Phone: 716-259-1700 **Fax:** 716-608-6188

Last Name: _____ **First Name:** _____

Who can we thank for this referral? _____

Address: _____

Cell Phone: _____ **Work Phone**: _____

Emergency Contact: _____

Occupation: _____

Email: _____
(For appointment reminders, invoices and clinic updates ONLY) ☐ I agree

Birthdate (dd/mm/yr): _____ **Gender:** _____ **Marital Status:** _____

EXTENDED HEALTHCARE COVERAGE

Insurance Company Name: _____
Group ID/Policy Number: _____
Member Number: _____
Relationship to Cardholder (self,spouse, child): _____
Name of Cardholder: _____

Workers' Comp

Insurance Company: _____
Insurance Phone Number: _____
Insurance Fax Number: _____
Claim #: _____
WCB #: _____
Date of Injury: _____
Adjuster Name: _____

Motor Vehicle Accident

Insurance Company: _____
Insurance Phone Number: _____
Insurance Fax Number: _____
Claim #: _____
Date of Injury: _____
Adjuster Name: _____

Assignment of Benefits:
I hereby assign and authorize my insurance benefits to be paid to Evolve Chiropractic of WNY, P.C.

_____
INITIALS

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE

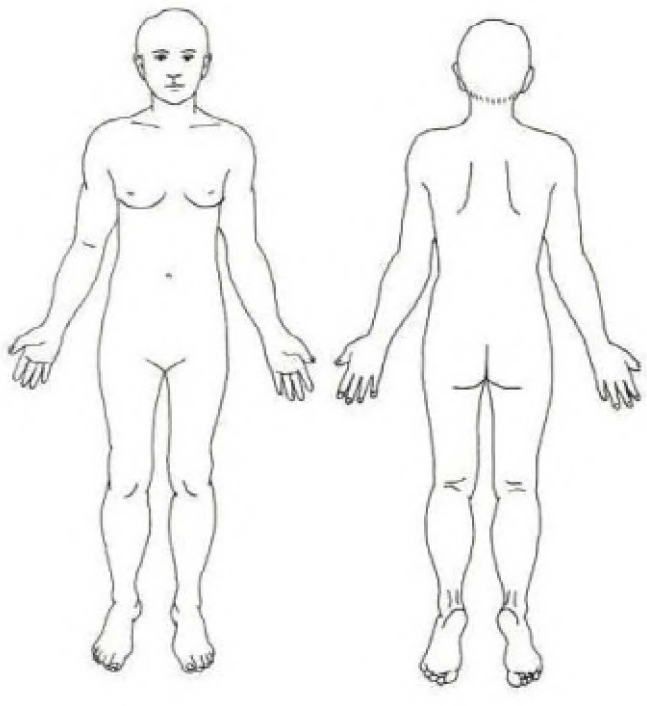
Reason for appointment? _____
_____
_____
_____

When did your condition begin? _____

Please describe your pain: _____
_____
_____

Please indicate the type of pain you are experiencing:
☐achy ☐burning ☐dull ☐numb ☐stabbing ☐tingling

Indicate the location of your pain by shading the appropriate area:



Indicate the severity of the pain by selecting a number:

☐0 ☐ 1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
No Pain **Extreme Pain**

Is this condition related to:
Work: ☐Yes ☐No Has your employer been notified? ☐Yes ☐No
Motor Vehicle Accident: ☐Yes ☐No Date of Injury: _____

Can you perform your daily home activities? ☐Yes ☐Yes, only with help ☐Not at all
Can you perform your daily work activities? ☐All ☐Only some ☐Not at all

Are you, or do you plan to become pregnant? ☐Yes ☐No ☐Unknown
If yes, how far along? _____

Had previous chiropractic care: ☐Yes ☐No Doctor: _____

Have you had X-rays, MRI or other tests? _____
_____
_____
_____

Please list any previous surgeries, illnesses, injuries (motor vehicle accident):
_____
_____
_____
_____
_____
_____

List ALL medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.)
_____
_____
_____
_____
_____
_____

SYSTEM REVIEW

Please check any conditions that are presently causing you a problem or that have caused you problems in the past

GENERAL SYMPTOMS
- ☐Fever
- ☐Sweats
- ☐Fainting
- ☐Sleep disturbance
- ☐Fatigue
- ☐Nervousness
- ☐Weight loss
- ☐Weight gain

RESPIRATORY
- ☐Chronic Cough
- ☐Spitting up phlegm
- ☐Spitting up blood
- ☐Chest pain
- ☐Wheezing
- ☐Difficulty breathing
- ☐Asthma

GENITOURINARY
- ☐Frequent urination
- ☐Painful urination
- ☐Blood in urine
- ☐Pus in urine
- ☐Kidney infection
- ☐Prostate trouble
- ☐Uncontrollable urine flow

NEUROLOGICAL
- ☐Visual Disturbance
- ☐Dizziness
- ☐Fainting
- ☐Convulsions Headache
- ☐Numbness
- ☐Neuralgia (nerve pain)
- ☐Poor coordination
- ☐Weakness

CARDIOVASCULAR
- ☐Rapid beating heart
- ☐Slow beating heart
- ☐High blood pressure
- ☐Low blood pressure
- ☐Pain over heart
- ☐Hardening of arteries
- ☐Swollen ankles
- ☐Poor circulation
- ☐Palpitations
- ☐Cold hands or feet
- ☐Varicose veins

GASTROINTESTINAL
- ☐Poor appetite
- ☐Difficult digestion
- ☐Heartburn
- ☐Ulcers
- ☐Nausea
- ☐Vomiting
- ☐Constipation
- ☐Diarrhea
- ☐Blood in stool
- ☐Gallbladder/jaundice
- ☐Colitis

EYES, EARS, NOSE, THROAT
- ☐Eye pain
- ☐Double vision
- ☐Ringing in ears
- ☐Deafness
- ☐Nosebleeds
- ☐Trouble swallowing
- ☐Hoarseness
- ☐Sinus infection
- ☐Nasal drainage
- ☐Enlarged glands

MUSCLE & JOINT
- ☐Neck pain
- ☐Low back pain
- ☐Arm pain
- ☐Shoulder pain
- ☐Leg pain
- ☐Knee pain
- ☐Foot pain
- ☐Pain/numbness down arms or legs
- ☐Pain between shoulders swollen joints
- ☐Spinal curvature
- ☐Arthritis
- ☐Fractures

FOR WOMEN ONLY
- ☐Painful menstruation
- ☐Hot flashes
- ☐Irregular cycle
- ☐Cramps or back pain
- ☐Vaginal discharge
- ☐Nipple discharge
- ☐Lumps in breast
- ☐Menopausal symptoms
- ☐Birth control pills
- ☐Miscarriages
- ☐Complications with pregnancy
- ☐Pregnancy
  - ☐Yes ☐No Week? _____
- ☐Other:_____

IMMUNE SYSTEM

Have you ever tested positive for any blood-borne diseases?
(HIV, AIDS, Hepatitis C, etc) ☐Yes ☐No

Are you immunocompromised? ☐Yes ☐No

Are you taking blood thinners? ☐Yes ☐No

CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

Temporary worsening of symptoms - Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.

Skin irritation or burn - Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.

Sprain or strain - Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.

Rib fracture - While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.

Injury or aggravation of a disc - Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

Stroke - Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently , and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of visions, speech, balance and brain

function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for you care. Inform your chiropractor immediately of any change in your condition.

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

1 Test

Name (Please Print)

_____

Signature of patient (or legal guardian)

_____

Signature of Chiropractor

Consent to Release Information:

I give EVOLVE CHIROPRACTIC WNY PC my consent to release/obtain information from the following individuals with respect to my care by report, letter, phone, fax, email or direct communication:

•Physician(s) •Employer •Insurer •Other

_____

INITIALS

IF I AM UNABLE TO ATTEND A SCHEDULED APPOINTMENT I WILL PROVIDE 24 HOURS NOTICE TO AVOID BEING CHARGED A MISSED APPOINTMENT FEE OF $25.00. I AGREE TO PAY MY FULL ACCOUNT AT THE TIME OF EACH VISIT OR TREATMENT, INCLUDING FEES FOR SERVICE AND ANY GOODS PURCHASED.

I hereby acknowledge that I have discussed with the Chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

1 Test

Name (Please Print)

_____

Date

_____

Patient Signature (or Legal Guardian)