

Zurek Chiropractic

Phone Number: (402)504-3434

Patient Information

Date: _____	SSN: _____	Birthday: _____
First Name: _____	Middle Name: _____	Last Name: _____
Sex: <input type="radio"/> M <input type="radio"/> F	Height: _____	Weight: _____
Marital Status: <input type="radio"/> Yes <input type="radio"/> No	Spouse Name: _____	# of Children: _____
Home #: _____	Cell #: _____	Work #: _____
Address: _____		
City: _____	State: _____	Zip: _____
Emergency Contact: _____	Emergency Relation: _____	Emergency Phone: _____
Email: _____		

Referral Information

Referring Physician: _____	Referred Patient: _____	Referred by: _____
Advertisement: <input type="radio"/> Yes <input type="radio"/> No	Advertisement: _____	
Referred Directory: <input type="radio"/> Yes <input type="radio"/> No	Referred Directory: _____	

Employer Information

Employed: <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Homemaker <input type="radio"/> Unemployed	Employer Name: _____	
Employer Address: _____		
Employer City: _____	Employer State: _____	Employer Zip: _____
Occupation: _____	Work Supervisor: _____	Supervisor #: _____
Work Duties: _____		

Insurance Information

Payment: <input type="radio"/> Personal <input type="radio"/> 3rd Party <input type="radio"/> Self	Resp. for Payment: _____	Responsible Phone: _____
Payment Name: _____	Primary Phone #: _____	Primary ID/Policy: _____
Payment Address: _____		
Payment City: _____	Payment State: _____	Payment Zip: _____
Primary Group #: _____	Primary Name: _____	Primary DOB: _____
Secondary Name: _____	Secondary Phone #: _____	Secondary ID/Policy: _____
Secondary Address: _____		
Secondary City: _____	Secondary State: _____	Secondary Zip: _____
Secondary Group #: _____	Secondary Name: _____	Secondary DOB: _____
Claim #: _____	Claim Contact: _____	Claim Phone #: _____
Attorney Name: _____	Attorney Phone #: _____	

Complaint Information

Injury Occurred:	<input type="radio"/> Automobile	<input type="radio"/> Work	<input type="radio"/> Third-Party	<input type="radio"/> Other	Injury Date:	_____
Injury Origin:	_____					
Desc Discomfort:	_____					
Frequency:	<input type="radio"/> Always	<input type="radio"/> Hourly	<input type="radio"/> Daily	<input type="radio"/> Occasionally		
Interfere w/ Activities:	<input type="radio"/> Yes	<input type="radio"/> No	Affected Sleep:	<input type="radio"/> Yes	<input type="radio"/> No	
Missed Work:	<input type="radio"/> Yes	<input type="radio"/> No	Unable to Work from:	_____	Unable to Work til:	_____
Affected Appetite:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Reduced Work:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Does it Worsen:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Weather Affects it:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Aggravates Condition:	_____					
Improves Condition:	_____					
Received Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
X-rays Taken:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Same Condition Before:	<input type="radio"/> Yes	<input type="radio"/> No	Date:	_____	Practitioner:	_____

History

Last Physical Exam:	_____	Primary Phys:	_____	Phys Phone #:	_____		
Phys City:	_____	Phys State:	_____	Phys Zip:	_____		
Health Conditions:	_____						
Previous Chiro Care:	<input type="radio"/> Yes	<input type="radio"/> No	Date:	_____	Explain:	_____	
Chance Pregnant:	<input type="radio"/> Yes	<input type="radio"/> No	Planning:	<input type="radio"/> Yes	<input type="radio"/> No		
Medications:	_____						
Supplements:	_____						
Broken Bones:	<input type="radio"/> Yes	<input type="radio"/> No	Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____
Sprains/Strains:	<input type="radio"/> Yes	<input type="radio"/> No	Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____
Hospitalized:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____			
Surgery:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____			
Auto Accident:	<input type="radio"/> Yes	<input type="radio"/> No	Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____
Struck Unconscious:	<input type="radio"/> Yes	<input type="radio"/> No	Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____
Eating Disorder:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____			
Stroke:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____			
Family Health Hist:	_____						

Patient Social

Alcohol:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Caffeine:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Diet Food Products:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Drugs:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
OTC Stimulants:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Exercise:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Homemade Food:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Processed Food:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Soft Drinks:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Tobacco:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Water:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never					

Health Checklist

<input type="checkbox"/> Allergies	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Anemia
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Cold Extremities	<input type="checkbox"/> Constipation	<input type="checkbox"/> Cramps
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Digestion Problems
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Excessive Menstruation	<input type="checkbox"/> Eye Pain or Difficulties
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Headache
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Irregular Menstrual Cycle	<input type="checkbox"/> Kidney Infection
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Polio	<input type="checkbox"/> Poor Posture
<input type="checkbox"/> Prostate Trouble	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Infection	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Spinal Curvatures	<input type="checkbox"/> Stroke	<input type="checkbox"/> Swelling of Ankles
<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Other: _____		

Patient Signature: _____

Date: _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient: _____

Name Printed of Guardian/Parental and Relationship to Patient: _____

Guardian/Parental Signature: _____

Date: _____

Doctor of Chiropractic Name: _____

Signature of Doctor of Chiropractic: _____

Date: _____