Welcome to Stone Chiropractic Center, LLC

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining you health.

New Patient Information

Name: ____

Address: ____

City: ________________ State: __________ Zip: ________________

Home Phone: ______-______-_______Work Phone: ______-______-_______ Cell Phone: ______-______-___________

Email Address: ______________________ Occupation: ______________________

Date of Birth: ________________ Social Security #: _______-______-_______ Gender: Male - Female

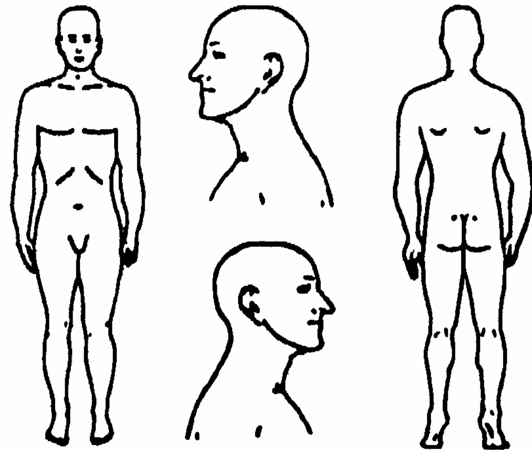
Women: Are you pregnant? ☐ Yes ☐ No If so, how far along? ________________ Nursing? ☐ Yes ☐No

Whom may we thank for referring you?______________________________________

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW

Main reason for consulting the office:

- ☐ Become pain free
- ☐ Explanation of my condition
- ☐ Learn how to care for my condition
- ☐ Reduce symptoms
- ☐ Resume normal activity level



What is your major complaint? ______________________Date problem began? ______________

How did this problem begin (falling, lifting, etc.)? ______________________________

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain

☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: ______________________________

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition (working, exercise, etc)? ______________________

What makes your pain better (ice, heat, massage, etc)? ______________________

Have you ever had chiropractic care? ! No ! yes
When? ____________Why? __________________
Where? ___________________________________
Were X-rays taken? ! No ! Yes
When was your last adjustment? _______________

Date of last physical examination: _________________

Who is your M.D./ General Practitioner _______________________________

Do you smoke? □ No □Yes

Do you drink alcohol? □ No □Yes - how many per day? _________________

Do you drink caffeine? □ No □Yes - how many per day? _________________

Do you exercise? □ No □Yes (what forms and how often): ____

List any **Allergies**:

□ Animals □ Aspirin □ Bees □ Chocolate □ Dairy □ Dust □ Eggs□ Latex □ Molds □ Penicillin □ Ragweed/Pollen

□ Rubber □ Seasonal Allergies □ Shellfish □ Soaps □ Wheat □ X-Ray Dye □ Other: ____________________________

List any **Surgeries**:

□ Back □ Brain □ Elbow □ Foot □ Hip □ Knee □ Neck □ Neurological □ Shoulder □ Wrist □ Other: ______________

____

Check if you have any of the following:

□ Abdomen aneurysm clips	□ Brain aneurysm clips	□ Cardiac pacemaker	□Carotid
□ Dentures	□ Diabetic insulin pump	□ Electrodes	□ Eye prosthesis
□ Permanent eye makeup	□ Harrington rod	□ Hearing aid	□ bypass surgery
□ Heart valve replacement	□ IUD	□ Joint replacement	□ Neurostimulators
□ Past/present metallic in eye	□ Penile prosthesis	□ Presently pregnant	□ Prosthesis
□ Sheet metal occupation	□ Shrapnel	□ Shunt	□ Wire structures
□ Fracture bones treated with metallic implants		□ Please check if none apply to you	

List **ALL** **Past Medical History** conditions:

□ Ankle Pain □ Arm Pain □ Arthritis □ Asthma □ Back Pain □ Broken Bones □ Cancer □ Chest Pain □ Depression

□ Diabetes □ Dizziness □ Elbow Pain □ Epilepsy □ Eye/Vision Problems □ Fainting □ Fatigue □ Foot Pain

□ Genetic Spinal Condition □ Hand Pain □ Headaches □ Hearing Problems □ Hepatitis □ High Blood Pressure

□ Hip Pain □ HIV □ Jaw Pain □ Joint Stiffness □ Knee Pain □ Leg Pain □ Menstrual Problems □ Mid-Back Pain

□ Minor Heart Problem □ Multiple Sclerosis □ Neck Pain □ Neurological Problems □ Pacemaker □ Parkinson’s

□ Polio □ Prostate Problems □ Shoulder Pain □ Significant Weight Change □ Spinal Cord Injury □ Sprain/Strain

□ Stroke/Heart Attack □ Other: ____

List your **Family History**:

☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Cancer ☐ Depression ☐ Diabetes ☐ Epilepsy ☐ Genetic Spinal Condition

☐ High Blood Pressure ☐ Heart Problems ☐ Multiple Sclerosis ☐ Neurological Problems ☐ Parkinson's ☐ Polio

☐ Prostate Problems ☐ Stroke/Heart Attack ☐ Other: ____

Have you had any auto or other accidents? ☐ No ☐Yes

Describe include date and treatment received for injuries incurred: ____________________________________

____

____

What is your **SECOND** complaint? ______________________________Date problem began? ___________________

How did this problem begin (falling, lifting, etc.)? ____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain

☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: ____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition (working, exercise, etc)? ___________________________________

What makes your pain better (ice, heat, massage, etc)? ____

What is your **THIRD** complaint? _________________________________Date problem began? _____________________

How did this problem begin (falling, lifting, etc.)? ____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: ____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? ____

What makes your pain better (ice, heat, massage, etc)? ____

I have reviewed the information on this questionnaire and it is accurate and to the best of my knowledge. I understand that this information will be used by Dr. Stone to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the receptionist at Stone Chiropractic Center, LLC.

I authorize my insurance company to pay Dr. Stone all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Dr. Stone to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature____ **Date** __________________

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, t.e.n.s., cold laser, aqua massage, mechanical massage, adjustor or EB-305, may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million (1/1,000,000) to one in twenty million (1/20,000,000), and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

______________________	______________________	__________
Printed Name	**Signature**	**Date**

WITNESS: Office Use Only

______________________	______________________	__________
Printed Name	**Signature**	**Date**

Authorizations and Releases

Consent for Treatment:

I, the undersigned, hereby authorize Dr. Mark Stone and whom ever he designates, his assistants to perform diagnostic tests, and to administer therapies as is necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.

Patient's Signature: ____ Date: _______________

Consent for Treatment of a Minor:

I hereby authorize Dr. Mark Stone and whom ever he designates, his assistants, to perform diagnostic tests and to administer therapies as he deems necessary to my

___________________________, ________________________.

Indicate relationship of child child's name

Parent's Signature: ____ Date: _______________

sEMG (Surface Electromyography) Waiver

Please be aware that the electromyography examination performed by this office is necessary for your care at Stone Chiropractic Center, LLC., and will not be covered by your insurance company, therefore, it will be your responsibility. The sEMG examination is performed on each patient and must be performed with every new injury, approximately 10th visit and completing treatment. The sEMG measures the amount of electrical activity your muscles release when they are contracting, while standing in a neutral position. This exam provides Dr. Stone with the information he needs to detect and correct the injury that you are presenting with.

Please sign below verifying that you understand your monetary responsibility for service and this fee will be due at the time of service.

Patient's Signature: ____ Date: ______________

Supplements/Supports Waiver

Please be aware that supplements such as cold pack, herbs, vitamins and therapeutic supplies that would be necessary for your care will not be covered by your insurance company and will therefore be your responsibility.

Please sign below verifying that you understand your responsibility for supplements and/or supports that I receive at Stone Chiropractic Center, LLC., and understand that payment is due at time of disbursement of such items.

Patient's Signature: ____ Date: _____________

Agreement for Payment of Services:
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and the any amount authorized to be paid directly to this office will be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I also agree to pay all costs of collection including but not limited to attorney fees.

Patient's Signature: ____ Date: _______________

Parent's Signature: ____ Date: _______________

I understand that the treatment I am about to receive by Dr. Mark Stone, at Stone Chiropractic Center, LLC, is not regarding a PERSONAL INJURY or WORKER'S COMPENSATION CASE.

________________________	________________________	___________
Printed Name	**Signature**	**Date**

WITNESS: Office Use Only

________________________	________________________	___________
Printed Name	**Signature**	**Date**

Stone Chiropractic Center, LLC, Dr. Mark P. Stone,C.C.S.P.,
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