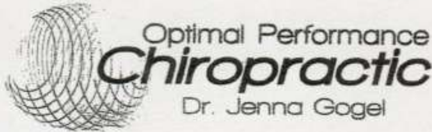


402 E 13th Street, Huntingburg, IN 47542
Phone: (812) 684-0095 www.op-chiropractic.com

Personal Information Date ____________________

First Name ________________________ M.I. _____ Last Name ________________________

Address ____

City ____________________________ State ______ Zip Code ____________________

Home Phone ____________________________ Cell Phone ____________________________

Work Phone ____________________ Ext _____ Email Address ____________________________

Birthdate ________________________ Social Security # ______________________________

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race / Ethnicity: ____

Employer ______________________________ Occupation ______________________________

Emergency Contact & Relationship ______________________________ Phone __________________

Referred by / How did you hear about us ____

Insurance Information (a copy of your card will be kept on file)

Name of Insured ____________________________ Relationship to Patient ____________________

Date of Birth ______________________ Employer ____

Address if different from above (Street, City, Zip) ____________________________________
____

HISTORY CHECKLIST

Patient Name ______________________ Birthdate __________

Have you ever been to a chiropractor? ☐ Yes ☐ No
Do you have chest pain? ☐ Yes ☐ No
Do you have any vertigo (dizziness)? ☐ Yes ☐ No
Do you get migraines or headaches? ☐ Yes ☐ No
Do you have double vision? ☐ Yes ☐ No
Do you have any change in bowel or bladder habits? ☐ Yes ☐ No
Do you have a recent change in vision? ☐ Yes ☐ No
Do you have indigestion/heartburn/acid reflux? ☐ Yes ☐ No
Do you pass out easily (faint)? ☐ Yes ☐ No
Do you have ringing in your ears? ☐ Yes ☐ No
Have you ever had cancer? ☐ Yes ☐ No
Are you losing weight without trying? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No
Do you have any nausea or vomiting? ☐ Yes ☐ No
Do you smoke or did you ever? ☐ Yes ☐ No
If yes, how many packs? ______________ # of years __________
Are you taking any over-the-counter drugs? ☐ Yes ☐ No
Type: ______________________________
Are you taking prescription medications? ☐ Yes ☐ No
Type: ______________________________
____
Do you have a primary care physician (family doctor)? ☐ Yes ☐ No
If yes, who? ______________________________
Are you seeing any other doctor for any reason? ☐ Yes ☐ No
Note: ______________________________

Family History - Did your mother or father have any of the following: Put an **M** for mother, **F** for father, **B** for both.

_______ High blood pressure	_______ Asthma	______ Cancer
_______ Heart attack	_______ Diabetes	______ Osteoporosis
_______ Emphysema	_______ Stroke	______ Thyroid Disease
_______ Seizures/Convulsions	_______ Arthritis	______ Kidney Disease

Surgeries (please list type and year):
____
____

Injuries (fracture, concussion, motor vehicle accident, etc – please include year)
____

Any other comments: ______________________________

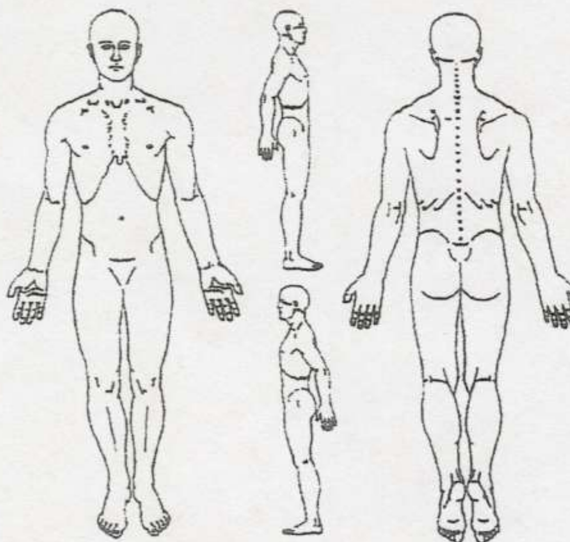
Pain Diagram and Rating

Please number and mark the **severity of pain** you are currently experiencing on a scale from 0 (no pain) to 10 (severe pain).

- Current pain:___ /10   0 1 2 3 4 5 6 7 8 9 10
- Average pain:___ /10   0 1 2 3 4 5 6 7 8 9 10

(Visual Analog Pain Severity Scale)

Please mark on the diagram the location of the pain.



Please describe the **type of pain** or sensation you are currently experiencing. (Check all that apply)

☐ Aching	☐ Shooting
☐ Burning	☐ Stabbing
☐ Cramps	☐ Stiffness
☐ Dull	☐ Swelling
☐ Numbness	☐ Throbbing
☐ Sharp	☐ Tingling

☐ Other, describe it: __________

- When did the pain begin? __________ Any flare-ups since then? If so, when?__________
- What brought the pain on? __________
- The pain ☐ is constant ☐ comes and goes. If it comes and goes, how often does the pain exist? __________
  And for how long? __________
- Does it interfere with your ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Other__________
- Activities or movements that are painful to perform:
  ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐None ☐Other__________
- When and what makes it better? __________
- When and what makes it worse? __________
- Any prior injuries to the area of pain? __________
- Have you seen another healthcare practitioner for the pain/condition? ☐Yes ☐No
  If yes, who? __________

Patient's Name __________ PLEASE PRINT   **Patient's Signature** __________   **Date** __________

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or is physically or legally incapacitated

Patient's Name __________ PLEASE PRINT   **Representative's Name** __________ PLEASE PRINT

Representative's Signature __________   Relationship/Authority to Patient __________

Date Signed __________   Witness __________

Clinician's Name __________ PLEASE PRINT   **Clinician's Signature** __________   **Date** __________

Patient Health Information Consent

- I understand how my Patient Health Information (PHI) is going to be used in this office. I understand and agree to allow Optimal Performance Chiropractic to use my PHI for purpose of treatment, payment, healthcare operations, and coordination of care. As an example, I agree to allow this office to submit requested PHI to the Health Insurance Company (or companies) I provided for the purpose of payment. I understand that the office will limit the release of all PHI to the minimum needed.
- I understand that I have the right to examine and obtain a copy of my own health records at any time and request corrections. I may request what disclosures have been made and submit in writing any further restrictions on the use of my PHI. The office is not obligated to agree to those restrictions.
- I understand my written consent need only be obtained one time for all subsequent care given in this office. I may provide a written request to revoke consent at any time during care. I have the right to file a formal complaint about any possible violations of these policies and procedures. If I refuse to sign this consent for the purpose of treatment, payment, and health care operations, Optimal Performance Chiropractic has the right to refuse care.

Financial Policy

- I understand that if I do NOT have insurance that ALL payments are due at the time of service. If I DO have insurance, ALL COPAYS & CO-INSURANCE are due at the time of service.
- I understand that there will be a 1.5% finance charge added to all balances after 60 days. There will also be a $25.00 charge on all returned checks.
- I understand that if my insurance carrier has not paid a claim within sixty (60) days of submission, I will be required to take an active part in the recovery of this claim. If my insurance carrier has not paid within ninety (90) days of submission, I accept responsibility in full for any outstanding balance.
- I understand Optimal Performance Chiropractic is a busy clinic and that I will be subject to a $25.00 free if I do not give the clinic a 24-hour notice to cancel or re-schedule.
- I understand that if I discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by myself.

Consent to Treatment

- I understand there are some risks associated with treatment including but not limited to, *bone fractures, sprains, strains, vertebral disc injuries, stroke, vascular injury, and bruising.*
- I have had the opportunity to ask questions and receive answers regarding treatments given and the possible risks listed above. I understand I have the opportunity to ask about alternative treatments if I am not comfortable with those recommended by Dr. Gogel.
- I consent to the treatments offered or recommended to me by my healthcare provider, Jenna Gogel, DC, including osseous and soft tissue manipulation, therapeutic modalities, and at-home instruction such as stretches, exercises, and hot/cold application.

Cervical Spine Manipulation (manual adjustments of the neck)

- I understand that there is a risk, though very rare, of cervical spine manipulation (CSM) including those risks listed in italics in the above category.
- I understand that I have the right to deny CSM, ask questions about CSM, and ask for alternative therapy/treatment in place of CSM.

- I understand that the biggest risk factors for vascular injury or stroke following CSM are as follows: black outs, loss of consciousness, nausea, vomiting, general unwell feelings, dizziness or vertigo (particularly if associated with head positioning), disturbances of vision, unsteadiness of gait and

general feelings of weakness, tingling or numbness or any alteration in facial sensation and movements), difficulty in speaking or swallowing, hearing disturbances, headache (particularly if worse than normal or worst ever), past history of trauma, cardiac disease, vascular disease, altered blood pressure, previous stroke or TIA, blood clotting disorders, anticoagulant therapy, oral contraceptives, long term oral steroids, a history of smoking, and immediately postpartum.

- I understand that it is my duty to inform Dr. Gogel of any of these risk factors current, past, or in future visits so that she can determine the appropriate treatment.
- I understand that my condition may change between visits and any new symptoms and risk factors that arise should be verbalized to Dr. Gogel before treatment is given.

I understand that these pages of consent and policies apply for the entire calendar year and that a new consent will be presented at the first visit of each calendar year following.

____

Patient Signature (or Legal Guardian) Date