DAMRON
CHIROPRACTIC & WELLNESS
Chiropractic | Rehab | Massage | Nutrition

3187 Western Row Road, Suite 114 · Maineville, OH 45039 · (513) 770-3434 · damronchiropractic.com

Welcome! Please fill this out as completely as you can. It becomes part of your confidential record and helps us understand your whole health, not just what hurts today. If anything is unclear, just ask us...we're glad to help!

PATIENT INFORMATION

TODAY'S DATE _____

FULL NAME (FIRST, LAST) _____

PREFERRED NAME _____ SEX ☐ M ☐ F

DATE OF BIRTH _____ AGE _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

PRIMARY PHONE _____ SECONDARY PHONE _____

EMAIL _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

EMPLOYER _____ OCCUPATION _____

PRIMARY CARE DOCTOR — NAME & LOCATION _____

DATE OF LAST PHYSICAL _____

May we share findings about your health with your primary care doctor? ☐ Yes ☐ No

How did you hear about us?

☐ Google search ☐ Google Maps ☐ Facebook / Instagram ☐ Friend, family or patient
☐ Drive by / our sign ☐ Community event ☐ Insurance / provider list ☐ Other

IF A FRIEND OR PATIENT REFERRED YOU, WHO CAN WE THANK? _____

EMERGENCY CONTACT

NAME _____ PHONE _____

RELATIONSHIP TO YOU _____

CHIROPRACTIC & CARE HISTORY

Have you been to a chiropractor before? ☐ Yes ☐ No

PREVIOUS CHIROPRACTOR / OFFICE _____ WHEN WAS YOUR LAST VISIT? _____

REASON FOR THAT CARE _____

HOW LONG WERE YOU UNDER CARE? _____

ANYONE ELSE YOU'VE SEEN FOR YOUR CURRENT SYMPTOMS? IF SO, WHO? _____

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SOCIAL HISTORY

HEIGHT (FT / IN) _____ CURRENT WEIGHT (LBS) _____

Recently gained or lost more than 10 lbs? ☐ Yes ☐ No

Desk / sedentary work: ☐ Heavy ☐ Moderate ☐ Light Hours per day: _____

Physical work: ☐ Heavy ☐ Moderate ☐ Light Hours per day: _____

Exercise: ☐ Never ☐ Daily ☐ Weekly ☐ Multi-weekly ☐ Monthly Type: _____

Smoking: ☐ Never ☐ Currently ☐ Previously Amount / how long: _____

Alcohol per week: Beer _____ Liquor _____ Wine _____ Caffeine per day: _____

Pain reliever: #/day _____ How long? _____ Type: _____

Prescription and/or over-the-counter medications you take now:

_____

_____

Illnesses, surgeries, auto accidents, or work injuries — and the year each happened:

_____

_____

Anything else you'd like us to know before we begin? (goals, concerns, what a good outcome looks like for you)

_____

_____

_____

_____

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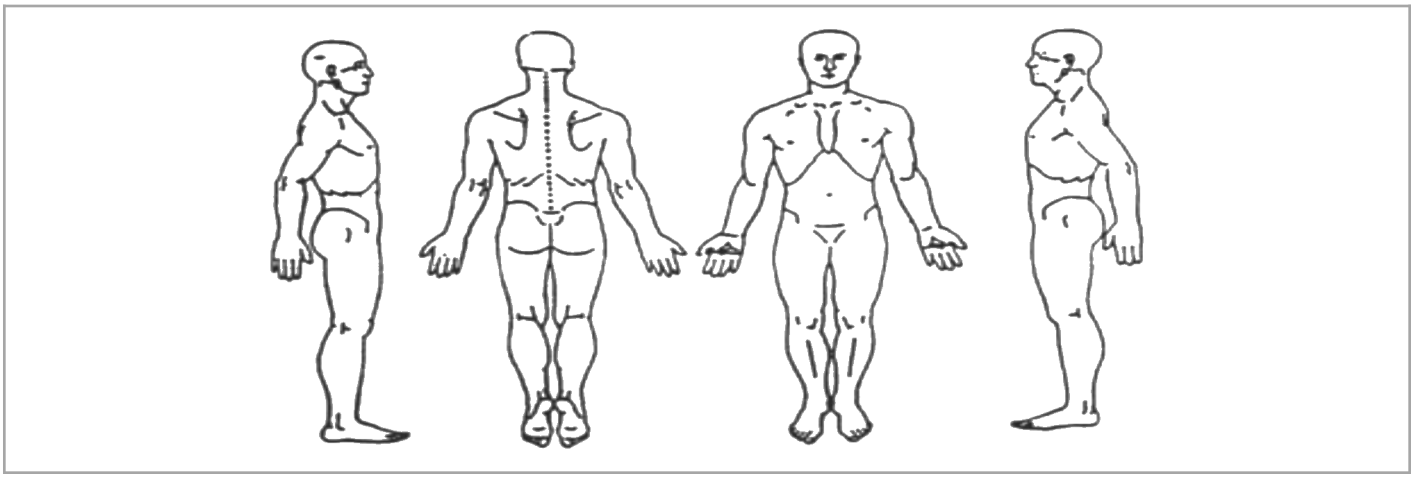
CURRENT COMPLAINTS

Mark or circle the area(s) where you feel discomfort or pain:



LOCATION OF YOUR MAIN COMPLAINT _____

Pain level right now (0 = none, 10 = severe): _____ How long? ☐ Under 1 month ☐ 1–3 months ☐ Over 3 months

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

☐ Dull ☐ Throbbing ☐ Spasm ☐ Sharp ☐ Burning ☐ Stinging ☐ Aching
☐ Numbing ☐ Shooting ☐ Cutting ☐ Tingling ☐ Pounding ☐ Cramping ☐ Other

DOES THE PAIN MOVE OR RADIATE ANYWHERE? (E.G. NECK PAIN DOWN THE RIGHT ARM) _____

For each action, check whether it Relieves (R) or Aggravates (A) your pain:

Bending forward	☐ R ☐ A	Bending back	☐ R ☐ A	Bending left	☐ R ☐ A
Bending right	☐ R ☐ A	Twisting left	☐ R ☐ A	Twisting right	☐ R ☐ A
Coughing	☐ R ☐ A	Sneezing	☐ R ☐ A	Standing	☐ R ☐ A
Sitting	☐ R ☐ A	Lifting	☐ R ☐ A	Walking	☐ R ☐ A

Because of the pain, which of these are hard to do? (check all that apply)

☐ Lift 10 lbs ☐ Carry groceries ☐ Drive short or long distances
☐ Sit to stand ☐ Extended computer use ☐ Get dressed ☐ Read/Concentrate
☐ Extended sitting ☐ Static standing ☐ Sleep through the night ☐ Climb stairs
☐ Walk ☐ Yard work ☐ Wash/Bathe ☐ Sweep/vacuum ☐ Do dishes

Any other health complaints? List up to five, with a pain level (1–10):

COMPLAINT 1 _____ PAIN (1–10) _____ How long? ☐ Under 1 month ☐ 1–3 months ☐ Over 3 months

COMPLAINT 2 _____ PAIN (1–10) _____ How long? ☐ Under 1 month ☐ 1–3 months ☐ Over 3 months

COMPLAINT 3 _____ PAIN (1–10) _____ How long? ☐ Under 1 month ☐ 1–3 months ☐ Over 3 months

COMPLAINT 4 _____ PAIN (1–10) _____ How long? ☐ Under 1 month ☐ 1–3 months ☐ Over 3 months

COMPLAINT 5 _____ PAIN (1–10) _____ How long? ☐ Under 1 month ☐ 1–3 months ☐ Over 3 months

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Check anything that applies. For each, circle **C** if it's current or **P** if it's in the past.

Muscles, joints & bones

☐ Neck pain (C/P) ☐ Mid-back pain (C/P) ☐ Lower back pain (C/P) ☐ Shoulder pain (C/P)
☐ Hip pain (C/P) ☐ Knee pain (C/P) ☐ Foot pain (C/P) ☐ Arthritis (C/P)
☐ Disc problems (C/P) ☐ Joint pain / swelling (C/P) ☐ Fibromyalgia (C/P) ☐ Plantar fasciitis (C/P)
☐ Carpal tunnel (C/P) ☐ Whiplash (C/P) ☐ Dislocations (C/P) ☐ Fractures (C/P)
☐ Osteoporosis (C/P)

Head, nerves & senses

☐ Headaches (C/P) ☐ Concussion (C/P) ☐ Dizziness (C/P) ☐ Jaw pain / locking (C/P)
☐ Sensitive to light (C/P) ☐ Sensitive to sound (C/P) ☐ Visual problems (C/P) ☐ Hearing problems (C/P)
☐ Memory loss (C/P) ☐ Trouble w/ balance (C/P) ☐ Numbness (C/P) ☐ Tingling (C/P)
☐ Seizures (C/P) ☐ Strokes (C/P) ☐ Multiple sclerosis (C/P) ☐ Parkinson's (C/P)
☐ Alzheimer's (C/P) ☐ Shingles (C/P)

General health

☐ Diabetes (C/P) ☐ Cancer (C/P) ☐ Heart problems (C/P) ☐ Chest pain (C/P)
☐ High cholesterol (C/P) ☐ Thyroid problem (C/P) ☐ Asthma (C/P) ☐ HIV / AIDS (C/P)
☐ Ear infections (C/P) ☐ Rashes (C/P) ☐ Urinary problems (C/P) ☐ Sleep problems (C/P)
☐ Fatigue (C/P)

FAMILY HISTORY

For each relative, note age (or age at death), cause of death if applicable, and any major health conditions:

Father _____

Mother _____

Brother(s) _____

Sister(s) _____

Grandmother (maternal) _____

Grandfather (maternal) _____

Grandmother (paternal) _____

Grandfather (paternal) _____

Spouse's health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

CHILDREN'S AGES AND HEALTH STATUS _____

INSURANCE & BILLING

Do you have medical insurance? ☐ Yes ☐ No

INSURANCE COMPANY _____ INSURED'S NAME _____

RELATIONSHIP TO PATIENT _____ INSURED'S DATE OF BIRTH _____ INSURED'S SSN _____

INSURED'S EMPLOYER _____ INSURED'S EMPLOYER ADDRESS _____

Do you have secondary insurance? ☐ Yes ☐ No SECONDARY INSURANCE COMPANY _____

There are three signatures in this section. Please read each one and sign on the line beneath it. If you'd like anything explained before you sign, just ask us.

1. Informed Consent to Chiropractic, Massage & Rehabilitation Care

What chiropractic and massage care involve, the risks, and your consent to be treated.

Chiropractic care involves moving the joints and soft tissues (adjustments and manipulation). The benefits can include less pain, less numbness, fewer muscle spasms, and better mobility. As with all health care, results are not guaranteed, and Damron Chiropractic & Wellness LLC cannot promise a cure or a specific outcome.

Doctors who use manual therapy are required to tell you the risks. They are uncommon: some patients have short-term soreness, and rarely, rib fractures or muscle/ligament strains. There are very rare reports of stroke associated with neck movement including upper-cervical adjustment, and rare reports of disc injury after cervical or lumbar adjustment. Present scientific evidence does not establish that adjustments cause these events, and the risk is considered extremely remote. You are told so you can make an informed choice.

Massage therapy is the treatment of soft tissue and is not a substitute for diagnosis or medical treatment. Under Ohio law (ORC 4731.15; OAC 4731-1-05(F)) a massage therapist does not diagnose disease, prescribe medication, or practice chiropractic. If anything feels uncomfortable during any treatment, tell us right away so we can adjust or stop.

I consent to chiropractic treatment (including spinal adjustments), massage, and rehabilitation care from Dr. Andrew Damron and/or another doctor employed by the practice, and I give permission to review my medical file and treat as clinically appropriate. This consent applies to my present and future care here. If I am signing for a minor, I am that child's parent or legal guardian.

☐ **I have read and agree to the above. (Signature 1 of 3)**

▸ _____

PATIENT SIGNATURE (OR PARENT / GUARDIAN FOR A MINOR)

DATE _____ PRINTED NAME _____

IF THE PATIENT IS A MINOR, PRINT THE CHILD'S FULL NAME _____ CHILD'S DATE OF BIRTH _____

2. Financial Responsibility, Insurance & Privacy

How payment and insurance work here, your authorization to treat and to release records, and your HIPAA privacy acknowledgment — all in one signature.

By signing below, I acknowledge and agree to all three of the following:

Financial responsibility. Payment is due at the time of service unless we've arranged otherwise. I understand I am personally responsible for all charges. If the office bills my insurance, it does so as a courtesy; insurance is an agreement between me and my carrier, carriers may deny claims, and I am ultimately responsible for any unpaid balance. Any payments received are credited to my account.

Authorization to treat & release information. I authorize the practice to treat me (or my minor child named above), to release the information needed to process my claims or as requested by a party with a legitimate interest in the claim, and to receive payment of benefits directly. I certify this form is accurate to the best of my knowledge, and I will tell the office promptly if my information changes.

Notice of Privacy Practices (HIPAA). Damron Chiropractic & Wellness is required by law to protect the privacy of my health information. I acknowledge I have been offered a copy of the Notice of Privacy Practices and may request one at any time, and I consent to the use and disclosure of my health information for treatment, payment, and health-care operations.

☐ **I have read and agree to the above. (Signature 2 of 3)**

▸ _____

PATIENT SIGNATURE (OR PARENT / GUARDIAN FOR A MINOR)

DATE _____ PRINTED NAME _____

3. X-Ray Pregnancy Release

Only if you could be pregnant. If this doesn't apply to you, check the box below and skip the signature.

☐ **This does not apply to me (I cannot become pregnant). I am skipping this section.**

To the best of my knowledge I am not pregnant, and I give permission for any necessary x-rays. If I have had a hysterectomy or tubal ligation, or am in/after menopause, I accept responsibility for any effect on a potential fetus. If I am using birth control or am within 10 days of the start of my menstrual cycle, I accept that responsibility as well. If I am not, I still accept responsibility for any effect on a potential fetus. I will notify the office if this changes.

☐ **I have read and agree to the above. (Signature 3 of 3)**

▸ _____

PATIENT SIGNATURE

DATE _____ PRINTED NAME _____