# Sitzmann Chiropactic

1607 E. Main Street, Lincolnton NC 28092 - (980) 284-2525

Date: _____

Name: _____ Preferred Name: _____

Phone: _____ Email: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Sex: Male Female Are you pregnant? □ Yes □ No If so, how many weeks? _____

Have you seen a chiropractor before? □ Yes □ No Who referred you to Sitzmann Chiropractic? _____

Emergency Contact Name: _____ Phone number: _____

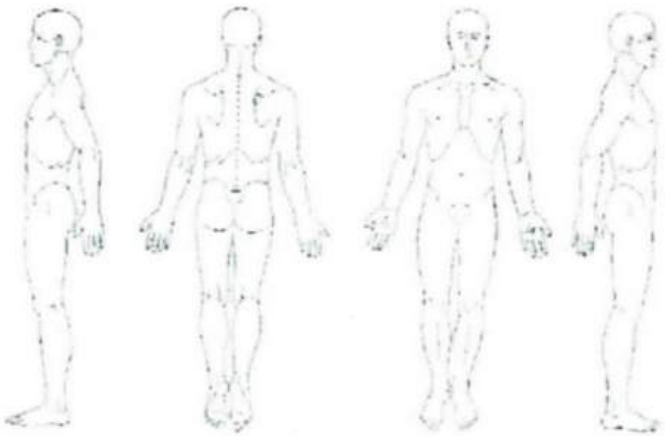
Describe the reason (s) for your doctor visit today: _____

_____

Describe your symptoms? Ache Numb Burning Tingling Stiffness Sharp _____

Mark any area (s) of discomfort with the following key:

A = Ache N = Numbness B = Burning T = Tingling S = Stiffness O = Other



Left Back Front Right

When did your symptoms start? _____

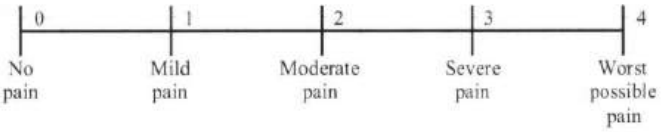
How did your symptoms begin? _____

What improves your symptoms? Ice Heat Rest Movement Stretching Medication _____

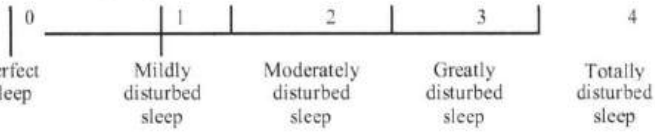
# Functional Rating Index

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

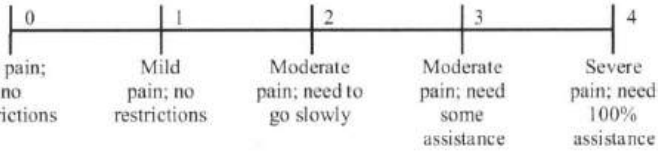
### 1. Pain Intensity



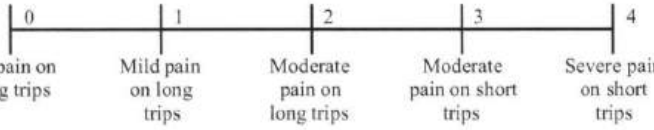

### 2. Sleeping



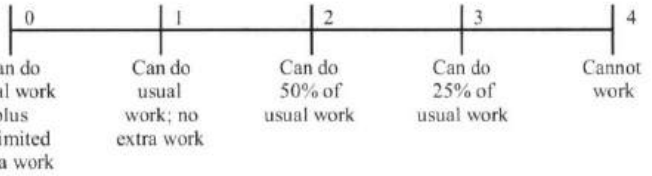

### 3. Personal Care (washing, dressing, etc.)



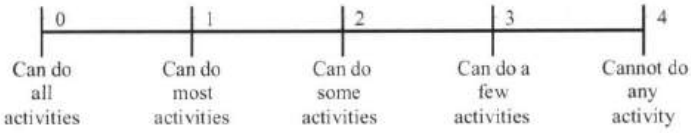

### 4. Travelling (driving, etc.)



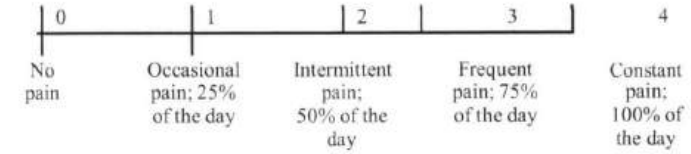

### 5. Work



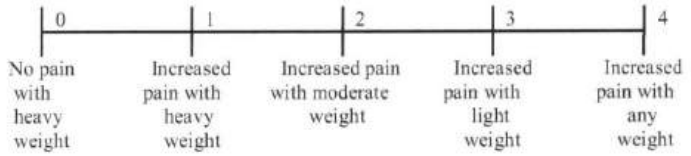

### 6. Recreation



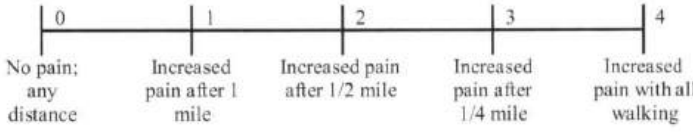

### 7. Frequency of Pain



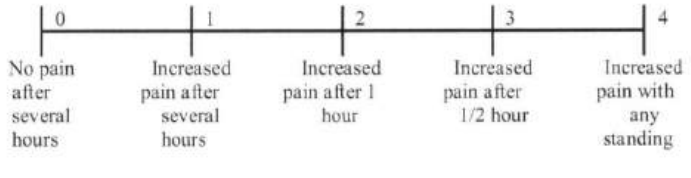

### 8. Lifting




### 9. Walking




### 10. Standing




Patient's Signature

Date

Have you seen another doctor for these symptoms? If yes, indicate name, type of medical provider, and care received: _____

_____

List all medications you take as well as the associated condition: _____

_____

List any surgeries you have had and include the year it was performed in: _____

_____

Are you currently experiencing any of these symptoms? Please select all that apply.

**Musculoskeletal:**
- □ Muscle Pain/Stiffness/Spasms
- □ Broken Bones_____
- □ Joint pain/Stiffness/Swelling
- □ Other: _____

**Eyes & Vision:**
- □ Eye Pain
- □ Blurred or Double Vision
- □ Sensitivity to Light
- □ Other: _____

**Head, Ears, Nose & Mouth/Throat:**
- □ Frequent or Recurrent Headaches
- □ Ear- Ache/Ringing/Drainage
- □ Sensitivity to Loud Noises
- □ Sinus Problems
- □ Sore Throat
- □ Other: _____

**Integumentary:** *(Skin, Nails & Breasts)*
- □ Non-healing Sores or Lesions
- □ Rash or Itching
- □ Change in Skin, Hair or Nails
- □ Change of Appearance of a Mole
- □ Breast Pain, Lump, or Discharge
- □ Other: _____

**Neurological:**
- □ Dizziness or Lightheaded
- □ Convulsions or Seizures
- □ Tremors
- □ Other: _____

**Allergic/Immunologic:**
- □ Food Allergies
- □ Environmental Allergies
- □ Other: _____

**Psychiatric:** *(Mind/Stress)*
- □ Nervousness/Anxiety
- □ Depression
- □ Sleep Problems
- □ Memory Loss or Confusion
- □ Other: _____

**Hematologic & Lymphatic:**
- □ Excessive Thirst or Urination
- □ Cold Extremities
- □ Swollen Glands
- □ Other: _____

**Endocrine:**
- □ Infertility
- □ Recent Weight Change
- □ Eating Disorder
- □ Other: _____

**Genitourinary:**
- □ Frequent or Painful Urination
- □ Blood in Urine
- □ Incontinence or Bed Wetting
- □ Other: _____

**Cardiovascular & Heart:**
- □ Chest Pains/Tightness
- □ Rapid or Heartbeat Changes
- □ Swelling of Hands, Ankles or Feet
- □ Other: _____

**Gastrointestinal:**
- □ Frequent Diarrhea
- □ Constipation
- □ Loss of Appetite
- □ Blood in Stool
- □ Nausea or Vomiting
- □ Abdominal Pain

**Constitutional:**
- □ Fever
- □ Fatigue
- □ Other: _____

**Respiratory**
- □ Cough
- □ Difficulty Breathing
- □ Other: _____

**Patient's signature:** _____ **Date:** _____

# CONSENT FORM

## Consent to Examination and Treatment

By signing below, I give the doctors and staff of Sitzmann Chiropractic permission to perform all examinations, tests, treatments, and anything else deemed necessary or beneficial to my care. I also understand that by either the doctor or an assigned staff member of Sitzmann Chiropractic will perform these actions.

## Consent to Retrieve Medical Records

By signing below, I give the doctors and staff of Sitzmann Chiropractic permission to collect any and all medical records deemed necessary to assist with my care. This includes records from hospitals or any other provider of services, which would be helpful in assisting in my case.

## Consent to Release of Medical Records

By signing below, I give the doctors and staff of Sitzmann Chiropractic permission to disclose all or any part of my record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge. This includes, but is not limited to, hospital or medical service companies, insurance companies, worker's compensation carriers, or welfare funds.

## Consent to Receive Appointment Reminder by text message or email

I herby give my consent to Sitzmann Chiropractic to send text message/ email reminders to my mobile telephone (as per the number and carrier I have listed). These messages will be a reminder of my previously booked appointment date and time, or a notification that I need to make an appointment for an adjustment. All patients have the right to stop this service. If you no longer wish to receive these text reminders please notify our office. If you change your mobile number please inform us so we can update our records.

## Assignment and Conveyance of Lien Interest for Personal Injury Patients (Motor Vehicle Accidents Only)

I hereby execute and provide an Irrevocable Lien interest and Assignment of proceeds to apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance, policy to which I am entitled, and from which I am paid in the form of any insurance settlement(s), claim(s), or verdict(s) resulting from any identified accident. The insurance carrier is instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds the total dollar amount of all sums which I owe on account to the above named doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled, or withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to the above named doctor and or threating facility. In the event my insurance settlement proceeds are paid directly to my attorney and I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to such named doctor and treating facility and remit payment for all such sums directly to such named doctor and/or treating facility upon receipt of my settlements award(s). The patient understand and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care.

## Assignment of Benefits for Insurance Purposes

At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payments of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a daily basis as a courtesy to you. You will be responsible for your deductible and/ or Co-payment. Your insurance should pay within 45 days from the date in which it was filed. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated of time. In the event that your insurance company does not pay on a timely basis, you may be asked to contact your insurance carrier. If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours. The patient understands and agrees to allow this chiropractic office to use the PHI for the purpose of treatment, payment, healthcare operations, and coordination of care.

## Notice of Privacy Policy

By my signature below, I understand my HIPAA rights at Sitzmann Chiropractic. Our office follows the privacy policy described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice. You can request a copy from the front desk.

## Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments (also known as spinal manipulations) and other chiropractic procedures, including various modes of physical therapeutic modalities and diagnostic X-rays on me (or the patient named below, for whom I am legally responsible) by Daniel Sitzmann, DC and/or other licensed doctors of chiropractic who now or in the future work at Sitzmann Chiropractic. I have had an opportunity to discuss with the doctor of chiropractic named above and/or office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand that the type of treatment used in this office is a low force treatment that helps reduce the possibility of the below risks but the information is provided so that I may make an informed decision. I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some possible risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, sprains and strains. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. 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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**Please read the above statements and sign below**

_____ _____

Patient Name Printed Patient Signature

_____ _____

Date Parent/Guardian's Signature (for patients under 18)