PLANCK
CHIROPRACTIC & REHAB

Confidential Patient Information

Full Name: _____ DOB: _____ Nickname: _____

Address _____
Street Apt# City State Zip Code

Marital Status: S M D W Age: _____ SS#: _____ Gender M F

Home Phone: _____ Cell Phone: _____ Email: _____

Occupation: _____ Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone Number: _____

Who may we thank for your referral? ○Family ○Friend ○Community Ad ○Postcard ○Provider ○Other

Please specify _____

YOUR PRESENT COMPLAINT _____

When did this current episode begin? Be specific (give a date) if possible: _____

Have you been treated by a physician for this condition in the last year? Yes No

Which word describes the frequency of your symptom? (check one)

❑ Constant (76% - 100% of awake time)
❑ Intermittent (26% - 50% of awake time)
❑ Frequent (51% - 75% of awake time)
❑ Occasional (0% - 25% of awake time)

Which phrases best describe *changes* in your symptoms during the day? (check all that apply)

❑ It is worse in the morning
❑ It is worse in the afternoon
❑ It is worse at night
❑ It changes with the weather
❑ It does not change

What helps *relieve* your symptoms? (check all that apply)

❑ Ice ❑ Heat ❑ Medication ❑ Nothing helps ❑ Other _____

What activities are limited by your discomfort? (check all that apply)

❑ Bending
❑ Coughing/ Sneezing
❑ Driving
❑ Getting up
❑ Lifting
❑ Lying Down
❑ Pulling
❑ Pushing
❑ Reading
❑ Sitting
❑ Sleeping
❑ Standing
❑ Turning Head
❑ Twisting at waist
❑ Walking
❑ Working
❑ Other _____

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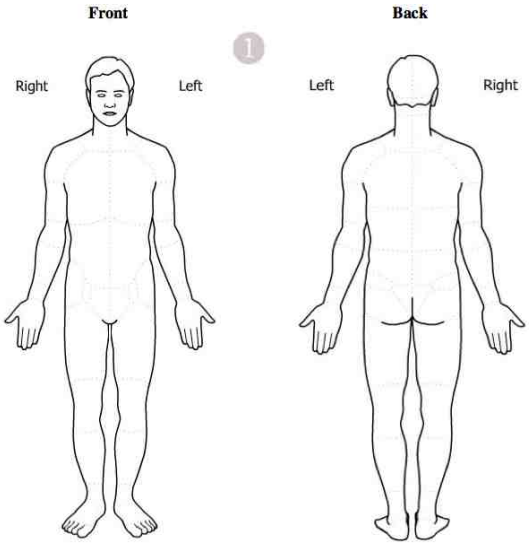
Identify your areas of discomfort by marking

the affected body parts in the illustration.



Smoking status: ❑ Every day ❑ Some day ❑ Former ❑ Never

How many alcoholic beverages do you consume per week? _____

How many days do you exercise each week? _____

Have you ever been diagnosed with any allergies? No Yes

If yes, please explain _____

Are you pregnant? No Yes Date of last cycle: _____

List all over-the-counter medications being taken. _____

List all vitamins or other dietary supplements being taken. _____

List all prescription medications being taken. _____

_____

Describe any operations you have had and the dates: _____

_____

Have you ever been diagnosed with cancer? No Yes If yes, please explain: _____

Has anyone in your family ever been diagnosed with cancer? No Yes If yes, please explain _____

_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Planck Chiropractic & Rehab extends credit to me and I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Planck Chiropractic & Rehab and whomever they may designate as assistants, to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination and treatment. I certify that the above information is true and correct.

Patient's Signature: _____ **Date:** _____

INFORMED CONSENT

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518 W. John St. | Matthews, NC 28105

PAST, FAMILY, AND SOCIAL HISTORY

PAST MEDICAL HISTORY

Have you *ever* had any of the following? *(Please select all that apply and use comments to elaborate.)*

Illnesses:

- ❑ Asthma
- ❑ Autoimmune Disorder *(Type)* ____
- ❑ Blood Clots
- ❑ Cancer *(Type)* _____
- ❑ CVA/ TIA (Stroke)
- ❑ Diabetes
- ❑ Migraine Headaches
- ❑ Osteoporosis
- ❑ Other: _____

Injuries:

- ❑ Back Injury
- ❑ Broken Bones
- ❑ Head Injury
- ❑ Neck Injury
- ❑ Falls
- ❑ Other: _____

Hospitalizations: *(Non-surgical with Date)*

_____

_____

Surgeries: *(If yes, provide type & surgery date)*

- ❑ Cancer _____
- ❑ Orthopedic
  - o Shoulder – L / R _____
  - o Elbow/Forearm – L / R ____
  - o Wrist/Hand – L / R _____
  - o Hip – L / R _____
  - o Knee – L / R _____
  - o Ankle/Foot – L / R _____
- ❑ Spinal
  - o Neck: _____
  - o Back: _____
- ❑ Other: _____

_____

Medical History Comments:

_____

FAMILY HISTORY *(Please mark **X** to all that apply and use comments to elaborate.)*

❑ Unknown ❑ Unremarkable

	Mother	Father	Sibling 1	Sibling 2	Sibling 3	Child 1	Child 2	Child 3
Gender	F	M						
Age at death *(if deceased)*								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								

Family History Comments:

_____

SOCIAL AND OCCUPATIONAL HISTORY

Highest Level of Education:

❑ High School ❑ College ❑ Post Grad. ❑ Other

Alcohol Use:

❑ Every Day ❑ Weekly ❑ Occasionally ❑ Never

Caffeine Use:

❑ Coffee ❑ Tea ❑ Energy Drinks ❑ Soda ❑ Never

Exercise Frequency:

❑ Daily ❑ 3-4x/wk ❑ 2-3x/wk ❑ Rarely ❑ Never

Social History Comments: _____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature_____ Date _____

Print Name *(First MI Last)*_____ Account # _____

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REVIEW OF SYSTEMS

Many of the following conditions respond to chiropractic treatment.

Are you *currently* experiencing any of these symptoms? *(Please select all that apply and use comments to elaborate.)*

Constitutional: *(General)*
- ❑ Fever
- ❑ Fatigue
- ❑ Other: _____
- ❑ *None in this Category*

Musculoskeletal:
- ❑ Joint Pain/Stiffness/Swelling
- ❑ Muscle Pain/Stiffness/Spasms
- ❑ Broken Bones _____
- ❑ Other: _____
- ❑ *None in this Category*

Neurological:
- ❑ Dizziness or Lightheaded
- ❑ Convulsions or Seizures
- ❑ Tremors
- ❑ Other: _____
- ❑ *None in this Category*

Psychiatric: (Mind/Stress)
- ❑ Nervousness/Anxiety
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ Other: _____
- ❑ *None in this Category*

Genitourinary:
- ❑ Frequent or Painful Urination
- ❑ Blood in Urine
- ❑ Incontinence or Bed Wetting
- ❑ Painful or Irregular Periods
- ❑ Other: _____
- ❑ *None in this Category*

Gastrointestinal:
- ❑ Loss of Appetite
- ❑ Blood in Stool or Black Stool
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Frequent Diarrhea
- ❑ Constipation
- ❑ Other: _____
- ❑ *None in this Category*

Cardiovascular & Heart:
- ❑ Chest Pains/Tightness
- ❑ Rapid or Heartbeat Changes
- ❑ Swelling of Hands, Ankles, or Feet
- ❑ Other: _____
- ❑ *None in this Category*

Respiratory:
- ❑ Difficulty Breathing
- ❑ Cough
- ❑ Other: _____
- ❑ *None in this Category*

Eyes & Vision:
- ❑ Eye Pain
- ❑ Blurred or Double Vision
- ❑ Sensitivity to Light
- ❑ Other: _____
- ❑ *None in this Category*

Head, Ears, Nose, & Mouth/Throat:
- ❑ Frequent or Recurrent Headaches
- ❑ Ear - Ache/Ringing/Drainage
- ❑ Hearing Loss
- ❑ Sensitivity to Loud Noises
- ❑ Sinus Problems
- ❑ Sore Throat
- ❑ Other: _____
- ❑ *None in this Category*

Endocrine:
- ❑ Infertility
- ❑ Recent Weight Change
- ❑ Eating Disorder
- ❑ Other: _____
- ❑ *None in this Category*

Hematologic & Lymphatic:
- ❑ Excessive Thirst or Urination
- ❑ Cold Extremities
- ❑ Swollen Glands
- ❑ Other: _____
- ❑ *None in this Category*

Integumentary: *(Skin, Nails, & Breasts)*
- ❑ Rash or Itching
- ❑ Change in Skin, Hair, or Nails
- ❑ Non-healing Sores or Lesions
- ❑ Change of Appearance of a Mole
- ❑ Breast Pain, Lump, or Discharge
- ❑ Other: _____
- ❑ *None in this Category*

Allergic/Immunologic:
- ❑ Food Allergies
- ❑ Environmental Allergies
- ❑ Other: _____
- ❑ *None in this Category*

Review of Systems Comments:

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature _____ Date _____

Print Name *(First MI Last)* _____ Account # _____

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TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

NOTICE: Refusal to consent to the integrative and complementary procedure should not affect your right to future care or treatment.

I (We) voluntarily request Dr. Planck as my physician, and such associates, technical assistants, and other health care providers as they may deem necessary, to treat my condition, which has been explained to me as: neck, mid or low back muscle, ligamentous or disc injury, “pinched nerve” with vertebral or sacroiliac subluxation and or extremity subluxation.

I (We) understand that the following integrative and complementary procedure(s) is planned for me and I (We) voluntarily consent and authorize these procedures: spinal adjustments and/or spinal manipulation, physical therapy modalities also known as ultrasonic, electrotherapy, heat or ice, diathermy, diapulse and spinal traction.

I (We) understand that no warranty or guarantee has been made to me as to the result of care.

I (We) realize that just as there may be risks and hazards in continuing my present condition without conventional medical treatment, there are also risks and hazards related to the performance of the integrative and complementary treatment, alternative forms of treatment, risks of treatment, risks of non-treatment, procedures to be used, and the risks and hazards involved, and I (We) believe that I (We) have sufficient information to give this informed consent.

I (We) certify this form has been fully explained to me, that I (We) have read it or have had it read to me and that I (We) understand its contents.

_____ _____
Signature Date

_____ _____
Witness Date