PATIENT INTRODUCTION FORM

Today's Date:________________________________

First Name: **MI:**	**Last Name:**
Home Address:	City: State: Zip:
Date of Birth: Age:	Home Telephone:
E-Mail Address:	Work Telephone:
Social Security No:	Employer's Name:
Drivers License No:	Marital (**Circle**): Single, Married, Divorced, Widowed Height: Weight:

Describe the reason for your visit today:____

____

THIS VISIT IS RELATED TO THE FOLLOWING:

- ☐ Work Related Injury
- ☐ Sports or Recreational Injury
- ☐ Car Crash Injury
- ☐ Other (Describe):
- ☐ Motorcycle-Bicycle Injury
- ☐ Non-Injury Symptoms
- ☐ School/Employment Physical
- ☐ Home Injury
- ☐ Check-up Only

INSURANCE INFORMATION

Does your insurance cover Chiropractic treatment?	☐ Yes ☐ No If yes, we need a copy of the card
If yes, indicate Insurance Company Name (Need copy of card). **If you are being seen for a work-related or car accident injury, we need the Claim Number and the Claims Adjuster's Name. If unknown, please be certain to let the front desk staff know.**	Carrier Name: ________________________ Address: ___________________________ Telephone: _________________________ Claim#/Group#:______________________ Claim Adjusters Name:
Are you the insured person or a dependent?	☐ Insured ☐ Dependent
If you are the insured persons dependent (spouse or child), we need the insured persons name, date of birth, social security number and the name of the insured's employer's business in order to do billing.	Name of Insured Person: __________________ Social Security Number: __________________ Insured Date of Birth: ____________________ Name of Insured Employer:
What is your co-payment amount for each visit?	Amount: $
What percentage does your insurance pay?	Percentage (%):
What is your insurance deductible amount each year?	Amount: $
Have you met your deductible this year?	☐ Yes ☐ No
Does your insurance limit each office payment amount?	☐ Yes ☐ No Limit: $
Does your insurance limit office visits per year?	☐ Yes ☐ No Number:
Does your insurance limit the amount paid per year?	☐ Yes ☐ No Limit: $

Our office will provide insurance billing services for you, if you so desire, as a courtesy. *Remember that you are ultimately responsible for any charges incurred in this office, including missed appointment fees. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier.* ***Your signature on this document indicates that you agree to pay Douglas F. Cancel, D.C. for all charges incurred in this office.***

WE EXPECT PAYMENT IN FULL AT THE CONCLUSION OF EACH TREATMENT FOR NON-INSURED PATIENTS OR THE CO-PAYMENT PORTION FOR PATIENTS WITH INSURANCE. THE FEE FOR EACH MISSED APPOINTMENT THAT OCCURS WITHOUT 24 HOURS ADVANCE NOTIFICATION IS $50.00 (exception- medical/family emergencies)

Signature of responsible party (Patient or Parent): ____ Date: ______________________

PAST AND PRESENT GENERAL HEALTH HISTORY

Check only those that apply and indicate if you have had them in the past or are currently having them:

YES	GENERAL QUESTIONS	PAST	PRESENT
☐	I bruise easily	☐	☐
☐	I heal slowly	☐	☐
☐	My body temperature is normally low (feel cold)*	☐	☐
☐	Smoke cigarettes or use tobacco products	☐	☐
☐	Diabetic-Hypoglycemic or need to have dialysis.	☐	☐
☐	Do you have a pacemaker or any other mechanical/electronic device in your body?	☐	☐
☐	Heart Attack	☐	☐
☐	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	☐	☐
☐	Dizziness, blacked out, or fainting spell history	☐	☐
☐	Epilepsy-Seizure-Convulsion history	☐	☐
☐	History of gout, lupus, psoriasis, temporary paralysis, or spinal meningitis	☐	☐
☐	Cancer history or treatment of any type	☐	☐
☐	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	☐	☐
☐	Told that you have scoliosis, spondylolisthesis, disc degeneration, or herniated disc	☐	☐
☐	Told that you have spina bifida, abdominal aneurysm, or vascular conditions	☐	☐
☐	Have you ever been hospitalized? Why:	☐	☐
☐	Thyroid disorders	☐	☐
☐	Coma from head injury or other problem	☐	☐
☐	Told you have osteoporosis of your spine or osteopenia (weak bones)	☐	☐
☐	Told you have osteoarthritis or rheumatoid arthritis of your spine or joints	☐	☐
☐	**Women only**: Check this box if you currently have any type of breast implants	N/A	N/A
☐	**Women only**: Check this box if there any chance that you are currently pregnant	N/A	N/A

PRIOR INJURY OR MUSCULOSKELETAL PAIN HISTORY

☐ **I do not have a previous history of painful injury or pain.** If you do, please check below:

☐ Work Injury	☐ Fall	☐ Sports Injury	☐ Lifting Injury	☐ Car accident
☐ Motorcycle Injury	☐ Bicycle Injury	☐ Pedestrian Injury	☐ Military Injury	☐ Other Injury
☐ Headaches/Migraines	☐ Neck Pain or Arm Pain	☐ Middle Back Pain	☐ Low Back/Leg Pain	☐ Other Pain

FRACTURES/BROKEN BONES

☐ **I have never had broken bones.** If you have had broken bones, please indicate which bones and when:

REGION	YEAR	REGION	YEAR
☐ Spinal Vertebra		☐ Skull	
☐ Collar bone (clavicle)		☐ Rib bone	
☐ Arm or hand bone		☐ Leg or foot bone	
☐ Pelvis bone		☐ Other	

PAST AND PRESENT GENERAL HEALTH HISTORY

PREVIOUS SURGERIES

☐ **I've never had a surgical procedure.** If you have undergone surgery, please list what type and when:

SURGERY	YEAR	SURGERY	YEAR
☐ Spine Surgery (neck or back)		☐ Appendix	
☐ Disc surgery in neck or back		☐ Gallbladder/Stomach/Kidney	
☐ Heart		☐ Cancer (any type)	
☐ Tonsillectomy		☐ Rib/Collar bone	
☐ Head/Brain		☐ Hernia	
☐ Shoulder/Arm/Leg		☐ Other	

CHECK RECENT OR CURRENT SYMPTOMS

SYMPTOM	HOW LONG	SYMPTOM	HOW LONG
☐ Headaches/Migraines		☐ Upper Back Pain, Soreness, or Stiffness	
☐ Neck Pain, Soreness, or Stiffness		☐ Hip Pain	
☐ Low Back Pain, Soreness, Stiffness		☐ Leg or Foot Pain, Numbness, or Tingling	
☐ Arm/Hand Pain, Numbness, or Tingling		☐ Other:	

SYMPTOMS/PAIN DESCRIPTION

Please circle any word or words below that best describe how your symptoms currently feel to you.

Pain	Pinching	Spreading	Vicious	Unbearable
Ache	Pricking	Shooting	Sickening	Soreness
Cutting	Tingling	Stabbing	Miserable	Pins and Needles
Tearing	Gnawing	Dull	Troublesome	Radiating
Crushing	Nagging	Bony	Pressing	Weakness
Pulling	Boring	Terrifying	Deep pain	Falls asleep
Irritating	Burning-Hot	Dreadful	Superficial pain	Suffocating
Annoying	Drill like	Fearful	Stinging	Punishing
Stiff or tight	Heavy	Unhappy	Throbbing	Crawling
Exhausting	Numbness	Torturing	Sharp	Tender

HAVE YOU BEEN TO A CHIROPRACTOR FOR ANY PRIOR CONDITION?

☐ No ☐ Yes. Chiropractor's Name: ______________________________________ Year: _________________
Problem seen for: ____
Do you have problems laying facedown on an examination table? ☐ No, ☐ Yes. Why?___________________
____

ARE YOU UNDER ANY OTHER MEDICAL/PSYCHIATRIC TREATMENT?

If yes, please explain:____

PAST AND PRESENT GENERAL HEALTH HISTORY

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING

☐ **I am not taking any medications.** If you are, please check any medications that you are currently taking.

☐ Muscle Relaxants	☐ Aspirin	☐ Statin Drugs
☐ Anti-inflammatory	☐ Tylenol	☐ Diuretic/Hypertension Drugs
☐ Narcotics for Pain	☐ Advil/Motrin	☐ Stroke prevention meds
☐ Heart medications	☐ Birth control medications	☐ Other

WHEN IS YOUR PAIN USUALLY BETTER?

☐ Morning	☐ Afternoon	☐ Evening
☐ During sleep hours	☐ Lying down flat	☐ Standing
☐ Walking	☐ Sitting	☐ Rest
☐ Stress (mental) is less	☐ Good posture	☐ Exercise/Stretching

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING:

☐ Excessive fatigue-malaise	☐ Bowel or bladder disorders	☐ Night pain or night time sweats
☐ Weight loss	☐ Ovarian pain	☐ Abdominal pain
☐ Low grade fever	☐ Kidney pain/painful urination	☐ Balance problems

DO YOU EXERCISE?

☐ I do no regular exercise	☐ I exercise 1-2 times a week	☐ I exercise 3-5 times a week
☐ I stretch regularly	☐ I do weight lifting at gym/home	☐ I do cardiovascular work outs
☐ I am willing to do exercise	☐ I am not willing to do exercises	☐ I do regular sports activities

WHAT ARE YOUR SLEEPING PATTERNS?

Please check either Yes or No

Y	N	
☐	☐	Do you sleep poorly at night recently?
☐	☐	Do you sleep on your stomach?
☐	☐	Do you consistently feel extremely tired when you wake up in the morning recently?

SYMPTOMS QUESTIONNAIRE

Please fill out only the sections that apply to you. Skip sections that do not relate to your condition.

NECK REGION

Y	N	
☐	☐	Do neck and head movements cause your neck pain to intensify?
☐	☐	Do you get dizzy when you look up or twist your head? If yes, how often:
☐	☐	Do you black out or lose your balance when you look up or twist your head? If yes, how often:
☐	☐	Do you have to support your head with your hand or grasp your mouth or hair to be able to lift your head up when you are lying down and attempting to sit up? If your difficulty/inability to lift your head without support is injury related, indicate how soon this occurred after injury? (___________min/hrs)
☐	☐	Do you feel your neck pain sends pain downwards between your shoulders?
☐	☐	Do you feel your neck pain sending pain downwards to the front of your chest?
☐	☐	Have you noticed your head leaning or tilting to one side recently?
☐	☐	Have you ever been diagnosed as having a disc bulge or herniation in your neck?

ARM, HAND OR FINGER REGION

Y	N	
☐	☐	Do you have pain, numbness, or tingling in your shoulder, upper arm, lower arm, or hand? Circle areas
☐	☐	Do you have pain, numbness, or tingling in your fingers? If Yes, circle which finger(s) are involved: Thumb, Index finger, Middle finger, Ring finger, Little finger
☐	☐	Do you get increased arm numbness when lying flat on your back* or sleeping on your side recently?*
☐	☐	Does changing your sitting posture increase your arm/hand symptom intensity?
☐	☐	If you sit and slouch forward for several minutes, do your arm symptoms intensify?
☐	☐	If you have arm symptoms, do they improve when you lift your arms over your head? *
☐	☐	If you have arm symptoms, do they worsen when you lift your arms over your head? *
☐	☐	If you have night time hand or arm pain, does it help to shake and massage them?
☐	☐	Do your hands feel tender when you grasp objects recently?
☐	☐	Do you feel weakness in your grip strength recently?
☐	☐	Do you drop objects in your hand recently?
☐	☐	Do you have difficulty writing or doing small motions with your fingers recently?
☐	☐	Do your hand(s) or wrist get swollen recently?
☐	☐	Do your hands burn recently?
☐	☐	Are your fingers frequently cold?
☐	☐	Have you been diagnosed as having Raynaud's syndrome in your past?

MID-BACK AND CHEST WALL REGION

Y	N	
☐	☐	Do you have pain that shoots or radiates outward along your rib cage?
☐	☐	Does your mid back or chest wall pain intensify when you take a deep breath in or cough recently?
☐	☐	Does your mid back or chest wall pain intensify when you twist your torso, bend, or stoop forward?
☐	☐	When you bend your mid back to the left or right side, does your mid back pain or chest pain increase?
☐	☐	Have you been diagnosed as having angina before?
☐	☐	Do you have a tight band-like chest feeling recently?
☐	☐	Do you recently have any associated unusual indigestion, chest pressure, or pain down your left arm?
☐	☐	Does your mid back pain mostly bother you during sleep?
☐	☐	Does your upper-middle back pain radiate inwards or upwards into your neck?

SYMPTOMS QUESTIONNAIRE

Please fill out only the sections that apply to you. Skip sections that do not relate to your condition.

LOW BACK, HIP AND LEG/FOOT REGION

Check any of the following body movements that intensify your low back pain or leg symptoms

☐	Sitting	☐	Bending forwards	☐	Standing up	☐	Walking
☐	Standing still	☐	Bending backwards	☐	Lying on your back	☐	Putting on shoes

Check all locations of any current leg pain, numbness, or tingling

☐	Hip	☐	Buttock	☐	Back of thigh	☐	Calf
☐	Groin area	☐	Knee	☐	Front of thigh	☐	Foot/toes

Please check either Yes or No

Y	N	
☐	☐	When you cough, sneeze, or bear down to have a bowel movement, does your low back pain or leg pain get worse recently?
☐	☐	Do you have a consistent pattern of getting severe leg pain after walking for similar distances that is relieved by resting or sitting? This pain resumes after walking for the same distance again, *
☐	☐	Do you get leg cramping while walking that is relieved by resting, leaning against an object, or sitting? This pain is worse at nighttime and relieved by walking around for a couple of minutes. *
☐	☐	Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down? This pain doesn't bother you at night time or while sitting. *
☐	☐	Does your leg or foot drag on the floor recently?
☐	☐	Do you get a lot of leg cramps at night time recently?
☐	☐	Have you had any urinary or bowel incontinence recently or had difficulty urinating or having bowel movements during the same time as your having low back pain or leg pain?
☐	☐	Have you had abdominal pain, indigestion, colicky symptoms with your low back pain?
☐	☐	Have you observed that your low back pain is not relieved by any type of postural change?
☐	☐	Do your feet feel cold recently? If yes, indicate which feet:
☐	☐	Have you ever been diagnosed as having a herniated or bulging disc in your low back in the past?
☐	☐	Have you ever had an injection of Chymopapain into your discs in your back or neck?
☐	☐	Have you recently noticed that either of your legs occasionally give out on you when you walk? *
☐	☐	Have one or both of your legs felt weak recently?
☐	☐	Have you ever been diagnosed as having a spondylolisthesis in your low back region?
☐	☐	Have you or either of your parents ever been diagnosed as having an abdominal aneurysm?
☐	☐	If you have radiating leg or foot pain, did you notice low back pain or soreness before your leg symptoms became noticeable?
☐	☐	If you have leg pain, is your leg pain primarily focused in the front of your thigh(s)?*
☐	☐	Has your anal-rectal region been completely numb recently?
☐	☐	**Men Only.** Do you have any recent prostate or urinary problems?
☐	☐	**Women Only.** Do you have any recent ovarian, uterine, or bladder problems?

Office Use Only

- ☐ 1
- ☐ 2-5
- ☐ >5

WILTSE et. al.

Patient #: ____________

PAIN DRAWING

Name: ____________ Todays Date: ____________

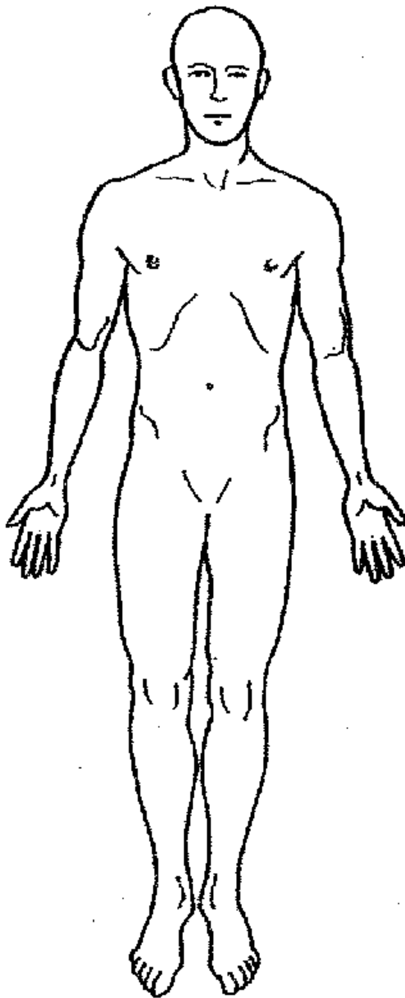
Date of Birth: ____________ Examiner: ____________

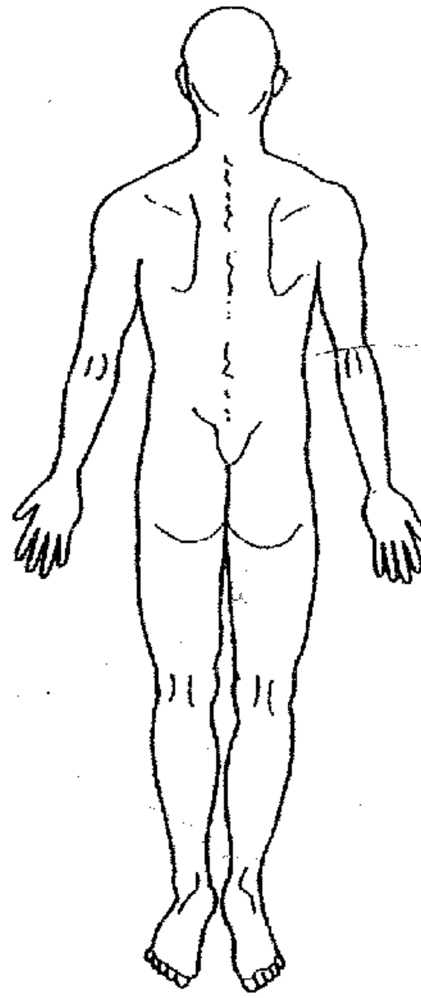
TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbols(s) listed below.

Ache >>>> >>>>	Numbness ==== ====	Pins and Needles oooo oooo
Burning xxxx xxxx	Stabbing //// ////	Throbbing ~~~~ ~~~~





DOUGLAS F. CANCEL, D.C./PERFORMANCE SPORT-CARE

P.O. Box 3915, Walnut Creek, CA 94598

1. Authorization to Release Medical Records
2. Authorization to Release Information
3. Assignment of Benefits and Payment Policy
4. Authorization for Treatment

I hereby authorize Douglas F. Cancel, D.C., to release my clinical records and radiological films directly to other caregivers for the purpose of my further diagnosis or treatment. This excludes the release of drug, alcohol, psychiatric or HIV records which require separate, written authorization.

I hereby authorize Douglas F. Cancel, D.C., to furnish to my insurance company's/companies' attorney or legal representative all information which said parties may request concerning my illness or injury. I hereby assign Douglas F. Cancel, D.C., all money which may be recovered from any source in connection with the accident or illness for which I am being treated by Douglas F. Cancel, D.C., not to exceed my indebtedness to him. I further agree and accept as follows:

That insurance is a contract between the patient or guarantor and the insurance company. Douglas F. Cancel, D.C., only bills insurance as a courtesy to patients and I am financially responsible to Douglas F. Cancel, D.C., for ALL charges for services rendered. (If you are an HMO patient, you are only responsible for any amount attributed to co pay, deductible and non-covered services should that apply to your plan.)

I recognize that Douglas F. Cancel, D.C., will bill and attempt to collect from my insurance company/companies as a courtesy. I fully understand that Douglas F. Cancel, D.C., may not accept my insurance company's usual and customary fees (UCR) as payment in full. This may lead to my receiving a bill for deductibles, co-payments, co-insurance and non-covered items. I agree to pay for any such balance. I understand that it is my responsibility to obtain all necessary referrals from other doctors and my insurance company/companies as required by my insurance company/companies, and this must be done before I can consult Douglas F. Cancel, D.C. In the event that services are rendered and later denied by my insurance company/companies for lack of referral or pre-authorization, I understand that it shall be my responsibility to pay Douglas F. Cancel, D.C., for all services rendered. I also understand that I am responsible for understanding my individual insurance policy and benefits prior to seeking services.

Although I may be represented by an attorney on matters related to the illness or injury for which Douglas F. Cancel, D.C. my have rendered services to me, I must still keep my account current and paid in full.

If my account becomes delinquent and is referred to an attorney or collection agency for collections, I agree to pay a 33% attorney's or collection fee, any court costs incurred by Douglas F. Cancel, D.C., and interest at the rate of 1.5% per month (or the maximum permitted by State Law, if less) on the unpaid balance from the date that payment was first due, in addition to the outstanding balance of the account.

I fully understand that while Douglas F. Cancel, D.C. is willing to send an insurance claim to my insurance company/companies, Douglas F. Cancel, D.C. will not be responsible for lost claims or claims which did not arrive at my insurance company/companies. I understand that if payment from my insurance company/companies has not been received by Douglas F. Cancel, D.C. within 75 days from the date of service, the TOTAL balance will become my responsibility and will be due immediately. All accounts that are 90 days old will be sent to collection. Patients are encouraged to stay in touch with their insurance company/companies as to the status of their claim.

This agreement is in addition to any other agreement which I may have with Douglas F. Cancel, D.C. I have read this document, understand it fully, have been provided an opportunity to ask questions and have them answered to my satisfaction, and I agree fully to the terms and conditions.

Print Name____

Signature____________________________________Date____________________________

(Patient or authorized representative)