JARRETT CHIROPRACTIC
A Professional Corporation

PERSONAL DATA

Name_____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Work Address _____

Date of Birth _____☐ Male ☐ Female Social Security# _____ - _____ - _____

Marital Status _____ Spouses Name _____

In case of emergency contact: _____ Phone_____

Whom may we thank for referring you? _____

Would you like to be added to our website for the latest updates on Health and Wellness?

☐ Yes: Please provide your email _____

If you would like to receive an appt reminder text, please provide your cell # and carrier name:
Cell# _____ Carrier:_____

MEDICAL HISTORY

What medications are you currently taking? _____

If female: Is there any chance you may be pregnant and should not be x-rayed? Yes _____ No _____

For what problem are you being seen today? _____

Have you seen another doctor for this problem? Y____ N ____ If yes, whom?_____

Who is your family practitioner? _____

Would you like a report sent to him/her for your medical file? Yes _____ No _____

I verify that the above information is accurate and complete.

Signature _____

Dr. T. Roy Jarrett, III, D.C. Dr. Michelle Booth, D.C.
Jarrett Chiropractic, P.C.
537 N. Great Neck Road Virginia Beach, VA 23454 757-463-0193 FAX:757-463-5338

OVER

Please check ☑ the appropriate box:
Past / Now

____ / ____ Headache ____ / ____ Tingling ____ / ____ Bone Disease ____ / ____ Prostate Trouble

____ / ____ Back Pain ____ / ____ Scoliosis ____ / ____ Nervous Disorder ____ / ____ Heart Problems

____ / ____ Neck Pain ____ / ____ Injuries ____ / ____ Stress Difficulty ____ / ____ Tumors/Cancer

____ / ____ Arm Pain ____ / ____ Joint Pain ____ / ____ Kidney Problems ____ / ____ Lung Problems

____ / ____ Leg Pain ____ / ____ Fractures ____ / ____ Urinary Infections ____ / ____ Joint Swelling

____ / ____ Numbness ____ / ____ Surgery ____ / ____ Menstrual Problems ____ / ____ Blood Problems

____ / ____ Digestive Problems ____ / ____ Bleeding Disorders ____ / ____ Other

____ / ____ Pacemaker ____ / ____ Defibrillator

I verify that the above information is accurate and complete_____
Signature

The following is a statement of our Financial Policy, which we require you to read and sign <u>prior</u> to any treatment.

Jarrett Chiropractic, P.C. requires your first visit to be paid in full. If Jarrett Chiropractic agrees to accept assignment of benefits from your insurance company, you will be responsible to pay the full amount of your deductible and your co-payment upon each visit. For your convenience, weekly payments are an available option.

Please choose which payment option you will be using:

_____ Cash _____ Check _____ Visa/MasterCard

I have read the above policy and understand the terms. I authorize Jarrett Chiropractic to furnish information regarding my case to my insurance company and to assign all benefits as a result of the claim. I understand and agree that all services rendered to me are charged directly to me and that if I terminate or suspend my care and treatment, any fees for services rendered to me will be immediately due at time of visit. Should I default on payment of my obligations for these services or action and have to collect payment becomes necessary, I agree to pay the cost of collection including filing fees, rebilling fees, court costs, and attorney's fees of 33 1/3% of the balance due.

Patients Signature _____ Date_____

Guardians Signature Authorizing Care
_____

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Acknowledgement of Notice of Privacy Practices

I, _____ [patient's name] acknowledge that I understand and agree to the Notice of Privacy Practices made available to me by Jarrett Chiropractic PC, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice

_____ _____
Date Signature

_____
Printed Name

For Office Use Only

The Practice has made a good faith effort to obtain an acknowledgement of _____'s [patient's name] receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons:

☐ Patient Unavailable ☐ Patient Physically Unable ☐ Patient Unwilling

The Practice has attempted provide the patient with a Notice of Privacy Practices in the following manner:

☐ In Person ☐ Mail ☐ Telephone

_____ _____
Date Signature

_____
Printed Name

Revised 2/11/2010

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INFORMED CONSENT

Patient Name _____ Date _____

The primary treatment used by doctors of chiropractic is spinal manipulation, or "adjustments". The Doctor will use this procedure in your treatment program.

The Nature of the Chiropractic Manipulation

The Doctor will use his hands to manipulate, loosen, and reposition the joints of your spine. Often with this procedure, you will hear a popping noise associated with the loosening and repositioning.

Material Risks Inherent to Chiropractic Manipulation

As with any healthcare procedure, there are certain complications that may arise from chiropractic manipulations. These complications may include aggravation of degenerative or injured spinal discs, rib fractures, ligament sprains, muscle strains, nerve injury, or spinal cord compression. Manipulation of the neck has been associated with injury to arteries in the neck leading to or contributing to stroke. Local soreness and stiffness are typical in the early phases of treatment.

Probability of those risks occurring

Fractures are rare occurrences and generally result from underlying bone weakness, which we check for during your history, examination, and radiographs. The exact incidence of stroke is uncertain, but is generally believed to occur in less than one per 1 million treatments. We employ physical tests that are advocated to screen for this risk, but they are generally accepted as being insensitive. All other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include over-the-counter medications; rest; prescription medications, which may include anti-inflammatory drugs, muscle relaxants, and pain medications; and surgery.

Material Risks Inherent to Other Treatment Options

While spinal manipulation is associated with complications in a small number of cases, it has a complication rate of several thousand times less than other typical treatment options.

I have read _____ or have had read to me _____ the above explanation of chiropractic manipulation and related treatment. My questions have been answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself 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.

_____ _____

Patient printed name Date

_____ _____

Patient signature Witness signature

Revised 2/11/2010

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Low Back Questionnaire

Do you have lower back pain? ☐ Yes ☐ No When did your pain begin? _____

Did the pain begin with: ☐ A sudden injury ☐ Without obvious cause

Is the pain: ☐ In the center ☐ On the left ☐ On the right

Does the pain radiate to:

The buttock:	☐ Right	☐ Left
The thigh:	☐ Right	☐ Left
The lower leg:	☐ Right	☐ Left
The foot:	☐ Right	☐ Left

Is the pain? ☐ Constant or ☐ On & Off

Do you have pain when you cough, sneeze or strain to have a bowel movement: ☐ Yes ☐ No

Is the pain worse when you: ☐ Sit ☐ Stand ☐ Bend ☐ Walk ☐ Lie down

Is the pain better when you: ☐ Sit ☐Stand ☐ Bend ☐ Walk ☐ Lie down

Have you had any difficulty with bowel or bladder control? ☐ Yes ☐ No

Do your legs ache or cramp when you walk? ☐ Yes ☐ No

Have your legs felt weak or clumsy? ☐ Yes ☐ No

Have you had any back pain before? ☐ Yes ☐ No

Have you seen any other doctors for your back pain? ☐ Yes ☐ No

Have you had x-rays, CT scan or MRI scan: ☐ Yes ☐ No If yes, when _____

Signature_____Date_____

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Mid Back Pain Questionnaire

Do you have mid back pain? ☐ Yes ☐ No When did pain begin? _____

Did the pain begin with: ☐ A sudden injury ☐ Without obvious cause

Have you had mid back pain before? ☐ Yes ☐ No

Have you seen any other doctors for you mid back pain? ☐ Yes ☐ No

Where is the pain? ☐ In the center ☐ On the left ☐ On the right

To where does the pain radiate? Shoulder ☐ Right ☐ Left
Shoulder Blade/Upper Back ☐ Right ☐ Left
Arm ☐ Right ☐ Left
Hand ☐ Right ☐ Left

Duration of the pain: ☐ Constant ☐ On and Off

Do you have pain when you cough, sneeze, or strain to have a bowel movement? ☐ Yes ☐ No

Is the pain worse when you: ☐ Sleep ☐ Sit ☐ Bend/Turn the neck ☐ Stand ☐ Lie down

Is the pain better: ☐ Sleep ☐ Sit ☐ Bend/Turn the neck ☐ Stand ☐ Lie down

Have you had any difficulty with bowel or bladder control? ☐ Yes ☐ No

Do your hands tingle or cramp? ☐ Yes ☐ No

Do your arms feel weak or clumsy? ☐ Yes ☐ No

Have you seen any other doctors for your mid back pain? ☐ Yes ☐ No Whom? _____

Have you had x-rays, CT scan or MRI scan: ☐ Yes ☐ No

Signature_____ Date_____

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Neck Pain Questionnaire

Do you have neck pain? ☐ Yes ☐ No When did pain begin? _____

Did the pain begin with: ☐ A sudden injury ☐ Without obvious cause

Have you had neck pain before? ☐ Yes ☐ No

Have you seen any other doctors for you neck pain? ☐ Yes ☐ No

Where is the pain? ☐ In the center ☐ On the left ☐ On the right

To where does the pain radiate? Shoulder ☐ Right ☐ Left
Shoulder Blade/Upper Back ☐ Right ☐ Left
Arm ☐ Right ☐ Left
Hand ☐ Right ☐ Left

Duration of the pain: ☐ Constant ☐ On and Off

Do you have pain when you cough, sneeze, or strain to have a bowel movement? ☐ Yes ☐ No

Is the pain worse when you: ☐ Sleep ☐ Sit ☐ Bend/Turn the neck ☐ Stand ☐ Lie down

Is the pain better: ☐ Sleep ☐ Sit ☐ Bend/Turn the neck ☐ Stand ☐ Lie down

Have you had any difficulty with bowel or bladder control? ☐ Yes ☐ No

Do your hands tingle or cramp? ☐ Yes ☐ No

Do your arms feel weak or clumsy? ☐ Yes ☐ No

Have you seen any other doctors for your neck pain? ☐ Yes ☐ No Whom? _____

Have you had x-rays, CT scan or MRI scan: ☐ Yes ☐ No

Signature_____ Date_____