



LARRY W. FULK, D.C. JAIME N. TRENT, D.C. JUSTIN L. FULK, D.C.

Patient Information

Full Name: _____ Today's Date: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail address: _____ Sex: Male Female

Race / Ethnicity: American Indian Alaska Native Asian African American
 Hispanic or Latino Native Hawaiian Other Pacific Islander White

Primary Language: English Spanish Other: _____

Marital: M S W D Birth Date: ____/____/____ Age: _____ Social Security #: _____ - ____ - _____

Do you have children? Yes No What ages? _____

How were you referred to our office?

- Friend/Family Member – Who may we thank: _____
- Yellow Pages Our Sign Newspaper Column Fitness Center Website
- Health Screening Special Promotion: _____ Other: _____

Occupation: _____ Employer: _____

Employer's Address: _____

Spouse: _____ Spouse's Employer: _____

Name of Nearest Relative: _____ Phone: _____

Address: _____

Please check any and all insurance coverage that may be applicable in this case.

- Major Medical Worker's Compensation Medicare Auto Accident Other None

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

As a courtesy, we will file insurance claims for you. It is important to note that your insurance coverage is a contract between you and your insurance company, not our office and your insurance company. This service is provided as a courtesy only and does not substitute for payment. Many insurance companies pay fixed allowances for certain procedures while many others pay a percentage of the charge. "Reasonable and Customary Fees" are determined by your insurance carrier and may vary greatly between carriers. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not covered by your insurance company.**

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers 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 schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

The patient understands and agrees to allow this chiropractic office 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 those records. 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 at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

FULK CHIROPRACTIC & ACUPUNCTURE, LLC - INFORMED CONSENT

The primary treatment used by doctors of chiropractic is the spinal manipulation, sometimes called spinal adjustment.

♦ **Chiropractic Informed Consent:**

Chiropractors use their hands or a mechanical instrument to manipulate your joints. This may cause an audible "pop" or "click," much as you may have experienced when you "crack" your knuckles. You may feel or sense movement.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. 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.

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

♦ **Nutritional Informed Consent:**

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease. A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy. Although, a Vitamin, a Mineral, Trace Element, Amino Acid, or Herb, may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of the eight (8) chemical components of the VSC (Vertebral Subluxation Complex).

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

I have read or have had read to me and I understand the above information. I hereby give my consent to treatments recommended in this office.

DATE _____

_____ Printed Name

_____ Signature

_____ Signature of Parent or Guardian (if a minor)

WITNESS:

_____ Printed Name

_____ Signature



CASE HISTORY

Patient Name: _____

Date: _____

Chief Complaint

What are the symptoms that brought you in to our office? _____

Are your symptoms a result of an accident or injury: Yes No

If "Yes" was the accident/injury related to: Work Auto

Please describe the accident or injury: _____

Have any days of work been lost as a result of your symptoms? Yes No

If "Yes" how many and when? _____

Medical History

Name of your Family Medical Doctor: _____

Medical Doctor Address & Phone No: _____

Date of last physical examination: _____

Findings: _____

Do we have permission to submit reports regarding your care to your MD? Yes No

Past Conditions

Have you had or do you now have any of the following conditions?

C = Currently **P** = Previously

Musculo-skeletal

C P Headaches

C P Neck Pain

C P Back Pain

C P Shoulder Pain

C P Arm Pain

C P Hip Pain

C P Leg Pain

C P Arm/Hand Numbness

C P Muscle Spasms

C P Joint Pain/Swelling

Constitutional

C P Fever

C P Unexplained Weight Loss

C P Unexplained Weight Gain

Eyes/Ears/Nose/Throat

C P Light Bothers Eyes

C P Buzzing in Ears

C P Ringing in Ears

C P Sinus Problems

C P Loss of Smell

C P Loss of Taste

Cardiovascular

C P Chest Pains

C P Chest Tightness

C P High Blood Pressure

C P Problems Breathing

C P Cold Hands

C P Cold Feet

C P Circulatory Problems

C P Stroke

C P Heart Problems

Gastrointestinal

C P Digestive Problems

Genito-urinary

C P Difficulty Urinating

Neurological

C P Nervousness

C P Irritability

C P Dizziness

C P Depression

C P Memory Loss

C P Epilepsy

C P Seizures

C P Convulsions

Other

C P Cancer

C P Rheumatoid Arthritis

C P Osteoarthritis

C P Fatigue

C P Fainting

C P Frequent Colds

C P Diabetes - Type 1

C P Diabetes - Type 2

C P Menstrual Difficulties

C P Sleeping Problems

C P Eating Disorder

C P Alcoholism

C P Drug Addiction

C P HIV Positive

Family Health History

Indicate if any family members have had any of the following conditions?

F = Father **M** = Mother **S** = Sister **B** = Brother

_____ Arthritis	_____ Disc Problems	_____ Scoliosis
_____ Back Pain	_____ Headaches	_____ Sinus Trouble
_____ Cancer	_____ Heart Trouble	_____ Stroke
_____ Diabetes - Type 1	_____ High Blood Pressure	Other: _____
_____ Diabetes - Type 2	_____ Pinched Nerve	_____

Social History

Which of the following most closely describes your smoking history?

- currently - every day currently - some days former smoker never smoked

If you currently smoke, how much: _____ cigarettes/packs per _____ day/wk

- Do you use alcohol? Never Rarely Socially (occasionally)
 Moderately (weekly) Heavily (daily)

- Do you consume caffeine? Never Rarely Occasionally
 Moderately (weekly) Daily

- Do you exercise? No Yes - If yes, how many times per week? _____
If yes, what type? weights aerobics walking/jogging sports
 work other _____

What are your hobbies? _____

What type of bed do you have? _____
How old is the bed? _____ What type of pillow do you use? _____

Current Medications

Current Medication List - include vitamin supplements (inform the front desk if you need more space)

Medication Name	Dosage	Type
EX: Lisinopril	10 mg	Oral Tablet
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Drug/Environmental Allergies: _____

Surgeries

If you have had any major illnesses, injuries, falls, broken bones, surgeries, or accidents, please list them below, and **include dates if possible**. Women, please include information about pregnancies and childbirth. _____

WOMEN ONLY: Is there any possibility you may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ?
Have you: <input type="checkbox"/> Gone through menopause <input type="checkbox"/> Had a hysterectomy

Print Name: _____ Date: _____

Sign Name: _____



NECK DISABILITY INDEX

Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just circle the one choice which closely describes your problem.**

Pain Intensity

- 0 I have no pain at the moment.
- 1 The pain is very mild at the moment.
- 2 The pain is moderate at the moment.
- 3 The pain is fairly severe at the moment.
- 4 The pain is very severe at the moment.
- 5 The pain is the worst imaginable at the moment.

Personal Care (Washing, Dressing etc.)

- 0 I can look after myself normally without causing extra pain.
- 1 I can look after myself normally but it causes extra pain.
- 2 It is painful to look after myself and I am slow and careful.
- 3 I need some help, but manage most of my personal care.
- 4 I need help every day in most aspects of self-care.
- 5 I do not get dressed. I wash with difficulty and stay in bed.

Lifting

- 0 I can lift heavy weights without extra pain.
- 1 I can lift heavy weights, but it gives extra pain.
- 2 Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- 4 I can lift very light weights.
- 5 I cannot lift or carry anything at all.

Reading

- 0 I can read as much as I want to with no pain in my neck.
- 1 I can read as much as I want to with slight pain in my neck.
- 2 I can read as much as I want to with moderate pain in my neck.
- 3 I cannot read as much as I want because of moderate pain in my neck.
- 4 I can hardly read at all, because of severe pain in my neck.
- 5 I cannot read at all.

Headaches

- 0 I have no headaches at all.
- 1 I have slight headaches that come infrequently.
- 2 I have moderate headaches that come infrequently.
- 3 I have moderate headaches that come frequently.
- 4 I have severe headaches that come frequently.
- 5 I have headaches almost all the time.

Concentration

- 0 I can concentrate fully when I want to with no difficulty.
- 1 I can concentrate fully when I want to with slight difficulty.
- 2 I have a fair degree of difficulty in concentrating when I want.
- 3 I have a lot of difficulty in concentrating when I want to.
- 4 I have a great deal of difficulty in concentrating when I want.
- 5 I cannot concentrate at all.

Work

- 0 I can do as much work as I want to.
- 1 I can only do my usual work, but no more.
- 2 I can do most of my usual work, but no more.
- 3 I cannot do my usual work.
- 4 I can hardly do any work at all.
- 5 I cannot do any work at all.

Driving

- 0 I can drive my car without any neck pain.
- 1 I can drive my car as long as I want with slight pain in my neck.
- 2 I can drive my car as long as I want with moderate pain in my neck.
- 3 I cannot drive my car as long as I want because of moderate pain in my neck.
- 4 I can hardly drive my car at all because of severe pain in my neck.
- 5 I cannot drive my car at all.

Sleeping

- 0 I have no trouble sleeping.
- 1 My sleep is slightly disturbed (less than 1 hour sleepless).
- 2 My sleep is mildly disturbed (1-2 hours sleepless).
- 3 My sleep is moderately disturbed (2-3 hours sleepless).
- 4 My sleep is greatly disturbed (3-5 hours sleepless).
- 5 My sleep is completely disturbed (5-7 hours sleepless).

Recreation

- 0 I am able to engage in all recreational activities with no neck pain at all.
- 1 I am able to engage in all recreational activities with some neck pain.
- 2 I am able to engage in most, but not all recreational activities because of pain in my neck.
- 3 I am able to engage in a few of my usual recreational activities because of pain in my neck.
- 4 I can hardly do any recreational activities because of pain in my neck.
- 5 I cannot do any recreational activities at all.

Signature: _____ Date: _____

Disability Index Score: %



LOW BACK DISABILITY INDEX

Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just circle the one choice which closely describes your problem.**

Pain Intensity

- 0 The pain comes and goes and is very mild.
- 1 The pain is mild and does not vary much.
- 2 The pain comes and goes and is moderate.
- 3 The pain is moderate and does not vary much.
- 4 The pain comes and goes and is severe.
- 5 The pain is severe and does not vary much.

Personal Care

- 0 I would not have to change my way of washing or dressing in order to avoid pain.
- 1 I do not normally change my way of washing or dressing even though it causes some pain.
- 2 Washing and dressing increase the pain, but I manage not to change my way of doing it.
- 3 Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- 4 Because of the pain, I am unable to do some washing and dressing without help.
- 5 Because of the pain, I am unable to do any washing or dressing without help.

Lifting

- 0 I can lift heavy weights without extra pain.
- 1 I can lift heavy weights, but it gives extra pain.
- 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
- 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- 4 I can lift very light weights.
- 5 I cannot lift or carry anything at all.

Walking

- 0 Pain does not prevent me from walking any distance.
- 1 Pain prevents me from walking more than one mile.
- 2 Pain prevents me from walking more than 1/2 mile.
- 3 Pain prevents me from walking more than 1/4 mile.
- 4 I can only walk while using a cane or crutches.
- 5 I am in bed most of the time and have to crawl to the toilet.

Sitting

- 0 I can sit in any chair as long as I like without pain.
- 1 I can only sit in my favorite chair as long as I like.
- 2 Pain prevents me from sitting more than one hour.
- 3 Pain prevents me from sitting more than 1/2 hour.
- 4 Pain prevents me from sitting more than 10 minutes.
- 5 Pain prevents me from sitting at all.

Standing

- 0 I can stand as long as I want without pain.
- 1 I have some pain while standing, but it does not increase with time.
- 2 I cannot stand for longer than one hour without increasing pain.
- 3 I cannot stand for longer than 1/2 hour without increasing pain.
- 4 I can't stand for more than 10 minutes without increasing pain.
- 5 I avoid standing because it increases the pain.

Sleeping

- 0 I get no pain in bed.
- 1 I get pain laying in bed, but it does not prevent me from sleeping.
- 2 Because of pain, my normal night's sleep is reduced by less than one-quarter.
- 3 Because of pain, my normal night's sleep is reduced by less than one-half.
- 4 Because of pain, my normal night's sleep is reduced by less than three-quarters.
- 5 Pain prevents me from sleeping at all.

Social Life

- 0 My social life is normal and gives me no pain.
- 1 My social life is normal, but increases my degree of pain.
- 2 Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- 3 Pain has restricted my social life and I do not go out very often.
- 4 Pain has restricted my social life to my home.
- 5 I have hardly any social life because of the pain.

Traveling

- 0 I get no pain while traveling.
- 1 I get some pain while traveling, but none of my usual forms of travel make it any worse.
- 2 I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- 3 I get extra pain while traveling which compels me to seek alternative forms of travel.
- 4 Pain restricts me from all forms off travel.
- 5 Pain prevents all forms of travel except that done lying down.

Changing Degree of Pain

- 0 My pain is rapidly getting better.
- 1 My pain fluctuates, but overall is definitely getting better.
- 2 My pain seems to be getting better, but improvement is slow at present.
- 3 My pain is neither getting better nor worse.
- 4 My pain is gradually worsening.
- 5 My pain is rapidly worsening.

Signature: _____ Date: _____

Disability Index Score: %