

# GOODMAN CHIROPRACTIC CENTERS

Kenny Goodman, DC J Garett Goodman, DC  
PO Box 1206 Thatcher, Az 85552

## New Patient Registration and History Questionnaire

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
LAST FIRST MIDDLE

Mailing Address: \_\_\_\_\_ Social Security # \_\_\_\_\_

City, State, Zip: \_\_\_\_\_  Male  Female Marital Status:  M  S  W  D

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

IN case of emergency, notify: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

How did you hear about our office / referred by : \_\_\_\_\_

Reason for Office Visit / Date of Onset: \_\_\_\_\_

What makes your symptoms Better? \_\_\_\_\_ What makes your symptoms Worse? \_\_\_\_\_

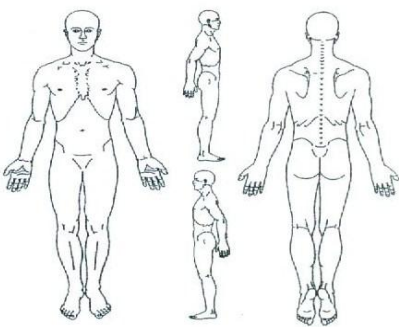
For your symptoms, what is the type of pain? (ache, Burn, dull, sharp, throbbing, etc.): \_\_\_\_\_

Are your symptoms local or do they travel to another area? (if they travel, to where?) \_\_\_\_\_

Are symptoms:  constant > 76%  frequent 51-75%  occasional 26-50%  intermittent < 25% of your waking hours.

**Please mark on the diagram to the right the following symbols as they relate to your symptoms:**

SS = spasms	ST = stiffness
DP = dull pain	SP = sharp pain
SH = shooting pain	TI = Tingling
NU = numbness	O = other



<u>Please list all medications and dosage:</u>	<u>Frequency</u>	<u>For what illness?</u>
_____		
_____		

List any allergies to medications, foods or other: \_\_\_\_\_

Are you pregnant?  Yes  No  
Do you Smoke?  Yes  No How Much? \_\_\_\_\_  
Do you drink Alcohol?  Yes  No How much? \_\_\_\_\_

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Please list all serious illness and serious accidents:

Month and Year

City and State

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Please list any recent X-rays, lab or other tests:

Date

Facility/Doctor

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Do you have a history of any of the following diseases? :

- |   |   |  |                                   |  |
|---|---|--|-----------------------------------|--|
| <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Lung Disease   | <input type="checkbox"/> Gout          | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis       |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach/Ulcer  | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Polio/MS | <input type="checkbox"/> Bleeding        |
| <input type="checkbox"/> Sciatica       | <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Transfusion   | <input type="checkbox"/> Asthma   | <input type="checkbox"/> Drug Dependence |
| <input type="checkbox"/> Colon Disease  | <input type="checkbox"/> Stroke         | <input type="checkbox"/> Cancer        | <input type="checkbox"/> AIDS     | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Paralysis      | <input type="checkbox"/> Seizures       | <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Anemia   |  |

Any other condition(s) not listed above that the doctor should be made aware of:

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**YOUR GROUP HEALTH INSURANCE COMPANY:** \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_ Insured: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Policy#: \_\_\_\_\_ SS# \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

### HIPAA Compliance:

Goodman Chiropractic Centers are required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information.

### Financial Agreement:

If any signer is entitled to benefits under any insurance policy, the benefits are hereby assigned to Goodman Chiropractic for application on the patient's bill; however, **IT IS UNDERSTOOD THAT THE UNDERSIGNED AND THE PATIENT ARE PRIMARILY LIABLE FOR PAYMENT OF THE PATIENT'S BILL (including any deductible)**. It is intended by this provision to allow Goodman Chiropractic to bill and receive payments directly from the above insurance company without giving up our right to bill and collect from the undersigned all unpaid services rendered by Goodman Chiropractic. **Our office will not enter a dispute with your insurance company over any claims.** Please be advised that verification of insurance coverage is not a guarantee of benefit payments. **In the event your account is submitted to a collection agency, you will be responsible for all associated charges and fees. The undersigned will be responsible for a \$25.00 returned check fee.**

Signature below acknowledges that I understand and accept these policies. I have also read the Notice of our Privacy Practices. If requested, a copy will be provided to me.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Staff Initials: \_\_\_\_\_

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## Informed Consent

**The nature of the chiropractic manipulation:** The Doctor will use their hands, an instrument or both to move the joints of your body; this may result in an audible “pop” or “click”.

**The material risks inherent in an adjustment:** As with any healthcare procedure, there are certain complications that may arise during a chiropractic manipulation. This may include: strains, dislocations, fractures, disc injuries and stroke. This list is not all inclusive.

**The probability of those risks:** Fractures are rare and can result from an underlying weakness in the bones. The other complications listed are considered rare. One source states that stroke is a possible occurrence in 1/1,000,000 cases or higher, even so we employ tests during our examination to identify if you may be susceptible to that kind of injury.

**Ancillary treatments recommended:** Ice, Moist Heat Packs, Electrical Muscle / Interferential Stimulations, Stretching / Strengthening Exercises, Neuromuscular Re-education, and Mechanical / Decompression Traction.

**Risks involved with the recommended ancillary treatments:** Ice, Heat and Electrical Muscle Stimulations (EMS) can cause burning. The EMS can cause skin irritation underneath the active pads. Stretching / Strengthening Exercises and Mechanical Traction can cause temporary post treatment soreness or reflex muscle spasms. This list is not all inclusive.

**Other treatment options for your condition can include:** Medical care with prescription drugs, self-management with over-the-counter medication, rest, and / or surgery. There are material risks inherent in each of these options including but not limited to: addiction to medication, side effects of medication, improper self-dosages and surgical risks including complications from either the procedure or the anesthesia or both.

### DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the chiropractic adjustment and the related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it was in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Patient Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature: \_\_\_\_\_

..... For Office use only .....

Dr. Signature \_\_\_\_\_

The patient had the following questions and was supplied the following answers:

It is my clinical opinion this patient is oriented to time and space: Yes No  
It is my clinical opinion this patient was able to understand the language involved: Yes No