

## ABOUT THE PATIENT

Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Marital Status: \_\_\_\_\_ Gender  M  F Significant Other's Name \_\_\_\_\_  
 Have you been to a chiropractor before?  No  Yes When was your last Chiropractic Appointment? \_\_\_\_\_  
 Your Employer \_\_\_\_\_ Type of Work \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_ Who Referred you to us? \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Ph # \_\_\_\_\_  
 Name of Medical Doctor(s) \_\_\_\_\_

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize 614 Chiropractic 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 the patient? \_\_\_\_\_
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- Understand that your health information is protected by the Health Insurance Portability and Accountability Act of 1996. If you have any questions, please talk to the front desk.
- For my balance my preferred payment method is:  Cash  Check  Credit Card  Car/Work Ins.

\_\_\_\_\_  
Patient / Parent Signature

(This represents a long term authorization for all occasions of service)

\_\_\_\_\_  
Date

## REASON 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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

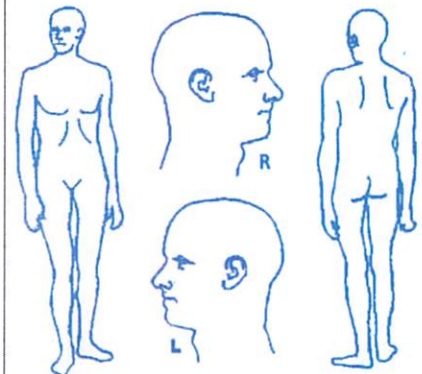
Are you pregnant?

Yes  No

How far along? \_\_\_\_\_

Due Date: \_\_\_\_\_

Please mark all areas of concern.



# GENERAL HEALTH HISTORY

Patient Name \_\_\_\_\_ *Mark the conditions that apply to you.*

Past Present

- Headaches
- Migraines
- Shortness of Breath
- Allergies / Asthma
- Medication Side Effects
- Diabetes
- Hands or Feet cold
- Muscle aches
- Trouble Walking
- Leg / Foot Numbness
- Fainting
- Gall Bladder Trouble
- Ringing in Ears
- Ear Problems
- Sleeping Problems
- Vision Problems
- Thyroid Problems
- Liver Disease
- Kidney Problems
- Light Bothers Eyes
- Other \_\_\_\_\_

Past Present

- Urinary Problems
- Easy Bruising
- Tobacco Use
- Dental Problems
- Fibromyalgia
- Blood Thinner use
- HIV Positive
- Cancer
- Depression
- Alcohol Use
- \_\_\_ High or \_\_\_ Low Blood Pressure
- Stroke History
- High Cholesterol
- TMJ
- Digestive Problems
- Pain all Over
- Tension / Irritability
- Chest Pains
- Heart Pacemaker
- Heart Problems

1. List any medications you are taking: \_\_\_\_\_
2. Please list all doctors you are currently seeing: \_\_\_\_\_
3. Has any Doctor or other professional advised you to "Go to a Chiropractor ":  No  Yes, Name \_\_\_\_\_

## PAST HISTORY

4. List any past auto collisions: \_\_\_\_\_ Was any care received? \_\_\_\_\_
5. List any past work injuries: \_\_\_\_\_ Was any care received? \_\_\_\_\_
6. List any past sport, recreational, or home injuries \_\_\_\_\_
7. Please describe any past conditions and treatment received: \_\_\_\_\_
8. Please list any past hospitalizations and surgeries: \_\_\_\_\_

## FAMILY HISTORY

- Father's side:  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_
- Mother's side:  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_
- Is there any other family history you want us to know? \_\_\_\_\_

# Paying for your care is easy here!



## Initial which one is you:

**No Insurance:**

- Easy! Our Chiropractic, Decompression Care Plans and simple payment arrangements have helped over 2500 people and will work great for you too!
- Insurance pays very little and maybe not at all for necessary services like Lasik, or necessary cosmetic surgery or our incredible Decompression & SoftWave Tissue Regeneration protocols.

Initial \_\_\_\_\_

**Health Insurance:**

- These days, insurance pays very little if anything for natural drugless care to get you healthy. So we make it easy!
- We will verify any benefits you may have and send your claims in to your insurance for you.
- If they pay anything after your deductible is met, we will accept payment directly from them.
- You are responsible for any deductible, co-insurance, co-pays and unpaid visits.
- Of course you can use your HSA, HRA and Flex dollars here!
- For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.

Initial \_\_\_\_\_

**Auto Injury**

- Most Auto related injuries are covered 100% in Ohio for patients not at fault. You can get the care you need and it normally costs nothing. Great for you!
- All we need is your claim number and insurance information.

Initial \_\_\_\_\_

**Medicare**

- Medicare pays for much of your care making it quite easy.
- We simply need a copy of your Medicare card.
- Medicare supplements normally don't pay anything.

Initial \_\_\_\_\_

**You have made a great decision to get care here!**  
***Our goal is to be your family chiropractor for life!***

## ***Informed Consent***

### **Section 1: Informed Consent for Chiropractic Care**

We are committed to providing you with safe, effective, and natural chiropractic care. Please read this form carefully.

**What is Chiropractic Care?** Chiropractic care at our office, provided by Dr. Nicholas Esser, focuses on gentle, specific adjustments to the spine and other joints to improve alignment, movement, and overall function.

#### **What to Expect During Your Care:**

- Thorough health history and physical exam (posture, movement, muscle strength, etc.).
- X-rays may be recommended.
- Personalized care plan that may include adjustments, soft tissue therapies, exercises, or referrals if needed.

#### **Benefits of Chiropractic Care:**

- Reduced pain or discomfort in back, neck, or joints
- Improved mobility, flexibility, and posture
- Enhanced overall wellness, energy, and physical performance

**Understanding Rare Risks:** Chiropractic care is very safe, but like any healthcare approach, there are rare risks:

- Temporary soreness or discomfort after adjustments
- In very rare cases, minor muscle or ligament strain
- Extremely rare risks involving neck adjustments (estimated at less than 1 in 1 million)

#### **What Happens if You Choose Not to Pursue Care?**

You may continue to experience discomfort, limited mobility, or other symptoms. Untreated issues could worsen over time.

**Other Care Options:** Rest, over-the-counter pain relievers, physical therapy, medications, injections, or surgery.

### **Section 2: SoftWave (ESWT) Suitability Questions**

Please **answer** the following to help us determine if SoftWave Tissue Regeneration is appropriate for you:

- Have you been injected with cortisone this month? Yes / No
- Have you been diagnosed with cancer/tumor within the last 12 months? Yes / No
- Have you been diagnosed with a skin infection in the last 12 months? Yes / No
- Are you pregnant or do you suspect you may be pregnant? Yes / No
- Are you under 16 years of age? Yes / No

**Our Commitment to You** We adhere to the highest professional standards to ensure your care is safe and effective. Our goal is to support your health naturally and respectfully.

### **Section 3: Decompression Suitability**

Please **circle** any that apply to you:

- Pregnant • Metal implants in spine • Advanced Osteoporosis • Hernia • Blood Thinners • Spinal Fusion • Fractured or Broken Vertebra • Failed Back Surgery • Tumor • Cardiac or Pulmonary Disease • Abdominal Aortic Aneurysm
- Other (related to today's treatment):  
\_\_\_\_\_

#### **Your Rights and Responsibilities:**

**Your Right to Choose:** You can stop or modify your care plan at any time. Just let us know what you're comfortable with.

**Your Responsibility:** Please share all relevant health information (e.g., past injuries, medical conditions, or medications) to help us provide the safest and most effective care.

**Photos and Text Reminders:** By signing this form, you also agree to the following (please cross out any that you want to opt out of):

**Photos for Social Media:** I allow my image to be shared on 614 Chiropractic LLC's social media or website for positive, professional purposes (e.g., celebrating patient milestones). I understand I may request removal of my photo at any time.

**Text Appointment Reminders:** I agree to receive text reminders for my appointments to help me stay on track.

**Your Consent:** By signing below, I confirm that: I have read and understood this form, and my questions have been answered to my satisfaction. I understand the benefits, rare risks, and alternatives to chiropractic care.

I consent to the recommended care plan for my current condition and any future conditions I seek treatment for at 614 Chiropractic LLC.

I understand I can stop or change my care plan at any time.

**Patient Name (Printed):**

\_\_\_\_\_

**Patient Signature:**

\_\_\_\_\_

**Date:** \_\_\_\_\_

**Parent/Guardian Name (if applicable):**

\_\_\_\_\_

**Parent/Guardian Signature:**

\_\_\_\_\_

**Date:** \_\_\_\_\_

