Corey D Idrogo, DC

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PERSONAL INFORMATION

Name _____ Date _____

Home Address _____ City _____ State _____ Zip _____

Home Phone_____ Work Phone _____

Cell Phone _____ Email Address _____

Contact Pref. H_ W_ C_ Email _

Birth date ___/___/___ Age ___ SS # ___ - ___ - _____

Marital Status (circle one) Single Married Divorced Widowed

Number of Children and Ages _____

Employer Phone_____ Occupation Phone_____

Business Address _____ City_____State _____ Zip _____

PARENT/SPOUSE INFORMATION

Name of Parent/Spouse_____ Employer _____

Parent/Spouse's Birth date ___/___/___ Parent/Spouse SS # ___ - ___ - _____

OTHER INFORMATION

Emergency Contact _____ Relation_____ Phone _____
Whom may we thank for referring you?_____

Have you ever been to a chiropractor? Yes_ No_ Who?_____ When? _____
If yes, were the results satisfactory? _____

PRIMARY CARE PHYSICIAN

Physician:_____ Phone:_____
May we update them on your condition? Yes _____ No _____

INSURANCE INFORMATION

If insured, please provide your insurance card to copy.
Relationship to insured Self *Spouse *Parent
* If other than "Self" provide Name and Date of Birth of insured:

Name: _____ D.O.B _____

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INJURY INFORMATION

Describe your major complaint_____

When did your problem begin? (specific date if possible)_____

How did your problem begin? _____
What increases your pain?_____ decreases?_____

How many days a week do you experience pain/discomfort?_____ days

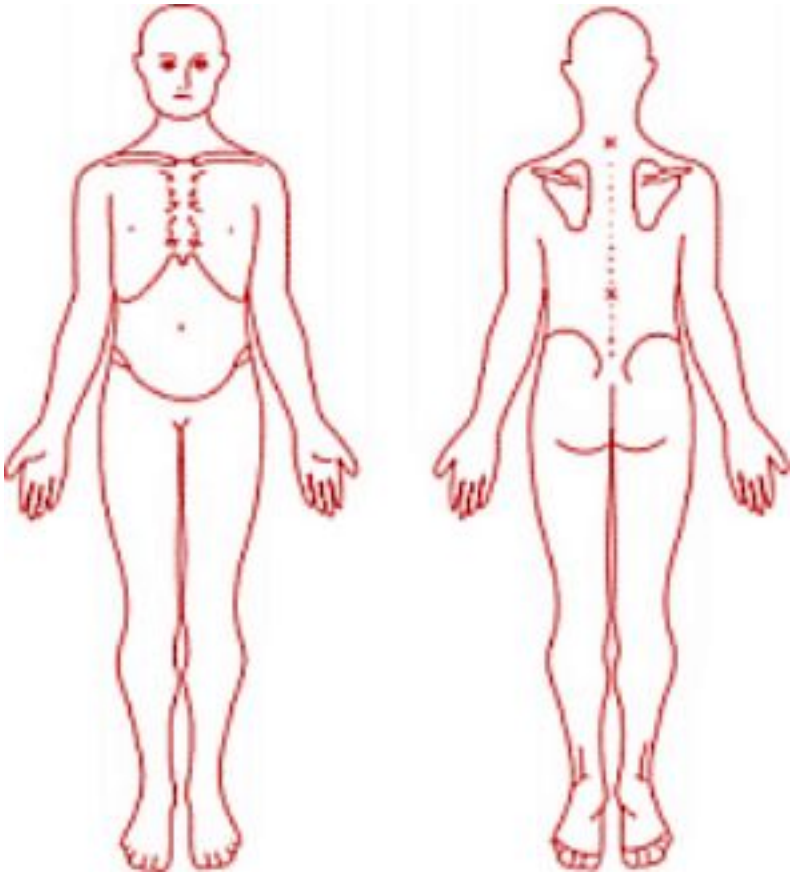
Are your symptoms: Decreasing _____ Not Changing _____ Increasing _____

Symptoms are worse in the: _____ Morning_____ Afternoon _____ Evening _____Same all day

Has your daily activity changed as a result of your condition? If so, please explain.

No ___Yes ___ _____

_____



Please check the corresponding pain description and frequency for each area (1,2,3, etc) indicated on the diagram to the left.

Description Area	1	2	3	4
SHARP	___	___	___	___
DULL	___	___	___	___
ACHE	___	___	___	___
WEAK	___	___	___	___
THROBBING	___	___	___	___
NUMB	___	___	___	___
SHOOTING	___	___	___	___
GRIPPING	___	___	___	___
BURNING	___	___	___	___
TINGLING	___	___	___	___

FREQUENCY

CONSTANT (76-100%)	___	___	___	___
FREQUENT (51-75%)	___	___	___	___
INTERMITTENT(26-50%)	___	___	___	___
OCCASIONAL(50-25%)	___	___	___	___
OTHER	___	___	___	___

Indicate your pain by circling your lowest pain level and highest pain level for each area indicated above. Area:

1 No Pain 1-------2-------3-------4-------5--------6-------7-------8-------9-------10 Unbearable
2 No Pain 1-------2-------3-------4-------5--------6-------7-------8-------9-------10 Unbearable
3 No Pain 1-------2-------3-------4-------5--------6-------7-------8-------9-------10 Unbearable
4 No Pain 1-------2-------3-------4-------5--------6-------7-------8-------9-------10 Unbearable

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What treatments have you previously tried for this condition?

_____ Physical Therapy _____ Chiropractic _____ Massage _____ Orthopedic
_____Family/Primary Doctor _____Other

If so, please write name: _____

Have you had Spinal X-Rays, MRI, CT SCAN? ____NO ____ Yes:

Date(s) taken: _____ Area taken: _____
_____ _____

Below please list all doctors you have seen since your accident/ onset of pain:

Name of doctors: _____
_____

Condition(s) being treated:
_____

List all prescription, non prescription medications and other supplements you take as well associated condition:
_____

_____

List any surgeries or hospitalizations you have had including month and year:

_____

_____

_____

List any allergies:_____

Family History: _____

Do you exercise:____Yes____ No Hours per week? _____
What activities: _____

Are you dieting? ____Yes____ No Since? _____

Do you smoke? ____Yes____ No Packs per day? _____ How many years? _____

Do you drink alcoholic beverages? ____Yes____ No Drinks per day _____

For Women: Are you pregnant/nursing? ____Yes____ No How many weeks: _____

Last menstrual cycle: _____

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REVIEW OF SYSTEMS

Have you noticed/have any of the following?

Musculoskeletal
___ Arthritis/Osteoporosis
___ Back problems
___ Cramping
___ Elbow/wrist pain
___ Foot/ankle pain
___ Fractures
___ Gout
___ Hip disorders
___ Implants/ plates
___ Joint/ Muscle pain
___ Knee problems
___ Scoliosis
___ Shoulder Problems
___ TMJ Issues
___ Other:_____
____ ***No additional musculoskeletal complaints***

Head ENT
___ Blurred /Double Vision
___ Cataracts
___ Dental Problems
___ Chronic Ear Infections
___ Difficulty Swallowing
___ Hearing Loss
___ Earache
___ Eye problems
___ Eye Surgery
___ Headaches/Migraines
___ Sinus Issues
___ Ringing in Ears
___ Swollen Lymph Nodes
___ TMJ Issues
___ Other:_____
____ ***No additional Head complaints***

Gastrointestinal
___ Abdominal pain
___ Black/ Bloody Stool
___ Bloating
___ Changes in bowel habits
___ Colitis
___ Colon Cancer
___ Constipation
___ Crohn's Disease
___ Difficulty Swallowing
___ Food Sensitivities
___ Gastric Reflux
___ Heartburn
___ Hemorrhoids
___ Irritable Bowel Syndrome
___ Nausea / Vomiting
___ Severe Diarrhea
___ Liver Disease
___ Other:_____
___ ***No additional GI Complaints***

Neurological
____ Anxiety/Panic attacks
___ Depression
___ Difficulty Concentrating
___ Dizziness
___ Epilepsy/Seizures
___ Headaches
___ Loss of smell/taste
___ Memory issues
___ Numbness
___ Pins & needles
___ Sleeping Issues
___ Stroke
___ Tempory Loss Vision/ Smell/ Hearing
___ Weak Muscles
___ Other:_____
____ ***No additional neuro complaints***

Cardiovascular
___ Atrial Fibrillation
___ Blood clots
___ Congenital Heart Defect
___ Coronary Heart Disease
___ Chest Pain/Tightness
___ Dizziness
___ Dyspnea (Trouble Breathing)
___ Excessive Bruising
___ Heart Attack
___ Heart Murmur
___ High blood pressure
___ High Cholesterol
___ Leg Pain upon walking
___ Low Blood Pressure
___ Swelling in legs/feet
___ Varicose Veins
___ Other:_____
___ ***No add. neuro complaints***

Genitourinary
___ Blood in Urine
___ Incontinence
___ Kidney Stones
___ Painful/Frequent Urination
___ Sexual Dysfunction
___ Urgency
___ Urinary/Bladder Infections
___ Other:_____
___ *No additional GI Complaints*

Endocrine
___ Diabetes
___ Cushing's Syndrome
___ Hyperthyroidism
___ Hypothyroidism
___ Other:_____
___ ***No add. Endocrine Complaints***

* All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any pay-able benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.

Everything I have answered is true and correct to the best of my knowledge.

Signature:_____ **Date:** _____

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CONSENT TO CHIROPRACTIC EXAMINATION AND TREATMENT

Chiropractic is a health care profession that focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. The primary treatment provided by Doctors of Chiropractic is spinal manipulative therapy, also referred to as an adjustment. A Doctor of Chiropractic uses his/her hands and/or a mechanical instrument on the patient's body in such a way as to move the patient's joints. This may cause an audible "pop" or "click", such as when a person "cracks" his knuckles. The patient may feel a sense of movement as well.

Other procedures commonly used by Doctors of Chiropractic include the following:

o physical examination	o postural analysis	o diagnostic studies
o ultrasound therapy	o hot/cold therapy	o vital signs
o laser therapy	o traction/decompression	o electrical muscle stimulation
o palpation	o rehabilitation	o bracing and support applications
o manual therapy	o acupuncture/dry needling	

The material risks associated with chiropractic treatment
Chiropractic treatment utilizes very safe, non-invasive procedures performed in chiropractic offices to reduce pain, restore range of motion, and promote overall body wellness, among other various benefits. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Possible complications include but are not limited to the following: muscle strain, dizziness, nausea, flushing, fractures, disc injuries, dislocations, cervical myelopathy, burns, costovertebral strains and separations. It is not uncommon for patients to experience temporary soreness after the first few treatments. In rare cases, manipulation of the neck has been associated with injuries to the arteries in the neck, leading to or contributing to serious complications, including stroke.

The probability of those risks occurring
Fractures are rare occurrences and generally result from underlying weakness of the bone for which the Doctor of Chiropractic checks during the taking of the patient's history, and during examination and X-ray. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options may include the following

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain-killers
- Hospitalization/Surgery

There are risks and benefits associated with all the above treatment options, which the patient may wish to discuss with his/her medical doctor.

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Failure to seek care could result in serious medical conditions going unrecognized. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that Dr. Corey Idrogo DC will advise me of any material risks in this regard.
2. Neither the practice of chiropractic nor the practice of medicine is an exact science, and my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. It is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, and an undesirable result does not necessarily indicate an error in judgment or treatment.
4. Dr. Corey Idrogo DC does not guarantee any results with respect to any course of care or treatment.

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DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. ONCE READ AND UNDERSTOOD, PLEASE CHECK THE APPROPRIATE BLOCK IN THE PARAGRAPH BELOW AND SIGN.
Patient:
I [ ] have read, or [ ] have had read to me, the above explanation of chiropractic adjustment and related treatment. I hereby authorize, Dr. Corey Idrogo DC.
and his/her assistants, associates and other appropriate persons to render care, to perform an examination and to provide an appropriate evaluation and treatment plan to address the complaints, problems, and medical history I have provided. I have discussed any questions, comments, or concerns with Dr. Corey Idrogo DC and have had my inquiries answered to my satisfaction. By signing below, I state that I have weighed the risks and/or benefits in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Initial _____

HIPAA Acknowledgement and Consent

I, the undersigned, acknowledge that I have had access to a copy of the **NOTICE OF PRIVACY PRACTICES**. I consent to your disclosure, which you deem necessary in connection with my or my child's condition. This information will only be distributed to your third party payer for purposes of reimbursement for services provided, and only upon direct request of your third party payer.

Initial _____

Authorization and Assignment
Please initial next to each line that applies to you.
Thank you.

Initial _____ **AUTHORIZATION TO RELEASE INFORMATION (*if applicable):*** You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you of any consequence thereof.

Initial _____ **ASSIGNMENT OF PAYMENT (*if applicable*):** My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any money due to him/her on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amounts of his/her charges and the amount paid him/her by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his/her charges, should my condition be such that is not covered by my policy or if for any other reason the insurance company and/or attorney refuses to pay my claim. Accepting assignment does not release the patient from the responsibility for their yearly deductible or for their co-payment on services provided by the clinic. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do so will result in collection action.

Initial _____ **MEDICARE ASSIGNMENT (*if applicable*):** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

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ACKNOWLEDGEMENT AND UNDERSTANDING:

I hereby acknowledge;

A. That there is no insurance company obligated to pay for the services, or if the insurance company involved, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor; or

B. If a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney; then payment of services rendered by Centered Health & Wellness LLC., will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last statement, whichever comes first.

Patient's Name _____ **Patient's Signature** _____

Date: _____ **Signature of Parent/Guardian** _____

(if patient is a minor)