ABOUT THE PATIENT

Name_____ Today's Date _____

Birthdate _____ Age _____ Gender: M F Marital Status: S M D W

Cell Phone _____ E-Mail Address _____

Address_____ City _____ State_____ Zip _____

Significant Other's Name _____ Kids' Names and Ages _____

Your Employer _____ Type of Work _____

Emergency Contact _____ Phone Number _____

Have you been to a chiropractor before? Y N How do you hear about us? _____

Name of Medical Doctors _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Oshkosh Spine Wellness Center to release and/or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is : Cash Check Credit Card Car/Work Insurance

Patient/Parent Signature _____ Date _____

REASONS FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ **How long has this been an issue?** _____
   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____
2. _____ **How long has this been an issue?** _____
   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____
3. _____ **How long has this been an issue?** _____
   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____
4. _____ **How long has this been an issue?** _____
   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. **Does your condition affect:** ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

_____

6. **What makes it better?**_____
7. **What makes it worse?** _____
8. **What Doctor's have you seen for this?**_____

_____

9. **Type of treatment:**_____
10. **Results:** _____

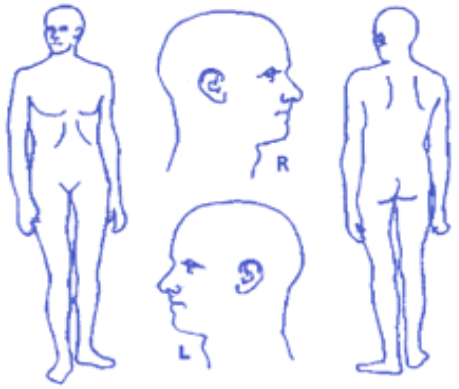
NOTES: _____

_____

_____

Are you pregnant?
❑ Yes ❑ No

Please mark All areas of concern.



INFORMED CONSENT

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication.

_____ **Date**_____

Print Patient's Name

_____

Patient's Signature or (Parent or Legal Guardian)

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Name _____ **Date**_____

Print Patient's Name

By _____

Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By _____

Signature of Parent/Guardian (circle one)

OSHKOSH SPINE WELLNESS CENTER

David Augustine, DC
314 N Koeller St Oshkosh, WI 54902 (920) 235-0000

REVIEW OF SYSTEMS

Name_____ **Date** _____

Please write in a number:

1. Presently have **2. Previously had** **3. Related to an accident (date_____)**

GENERAL
1. ____Allergy
2. ____Chills
3. ____Convulsions
4. ____Dizziness
5. ____Fainting
6. ____Fatigue
7. ____Fever
8. ____Headache
9. ____Sleep loss
10. ____Weight loss
11. ____Nervous/Depress
12. ____Neuralgia
13. ____Numbness
14. ____Sweats
15. ____Tremors

EYES,EARS, NOSE THROAT
16. ____Asthma
17. ____Colds
18. ____Sore throat
19. ____Deafness
20. ____Dental Decay
21. ____ Earache/noises
22. ____Ear Discharge
23. ____Sinus Infection
24. ____Enlarged glands
25. ____Enlarged thyroid
26. ____Nose bleeds
27. ____Failing vision
28. ____Far sighted
29. ____Gum trouble
30. ____Hay fever
31. ____Hoarseness
32. ____Nasal obstruction
33. ____Near sighted

MUSCULOSKELETAL
34. ____Arthritis
35. ____Bursitis
36. ____Foot Trouble
37. ____Hernia
38. ____Low Back Pain
39. ____Lumbago
40. ____Neck pain/stiff
41. ____Shoulder blade pain

PAIN OR NUMBNESS IN:
42. ____Shoulders
43. ____Arms
44. ____Elbows
45. ____Hands
46. ____Hips
47. ____Legs
48. ____Knees
49. ____Feet
50. ____Painful tailbone
51. ____Poor Posture
52. ____Sciatica
53. ____Spinal curvature

GENITO-URINARY
54. ____Bedwetting
55. ____Blood in urine
56. ____Freq urination
57. ____Inability to control bladder
58. ____Kidney infection
59. ____Painful urination
60. ____Prostate trouble
61. ____Pus in urine
62. ____Painful menstruation
63. ____Hot Flashes
64. ____Irregular cycle
65. ____Lumps in breasts
66. ____Bladder infection

CARDIOVASCULAR
67. ____Hardening of arteries
68. ____High Blood pressure
69. ____Low Blood pressure
70. ____Pain over heart
71. ____Poor circulation
72. ____Rapid heart beat
73. ____Slow heart beat
74. ____Swelling of ankles

RESPIRATORY
75. ____Chest pain
76. ____Chronic cough
77. ____Difficult breathing
78. ____Spitting up blood
79. ____Spitting up phlegm
80. ____Wheezing

GASTROINTESTINAL
81. ____Belching or gas
82. ____Colitis
83. ____Colon trouble
84. ____Constipation
85. ____Diarrhea
86. ____Difficult digestion
87. ____Distention of abdomen
88. ____Excessive hunger
89. ____Gall Bladder trouble
90. ____Hemorrhoids
91. ____Intestinal worms
92. ____Jaundice
93. ____Liver trouble
94. ____Nausea
95. ____Pain over stomach
96. ____Poor appetite
97. ____Vomiting
98. ____Vomiting blood

OTHER: