Damron Chiropractic & Wellness
3187 Western Row Road Suite 114
Maineville, OH 45039

Welcome to our office! Please complete the following questionnaire as thoroughly as possible. This confidential history will be part of your permanent records and will help us get a better understanding of your overall health. Thank you!

Today's Date: _____

Name**:** _____ I prefer to be called/nickname: _____

Home Address: _____ City: _____ St: _____ Zip: _____

Primary phone #:_____Secondary phone #: _____

SSN# _____ Date of Birth: _____ Age: _____ □ Male □ Female

Email Address: _____ □ Single □ Married □ Divorced □ Widowed □ Partner

Employer: _____ Occupation: _____

Primary Care Doctor name and location:_____ Date of last physical: _____

May we communication our findings on your current health condition to the above provider □ YES □ NO

How did you hear about us? □ Online □ Drive By / Sign □ Friend and/or Patient □ Other: _____

If referred by a friend or patient, whom may we thank for your referral? _____

Emergency Contact:
Name: _____ Phone #: _____ Relation: _____

Have you ever been to a chiropractor before? □ Yes □ No If so, when was your last visit? _____
Name of your last chiropractor's office _____ Reason for care_____
How long were you under care? _____
Have you seen any other professionals for your current symptoms? _____

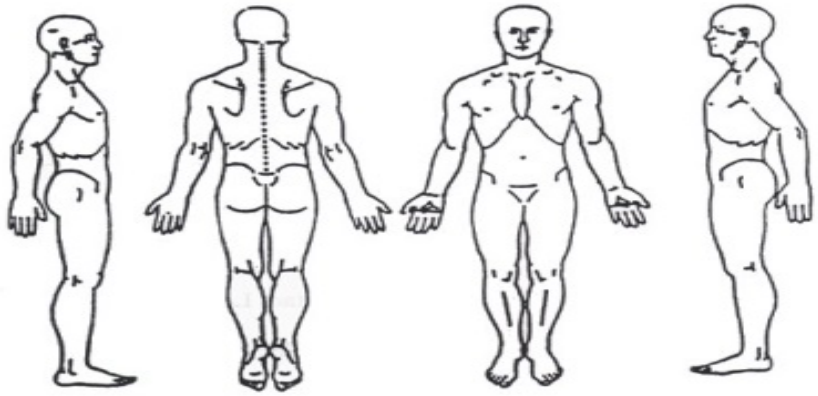
Social History:
Height: ___ feet ____ inches Current Weight: _____ lbs Have you recently gained/lost more than 10 lbs? Y N
Desk/Sedentary Work: □ Heavy □ Moderate □Light Hours per day: ____
Physical Work: □Heavy □ Moderate □Light Hours per day: ____
Exercise Frequency: □ Never □ Daily □ Weekly □ Multi-Weekly □ Monthly Type: _____
Smoking: □ Never □ Currently □ Previously Packs/day_____ Packs/week_____ How long? _____
Alcohol: Beers/week: _____ Liquor/week: _____ Wine/week: _____ How long? _____
Caffeine: Cups/day: _____ How long? _____ Pain Reliever: #/day _____ How long? _____ Type: _____

Please List Any Prescription and/or Over-The-Counter Medications You Are Presently Taking:
_____
_____
_____

Please List All Illnesses, Surgeries, Auto Accidents (Minor & Major), and/or Work Injuries & the Year in Which They Occurred:
_____
_____
_____

Current Complaints

Body Diagram – Please Circle or Mark the Area(s) You are Experiencing Discomfort or Pain:



Location of Main Complaint: _____

Level of pain on a scale of 0 -10 *(0 being no pain to 10 being severe pain):* _____

How long have you had this condition? □ < 1 Month □ 1-3 Months □ >3 Months

How would you describe the pain? (Mark all that apply)

□ Dull □ Throbbing □ Spasm □ Sharp □ Burning □ Stinging □ Aching
□ Numbing □ Shooting □ Cutting □ Tingling □ Pounding □ Cramping □ Other: _____

Does the pain move or radiate to other areas? *(Ex: Neck pain radiates down the right arm)* _____

Mark which action relieves or aggravates the pain: *R = Relieves A = Aggravates (Mark all that apply)*

_____ Bending Forward _____ Bending Back _____ Bending Left _____ Bending Right
_____ Twisting Left _____ Twisting Right _____ Coughing _____ Sneezing
_____ Standing _____ Sitting _____ Lifting _____ Walking

Which of the following do you have difficulty doing because of the pain?

□ Lifting objects less than 10 pounds
□ Lifting objects more than 10 pounds
□ Exercising, working out, running, physical activity
□ Pushing objects while seated or standing
□ Pulling objects while seated or standing
□ Hobbies you enjoy *(Dancing, Sports, Swimming, Bowling, Skiing, Etc.)*
□ Driving for short or long distances
□ Concentrating
□ Grasping, Holding, or Pinching
□ Loss of Sensation
□ Being able to have a normal, restful night's sleep
□ Climbing stairs

Other Health Complaints:

1: _____ Pain Scale 1-10: _____

2: _____ Pain Scale 1-10: _____

3: _____ Pain Scale 1-10: _____

4: _____ Pain Scale 1-10: _____

5: _____ Pain Scale 1-10: _____

Medical History – ***Please Mark All That Apply***

Concussion	□ Currently	□ Past	**Foot Pain**	□ Currently	□ Past	**Multiple Sclerosis**	□ Currently	□ Past
Dizziness	□ Currently	□ Past	**Tingling**	□ Currently	□ Past	**Parkinson's**	□ Currently	□ Past
Arthritis	□ Currently	□ Past	**Numbness**	□ Currently	□ Past	**Seizures**	□ Currently	□ Past
Headaches	□ Currently	□ Past	**Carpal Tunnel**	□ Currently	□ Past	**Strokes**	□ Currently	□ Past
Jaw Pain/Locking	□ Currently	□ Past	**Fibromyalgia**	□ Currently	□ Past	**Urinary Problems**	□ Currently	□ Past
Disc Problems	□ Currently	□ Past	**Plantar Fasciitis**	□ Currently	□ Past	**Cancer**	□ Currently	□ Past
Diabetes	□ Currently	□ Past	**Whiplash**	□ Currently	□ Past	**Heart Problems**	□ Currently	□ Past
Neck Pain	□ Currently	□ Past	**Dislocations**	□ Currently	□ Past	**Chest Pain**	□ Currently	□ Past
Mid-Back Pain	□ Currently	□ Past	**Fractures**	□ Currently	□ Past	**Rashes**	□ Currently	□ Past
Lower Back Pain	□ Currently	□ Past	**Osteoporosis**	□ Currently	□ Past	**Joint Pain/swelling**	□ Currently	□ Past
Shoulder Pain	□ Currently	□ Past	**Alzheimer's**	□ Currently	□ Past	**Asthma**	□ Currently	□ Past
Hip Pain	□ Currently	□ Past	**Shingles**	□ Currently	□ Past	**Ear Infections**	□ Currently	□ Past
Knee Pain	□ Currently	□ Past	**Memory Loss**	□ Currently	□ Past	**HIV/AIDS**	□ Currently	□ Past
Sensitive to Light	□ Currently	□ Past	**Thyroid Problem**	□ Currently	□ Past	**High Cholesterol**	□ Currently	□ Past
Sensitive to Sound	□ Currently	□ Past	**Fatigue**	□ Currently	□ Past	**Sleep Problems**	□ Currently	□ Past
Visual Problems	□ Currently	□ Past	**Trouble with Balance**	□ Currently	□ Past			
Hearing Problems	□ Currently	□ Past						

Family History:

Relative	**Age if Living**	**Age if Dead**	**Cause of Death**	**State of Health**	**Illnesses**
Father:	_____	_____	_____	_____	_____
Mother:	_____	_____	_____	_____	_____
Brother(s):	_____	_____	_____	_____	_____
Sister(s):	_____	_____	_____	_____	_____
Grandmother (mat):	_____	_____	_____	_____	_____
Grandfather (mat):	_____	_____	_____	_____	_____
Grandmother (pat):	_____	_____	_____	_____	_____
Grandfather (pat):	_____	_____	_____	_____	_____

Spouses heath status: □ Poor □ Fair □ Good □ Excellent

Children's ages and health status:

_____

_____

Insurance/Billing Information:

Do you have medical insurance □ Yes □ No

Insurance Company Name: _____

Insured's Name _____

Relationship to the patient _____

Insured's Date of Birth _____

Insured's SSN # _____

Insured's Employer _____

Insured's Employee Address _____

Do you have secondary insurance? □ Yes □ No

Insurance Company Name _____

Informed Consent to Chiropractic / Massage Therapy / Rehabilitation Therapy & Treatment

- Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are some risks associated with such treatment. In particular, you should note: While extremely rare, some patients may experience short-term aggravation of symptoms, rib fractures, or muscle or ligament strains/sprains as a result of manual therapy techniques; and there are very few reported cases of stroke associated with common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of a stroke. Furthermore, the apparent association is noted very infrequently. However, you are being made aware of this possible association as a stroke sometimes causes serious neurological impairment, and by on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote; and there are rare reported cases of disc injuries following cervical and lumbar spinal adjustments although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.
- Chiropractic treatment, including spinal adjustments, consists of procedures that involve moving the joints and soft tissues, called manipulations or adjustments. I understand that there may be benefits from these treatments including lessened pain, reduced numbness, reduction of muscle spasms, and increased mobility. Chiropractic care can contribute to my overall well-being, but it is not certain that I will achieve these benefits through chiropractic care. I recognize that chiropractic care is not different from other health care in that Damron Chiropractic & Wellness LLC has not and cannot guarantee a cure or certain outcomes as a result of these procedures. I also acknowledge I will be treated by either Dr. Andrew Damron and / or a practicing Dr. employed by Damron Chiropractic & Wellness LLC. I hereby give Dr. Damron and / or a practicing Dr. employed by Damron Chiropractic & Wellness LLC permission to review my medical file and treat as they see fit.
- I am physically sound and have medical approval to proceed with a normal routine of exercise, and all exercise shall be undertaken by me at my sole risk. I am in good health and have no physical condition that would be aggravated by my involvement in cardiovascular exercise, weight lifting, weight training, and/or body building, nor do I have any physical limitations that would preclude said involvement.
- I agree that I am responsible for any damages caused by myself to Damron Chiropractic & Wellness and its facilities and equipment, and for any personal injury or property damage caused by member to any Damron Chiropractic & Wellness member, guest, or to the property of either and member agrees to indemnify and hold Damron Chiropractic & Wellness harmless of any loss caused by myself for which Damron Chiropractic & Wellness is accused or held liable including attorney's fee and court costs.
- I certify that I realize the risk of cardiovascular exercise, weight lifting, weight training , and/or body building and am fully aware of the possibility of mechanical and/or other negligence of cardiovascular equipment, weight machines, weight training, and/ or apparatus ("equipment"), whether or not due to the negligence of Damron Chiropractic & Wellness or otherwise, as well as the possibility of injury to me as a results of use of such equipment. I therefore fully understand the serious consequences which might result due to my involvement in cardiovascular exercise, weight lifting, weight training, and/or body building while at Damron Chiropractic & Wellness or their respective trustees, staff, officers, directors, members, managers, shareholders, and agents from my use of Damron Chiropractic & Wellness facilities and it's equipment.
- I am forewarned that Damron Chiropractic & Wellness will not in any event provide medical and/or hospitalization insurance for my benefit, and in the event of any injury to my person occurring either as a result of being on any portion of the premises of Damron Chiropractic & Wellness, I hold harmless and keep indemnified Damron Chiropractic & Wellness and their respective trustees, beneficiaries, staff, officers, directors, shareholders, and agents from and against any and all legal actions, claims, costs, expenses, or demands, in respect of such injury or injuries, howsoever caused arising out of or in connection with any use of the Damron Chiropractic & Wellness facilities or my being on any portion of said premises and notwithstanding that the same may have contributed to or may be caused by my negligence of Damron Chiropractic & Wellness, and its respective staff, representatives, agents, officers, directors, members, shareholders, trustees, or beneficiaries.
- If at any point during the session I feel uncomfortable or uneasy with the techniques being incorporated, and/or if I experience any pain, I understand it is my responsibility to IMMEDIATELY inform the personnel, so that the techniques can be adjusted to a level of comfort, or terminated if necessary.
- I understand that massage therapy is the treatment of disorders of the human body by the manipulation of soft tissue through the systematic external application of massage techniques including touch, stroking, friction, vibration, kneading, stretching, compression, and joint movements with the external application of water, heat, cold, topical preparations, and certain mechanical devices. If at any point during the massage I feel uncomfortable or uneasy with the procedures being administered, or if I feel pain, I understand that it is my responsibility to IMMEDIATELY inform the massage therapist, so the procedure can be adjusted or terminated if necessary.
- I understand that massage therapy is not a substitute for diagnosis, medical treatment, or medication. Any communication by the therapist to me is not a substitute for the advice of any licensed doctor. I understand the therapist does not diagnose illness or disease, prescribe medication, and that under the Massage Therapy Scope of Practice (OH Revised Code 4731.15 and Administrative Code 4731-1-05 (F) does not include: application of ultrasound, diathermy, electrical stimulation, colonic irrigation, the practice of chiropractic, force applied to a joint to break capsular adhesions, prescriptions of therapeutic exercise, treatment of infectious, contagious, or venereal diseases; prescription, dispensing, personally furnishing, or administration of drugs; and the performance of surgery or practice of medicine in any other form.
- I have informed the massage therapist of all my known physical conditions, medical conditions, and medications both past and present. I will notify the massage therapist about any changes in my health since my last visit. I agree to pay the agreed upon amount in this session and future sessions. **I agree to pay the $35 cancellation fee should I cancel within at least 24-hour's notice.**

I have read, or have had read to me, this consent. I acknowledge I have discussed, or have had the opportunity to discuss, with Dr. Damron and / or a practicing Dr. employed by Damron Chiropractic & Wellness LLC the nature and purpose of chiropractic treatment in general, and my treatment in particular (spinal adjustment), as well as the contents of this Consent. Any questions that I have had have been answered to my satisfaction. By signing below, I consent to the chiropractic treatments offered or recommended to me by Dr. Damron, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care at Damron Chiropractic & Wellness LLC.

*****IF MINOR CHILD PLEASE PRINT MINOR'S NAME ON THIS LINE**

PLEASE PRINT _____ **DATE OF BIRTH:** _____

Last Name, First

X _____ _____

Patient's Signature Date

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

X _____ _____

Patient's Signature Date

Notice of Privacy Practices

Damron Chiropractic & Wellness is required by law to maintain the privacy and confidentiality of your protected health information. If you would like a copy of our privacy practices you can request one at any time. By signing below, you acknowledge that you have had the opportunity to read the Privacy Notice. By way of my signature I provide Damron Chiropractic & Wellness with my authorization and consent to use and disclose my protected health information for the purposes.

X _____ _____

Patient's Signature Date

Authorization to Treat / Authorization to Release Information

I hereby give my authorization/consent to treat me or my minor child as named herein on this form. Our office policy requires payment in full for all services and goods rendered at the time of your visit to the office, unless other arrangements have been made. I clearly understand and agree that all services and goods rendered to me are charged directly to me and that I am personally responsible for payment. I hereby authorize payment of any and all benefits, medical or otherwise, to the physician for benefits due me for the services and/or goods rendered. I further authorize the physician, facility, and/or supplier to release any information it deems necessary as required to process my claims or requested by any 3rd party that has a direct or indirect interest in the claim or treatment. **I understand the above information in its entirety and hereby guarantee that this form was completed accurately to the best of my knowledge. I also understand that it is my responsibility to inform this office, in a timely manner, of any and all changes to this information.**

X _____ _____

Patient Signature Date

X-Ray Pregnancy Release –***Women Only***

This is to certify that, to the best of my knowledge, I am not pregnant and this office has my permission to take any necessary x-rays. If I have had a hysterectomy or tubal ligation, or are presently in menopause or post-menopause, I will assume all responsibility for any effect on a fetus potentially present. I may be presently using birth control pills or an IUD as a method of birth control, or I am within 10 days of the onset of my menstrual cycle, and assume all responsibility with regards to a potential fetus. If I am not using birth control pills, or not within the first 10 days after the onset of my last menstrual cycle, I will assume all responsibility for any effect on a fetus potentially present. If this information changes at any point in the future I will notify the office.

X _____ _____

Patient Signature Date