Waverly Chiropractic Specialties ~ John G. Schutz D.C. ~ 1240 10th Ave SW, Waverly

GENERAL PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

_____

Birthdate: _____ Age: _____ Sex: M____ F ____

Social Security # _____

Phone: _____Cell: _____

Occupation: _____

Employer: _____

Spouse: _____

Emergency Contact: _____

Relationship: _____Phone: _____

How did you hear about us?

_____

FINANCIAL INFORMATION

Please present your insurance cards to the front desk

Who is financially responsible? _____

Relationship to Patient: _____

Address: _____

Phone: _____

ACCIDENT/INJURY INFORMATION

Is this due to an accident/injury? Yes or No, if yes date _____
Type of accident/injury: Auto Work Home Other
Describe Accident: _____
_____

PAST ACCIDENTS/INJURIES/SURGERIES/MEDICATIONS

List any sport, recreational or home injuries _____
_____
List any automobile accidents and injuries _____
_____
List any hospitalizations and surgeries_____
_____
List medications, over the counter drugs and vitamins you take
_____
_____

REASONS FOR SEEKING CARE

1. _____How long has this been an issue? _____
Is it: Dull____ Sharp_____Ache_____Numb/Tingle_____Stabbing_____Constant____Occasional____Staying the Same____Worsening____
Rate the pain: No pain 0 1 2 3 4 5 6 7 8 9 10 Severe My pain is worse in morning/evening? _____

2. _____How long has this been an issue? _____
Is it: Dull____ Sharp_____Ache_____Numb/Tingle_____Stabbing_____Constant____Occasional____Staying the Same____Worsening____
Rate the pain: No pain 0 1 2 3 4 5 6 7 8 9 10 Severe My pain is worse in morning/evening? _____

3. _____How long has this been an issue? _____
Is it: Dull____ Sharp_____Ache_____Numb/Tingle_____Stabbing_____Constant____Occasional____Staying the Same____Worsening____
Rate the pain: No pain 0 1 2 3 4 5 6 7 8 9 10 Severe My pain is worse in morning/evening? _____

Please mark an X on the diagram to the right where you have symptoms.

What makes your conditions better?_____

What makes your conditions worse?_____

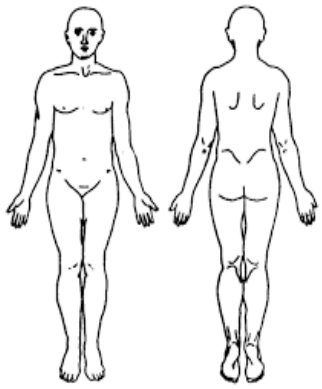
What doctors have you seen?_____

List past treatments_____

Results of these treatments_____

I am interested in: Temporary relief YES NO A solution to my problem YES NO

Pt/Guardian Signature_____ Date: _____



John G. Schutz, D.C.

Waverly Chiropractic Specialties ~ John G. Schutz D.C. ~ 1240 10th Ave SW, Waverly

FAMILY HISTORY: **(Please circle all who apply)**

Diabetes	Mother	Father	Sister	Brother	Kidney problems	Mother	Father	Sister	Brother
Heart disease	Mother	Father	Sister	Brother	Headaches	Mother	Father	Sister	Brother
Heart problems	Mother	Father	Sister	Brother	Back or neck pain	Mother	Father	Sister	Brother
Cancer	Mother	Father	Sister	Brother	Arthritis	Mother	Father	Sister	Brother

Other: _____

Please check all that apply:

Now	Previously	GENERAL
____	____	Anemia
____	____	Cancers or Tumors
____	____	Diabetes
____	____	Epilepsy
____	____	Hepatitis
____	____	Polio
____	____	Rheumatic Fever
____	____	Scarlet Fever
____	____	Thyroid Conditions
____	____	Sexually Transmitted Diseases
____	____	Surgeries (any type)
____	____	AIDS or AIDS related complex
____	____	Tuberculosis

BY SYSTEMS

____	____	Convulsions
____	____	Dizziness
____	____	Mental Illness
____	____	Depression or Nervousness
____	____	Headaches
____	____	Paralysis
____	____	Night Sweats
____	____	Tremors
____	____	Weight Gain or Weight Loss
____	____	Alcoholism
____	____	Childhood Diseases

EYES EARS NOSE THROAT RESPIRATORY

____	____	Chronic Colds
____	____	Chronic Cough
____	____	Sinusitis
____	____	Allergies
____	____	Difficulty Breathing
____	____	Pneumonia
____	____	Chest or Rib Pain

Now	Previously	CARDIOVASCULAR
____	____	Chest Pain
____	____	Rapid Heart Beat
____	____	High or Low Blood Pressure
____	____	Pace Maker
____	____	Other_____

MUSCULOSKELETAL

____	____	Arthritis
____	____	Neck Pain
____	____	Pain or Weakness Radiating Into Arms
____	____	Mid Back Pain
____	____	Pain Radiating Around Ribs
____	____	Low Back Pain
____	____	Pain or Weakness Radiating Into One or Both Legs
____	____	Arm, Elbow or Wrist Pain
____	____	Leg, Knee, or Ankle Pain

GASTROINTESTINAL & GENITOURINARY

____	____	Acid Reflux
____	____	Stomach Pains
____	____	Nausea
____	____	Gallbladder Condition/Problems
____	____	Liver Condition/Problems
____	____	Blood In Stool
____	____	Constipation or Diarrhea
____	____	Colitis/Diverticulitis
____	____	Excessive Urination
____	____	Blood in Urine
____	____	Painful Urination
____	____	Kidney Condition/Problems
____	____	Prostate Condition/Problems

FEMALE REPRODUCTIVE

____	____	Premenstrual Syndrome
____	____	Menstrual Conditions/Problems
____	____	Menopausal Symptoms/Hot Flashes
____	____	Breast Soreness/Lumps/Discharge

ARE YOU PREGNANT? YES NO

EXERCISE

____ Light
____ Moderate
____ Heavy
____ Daily

WORK ACTIVITY

____ Sitting Mostly
____ Standing Mostly
____ Light Labor
____ Heavy Labor
____ Unemployed

HABITS

____ Smoking
____ Alcohol
____ Caffeine/Soda Pop
____ Drugs

Packs Per Day _____
Drinks Per Day/Week _____
Cups per Day _____
Type _____

John G. Schutz, D.C.

Pt/GuardianSignature_____Date_____

ATHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Waverly Chiropractic Specialties. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my scheduled care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this clinic to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning your information, 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 in our waiting room or at the front desk.

Patient/Parent/Legal Guardian Authorizing Care _____Date _____

Informed Consent Notification for Chiropractic Care

For Adult and Minor Child

As is the case with the practice of medicine, chiropractic care is not an exact science and therefore risks and limitations do apply. Below is a non-conclusive list of possible adversities associated with chiropractic adjustments, manual therapies, exercise therapies, physiologic modalities, and spinal decompression.

Sprains/strains and or other injury to muscles, ligaments, spinal discs; bruising to the spine, ribs, and extremities, headache, spinal and rib fractures, extremity pain. Heart related adversities including heart attack with exercise therapy. Burns to the skin with heat therapy, ultrasound, and electric modalities, frost-bite to the skin with the use of ice or cold therapies.

It is inconclusive at this time as to the association of spinal manipulation relative to stroke. A nine year study on over 110 million people, demonstrated no greater likelihood when seeing a chiropractor compared to seeing a medical provider.

Options for treating your symptoms may include medical intervention, other therapies, over the counter medications, and surgery, if you chose any of these please speak to the treating health care provider to discuss these risks. You also have the choice to refuse care; by doing so there is every possibility that the underlying cause or pathology of your condition will continue to worsen. Over time this process may complicate treatment making it more difficult and less effective.

Rarely, one may feel somewhat worse during the initial phase of chiropractic care. If you ever have a condition that would otherwise not come to the doctor's attention, it is your responsibility to inform the doctor. Please make sure you inform our doctor of any adversities to your care or changes in your health.

I have read, or have had read to me the above consent information, I have discussed and understand the risks associated with the use of manual therapies, physiologic modalities, exercise therapy and spinal decompression of which this clinic employs. I also understand there is no guarantee of cure or successful treatment outcome. **By signing below I hereby give my consent for chiropractic treatment and diagnostic procedures for myself or my child _____**.

(Print child's full name)

Patient/Parent/Legal Guardian Signature _____Date _____

Relationship to The Patient (circle one): **SELF FATHER MOTHER LEGAL GUARDIAN**

Waverly Chiropractic Specialties ~ John G. Schutz D.C. ~ 1240 10th Ave SW, Waverly

PAIN/CONDITION DISABILITY QUESTIONNAIRE and INSTRUCTIONS: These Questions ask your views on how your pain or condition currently affects your everyday functional activities. Please answer every question and mark the ONE number on EACH scale that best represents the way you feel.

Patients Name _____ Date _____
(PATIENT MUST FILL IN NAME)

Reason for your visit (condition) _____

Please rate your symptoms: 0--------1--------2--------3--------4-------5--------6--------7--------8--------9--------10--------
NONE SEVERE

Does your condition interfere with your normal work inside or outside the home?
Work Normally Unable to work at all
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------

Does your condition interfere with personal care?
Take care of myself completely Need help with all my personal care
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------

Does your condition interfere with traveling?
Travel anywhere I like Only travel to see doctors
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------

Does your condition affect your ability to sit or stand?
No problems Cannot do at all
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------

Does your condition affect your ability to lift overhead, grasp objects, or reach for things?
No problems Cannot do at all
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------

Does your condition affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems Cannot do at all
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------

Does your condition affect your ability to walk or run?
No problems Cannot walk/run at all
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------

Has your sleep been impaired since your condition began?
No impairment Severe impairment
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------

Do you take pain or other types of medication to control your condition?
No medication needed On pain medication throughout the day
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------

Does your condition interfere with recreational activities and hobbies that are important to you?
No interference Total interference
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10----------

John G. Schutz, DC