R2 MEDICAL CENTERS

2072-B East Commercial Ave Lowell, IN 46356 Phone: 219-696-8916 Fax: 219-696-6880

WELCOME TO R2 MEDICAL CENTERS! Todays date: _____/_____/_____

To begin, how did you hear about our office? _____

PATIENT INFORMATION:

Patient name: _____ Date of Birth: _____/_____/_____ ☐ Male ☐ Female

SS#/SIN: _____-_____-_____ Email address: _____

Home phone number: (_____) _____-_____ Cell phone number: (_____) _____-_____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patients address - Street:_____ City: _____ State: _____ Zip: _____

Spouse/Parent/Guardian's name: _____

Emergency contact name: _____ Phone number: (_____) _____-_____

Emergency contact relationship to patient: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

**In case of medical emergency, if the patient is of school age 15+, it is okay to treat in my absence.*

Parent or guardian signature: _____ Date: _____/_____/_____

RESPONSIBLE PARTY:

☐ *Check if the patient is the responsible party (If so, you are not required to fill out this section)*

Name of responsible party: _____ Relationship to patient: _____

Party's address - Street:_____ City: _____ State: _____ Zip: _____

Home phone number: (_____) _____-_____ Cell phone number: (_____) _____-_____

Date of Birth: _____/_____/_____ Is the responsible party currently a patient? ☐ Yes ☐ No

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INSURANCE HOLDER:

Do you have insurance? ☐ *YES* ☐ *NO (If NO, then you are not required to fill out this section)*

Name of insured: _____ Relationship to patient: _____

Date of Birth: _____/_____/_____ SS#/SIN: _____-_____-_____ INS ID number: _____

Employer: _____ Union Number: _____ Insurance company:_____

Employer address - Street:_____ City: _____ State: _____ Zip: _____

Insurance address - Street:_____ City: _____ State: _____ Zip: _____

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HEALTH HISTORY: Todays date: _____/_____/_____

Patient name: _____ Date of Birth: _____/_____/_____ Chief complaint: _____

HISTORY OF PRESENT ILLNESS:

Location: _____ Quality: _____ Severity: _____
(Where is the pain/problem located?) (Example: Normal vs abnormal color, activity, ect) (Pain on scale 1-10, 10 being most severe)

Duration: _____ Timing: _____ Context: _____
(How long have you had this pain, when did it begin?) (Does the pain/problem occur at a certain time?) (Where were you at the onset of this pain/problem?)

Associated signs/symptoms: _____
(What other associated problems have you been having?)

Modifying factors: _____
(What makes the pain/problem worse or better? Have you had previous episodes?)

PAST MEDICAL HISTORY:

Have you ever had the following (CIRCLE "YES" or "NO" or leave blank if you are uncertain)

Measles:	YES NO	Anemia:	YES NO	Back trouble:	YES NO
Mumps:	YES NO	Bladder infection:	YES NO	High Blood Pressure:	YES NO
Chicken Pox:	YES NO	Epilepsy:	YES NO	Low Blood Pressure:	YES NO
Whooping cough:	YES NO	Migraines:	YES NO	Hemorrhoids:	YES NO
Scarlet fever:	YES NO	Tuberculosis:	YES NO	Asthma:	YES NO
Diphtheria:	YES NO	Diabetes:	YES NO	Hives of Eczema:	YES NO
Small pox:	YES NO	Cancer:	YES NO	AIDS and HIV:	YES NO
Pneumonia:	YES NO	Polio:	YES NO	Infectious MONO:	YES NO
Rheumatic fever:	YES NO	Glaucoma:	YES NO	Bronchitis:	YES NO
Arthritis:	YES NO	Hernia:	YES NO	Mitral Valve Prolepses:	YES NO
Venereal Disease:	YES NO	Blood Transfusion:	YES NO	Stroke:	YES NO
Hepatitis:	YES NO	Plasma Transfusion:	YES NO	Date of last chest x-ray:	_____
Ulcer:	YES NO	Kidney Disease:	YES NO	Thyroid Disease:	YES NO
Bleeding Tendency:	YES NO	Any other diseases:	YES NO	_____	

Previous Hospitalizations/Surgeries/Serious Illnesses:

_____ When: _____ Hospital/City/State: _____

_____ When: _____ Hospital/City/State: _____

MEDICATIONS:

(LIST and be sure to include NON-Prescription)

Have you ever taken Fen-Phen/Redux? YES NO

Are you taking any medications for acid indigestion? YES NO
(Include prescription/over the counter) If YES, what type?: _____

ALLERGIES:

(List ALL allergies/sensitivities to medications, food, and other items)

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

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PATIENT SOCIAL HISTORY: Todays date: _____/_____/_____

Patient name: _____ Date of Birth: _____/_____/_____

FAMILY MEDICAL HISTORY:

Disease (if applicable)	Relation
_____	_____
_____	_____
_____	_____

INDICATE WHICH OF THE BELOW YOU HAVE EXPERIENCED WITHIN THE LAST 1-2 MONTHS

On a scale of 1-5, below indicate how often you deal experience the associated issue. 1 – Being Never 5 – Being Always

EYES/EARS/NOSE THROAT/RESPIRATORY		MUSCULAR & SKELETAL		NEUROLOGICAL		GENERAL	
Asthma	1 2 3 4 5	Muscle Aches	1 2 3 4 5	Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Stuffy nose	1 2 3 4 5	Fibromyalgia	1 2 3 4 5	Migraines	1 2 3 4 5	Malaise	1 2 3 4 5
Hay Fever	1 2 3 4 5	Arthritis	1 2 3 4 5	Dizziness	1 2 3 4 5	Weakness	1 2 3 4 5
Sore throat	1 2 3 4 5	Joint pain	1 2 3 4 5	Numbness	1 2 3 4 5	Tiredness	1 2 3 4 5
Chronic cough	1 2 3 4 5	Low back pain	1 2 3 4 5	Tingling	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Chest congestion	1 2 3 4 5	Neck pain	1 2 3 4 5	Pins/Needles	1 2 3 4 5	Irritability	1 2 3 4 5
Frequent sneezing	1 2 3 4 5	Wrist/Hand pain	1 2 3 4 5			Constipation	1 2 3 4 5
Itchy/watery eyes	1 2 3 4 5	Elbow pain	1 2 3 4 5			Diarrhea	1 2 3 4 5
Drainage	1 2 3 4 5	Shoulder pain	1 2 3 4 5			Feeling groggy	1 2 3 4 5
Earache/infection	1 2 3 4 5	Hip pain	1 2 3 4 5			Forgetfulness	1 2 3 4 5
Itching	1 2 3 4 5	Knee pain	1 2 3 4 5				
Hoarseness	1 2 3 4 5	Ankle pain	1 2 3 4 5				
Short of breath	1 2 3 4 5	Foot pain	1 2 3 4 5				
Wheezing	1 2 3 4 5	Pain between Shoulder blades	1 2 3 4 5				

To the best of knowledge, the questions on this form have all been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the Doctor of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services that I may need.

_____ Todays date: _____/_____/_____

Signature of the Patient, Parent, or Guardian

_____ Todays date: _____/_____/_____

Signature of the Doctor

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HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to make available to you a copy of our Notice of Privacy Practices, which states how we may use and or disclose your health information. A copy of our current Notice of Privacy Practices is available upon request to staff, as well as on our website. You are entitled to a copy of our Notice of Privacy Practices. Please sign this form to acknowledge that the Notice of Privacy Practices was made available to you. You may refuse to sign this acknowledgement if you wish.

I _____ am aware that the Notice of Privacy Practices is in effect as of March 20, 2006. I acknowledge that this copy of R2 Medical Centers Notice of Privacy Practices was made available to me.

(Print Patient, Parent, Guardian name)

_____ Todays date: _____/_____/_____

Please print the Patients name

_____ Todays date: _____/_____/_____

Signature of the Patient, Parent, or Guardian

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

_____ The patient refused to sign
_____ Other

_____ Todays date: _____/_____/_____

Employee signature

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CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and/or manual therapy techniques as well as other chiropractic procedures. These may include various modes of physical therapeutic modalities and procedures, as well as diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible). These services performed by the Doctor of Chiropractic and/or other licensed doctors who now or in the future work at R2 Medical Centers.

I have had an opportunity to discuss with the Doctor the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to the following:

Manipulation (Chiropractic adjustments): Increased pain/discomfort, fractures, disc injuries, strokes, dislocations/sprains

Therapeutic Modalities and Procedures (Rehabilitation): Additional pain/discomfort. Endurance exercises may cause increased risk of Acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: Ionizing radiation can be harmful to a fetus for those who are pregnant or might become pregnant

I do not expect the Doctor to be able to anticipate and/or explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure in which the Doctor feels at the time, based upon the facts that are known to him/her, is in my best interest. The Doctor has additionally explained the risks associated with my refusal of treatment.

I _____ have read, or have had read to me, the above consent. I have also had an
(Print Patient, Parent, Guardian name) opportunity to ask questions about it's content. By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which is seek treatment.

_____ Todays date: _____/_____/_____

Signature of the Patient, Parent, or Guardian

_____ Todays date: _____/_____/_____

Signature of the Doctor