Disclosure and Consent for Care

To the patient or guardian of a minor: *You have a right to be informed about your condition and the recommended treatment to be used. You have the right to understand what other options are available for your care, as well. This is to inform you of the rare potential risks and hazards involved with care. This is not meant to alarm you, but rather it is our effort to make you better informed so you can give us your consent to the procedure(s).*

I hereby request and consent to the performance of chiropractic adjustments/manipulation and other procedures performed in this office on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and or/other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below my diagnosis, the nature and purpose of chiropractic adjustments /manipulation and any other procedures and alternatives that may be performed or recommended.

I understand that there are some rare risks to examination and treatment in the practice of chiropractic, including, but not limited to, fracture, disc injuries, dislocations, sprains and strokes. There may be increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all the risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure(s), that the doctor feels at the time of treatment, based on the facts then known, are in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the treatment results or outcome.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and my questions have been answered satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition(s) for which I am seeking treatment.

To be completed by the patient:

_____
Print name

_____
Signature of patient

_____
Date signed

To be completed by doctor:

_____
Witness to patient's signature

Date _____

To be completed by the patient's representative:
(e.g. if patient is a minor or legally incapacitated)

_____
Print name of patient

_____
Printed name of patient's representative

_____
Signature of patient's representative

_____
Relationship to the patient

Date _____