Patient Introduction Card

No. _____ Date: _____

Name (Mr. Mrs. Miss Ms.): _____ Home Phone: (___) _____

Email Address (ex: name@email.com): _____

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

☐ Married ☐ Single ☐ Other: _____ Age: _____ Date of Birth: ____ / ____ / _____

Occupation: _____ Employer: _____

Office Address: _____ Office Phone: (___) _____

Previous Chiropractic Care? ☐ YES ☐ NO If YES, Doctor's Name: _____

Name of your Insurance Company: _____

Major Complaint: _____ Social Security No: _____

Who (or what source) referred you? _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged.

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ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI)_____ **Today's Date:** _____

AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- **Was anyone else in the vehicle with you?** ☐ **No** ☐ **Yes** - *(Number of people)* _____
- **You were?** ☐ **Front seat** – *Driver / Passenger* ☐ **Rear Seat**– Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row
- **Name of Driver**, *if not self*: _____ **Name of Driver of other vehicle:** _____
- **Did airbags deploy?** ☐ **No** ☐ **Yes** **Did Police arrive?** ☐ **No** ☐ **Yes** **Using Seatbelt?** ☐ **No** ☐ **Yes**
- **Did you strike the windshield or object in car?** ☐ **No** ☐ **Yes** - *(Describe)* _____
- **Were you knocked unconscious?** ☐ **No** ☐ **Yes** *(How long?)* _____
- **Where was your vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: _____
- **Where was the other vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: _____
- **Your Auto Ins:** _____ **Policy #:** _____ **Claim #:** _____ **Phone #:**_____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____
- **Other's Auto Ins:** _____ **Policy #:** _____ **Claim #:** _____ **Phone #:**_____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

WORKER'S COMPENSATION INJURY – ADDITIONAL INFORMATION

Employer: _____ **Occupation:** _____ **Claim #:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Contact Person: _____ **Phone:** _____ **Email:** _____

GENERAL ACCIDENT/INJURY INFORMATION – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED*)

Date of Accident: ____/____/_____ **Time**: ___:_____ AM / PM

Please describe the accident in as much detail as possible? _____

_____

_____

_____

Before the accident/injury:

- **Have you ever had any complaints in the involved area before?** ☐ **No** ☐ **Yes**
  - *If yes* - **Were they present at the time of the accident/injury?** ☐ **No** ☐ **Yes**
    - *If yes* - **Summarize these complaints prior to the accident:** _____
- **Were you capable of performing all of your work activities without restriction?** ☐ **No** ☐ **Yes**

At the time of the accident/injury:

- **Did you feel pain immediately after the accident?** ☐ **No** ☐ **Yes** ☐ **Later that day** ☐ **Next day** ☐ **When?** _____
- **Were you taken anywhere after the accident?** ☐ **No** ☐ **Yes** ☐ **Later that day** ☐ **Next day** ☐ **When?** _____
  - *If yes*, **How?**_____ **Where?**_____
  - *If yes*, **Did you receive treatment?** ☐ **No** ☐ **Yes** - *(Describe)* _____

Since the accident/injury:

- **Are your symptoms:** ☐ **Improving?** ☐ **Getting Worse?** ☐ **The Same?**
- **Are your work activities restricted as a result of this accident/injury?** ☐ **No** ☐ **Yes** - *(How?)* _____
- **Have you missed any work since this accident?** ☐ **No** ☐ **Yes** - *(Dates?)* _____
- **Have you retained an Attorney?** ☐ **No** ☐ **Yes - Name:**_____ **Phone:** _____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

Patient No: _____

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Are you *currently* experiencing any of these symptoms? *(Check all the apply)*
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: *(constitutional)*
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems _____
- ☐ Leg Problems _____
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones_____
- ☐ Other: _____
- ☐ *None in this Category*

Neurological:
- ☐ Numbness or tingling sensations
- ☐ Loss of Feeling
- ☐ Dizziness or light headed
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Other: _____
- ☐ *None in this Category*

Mind/Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____
- ☐ *None in this Category*

Genitourinary:
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/strain w Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: _____
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains
- ☐ Rapid or Heartbeat changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ Other: _____
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other: _____
- ☐ *None in this Category*

Eyes and Vision:
- ☐ Wear contacts/glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other: _____
- ☐ *None in this Category*

Ears, Nose and Throat:
- ☐ Bleeding gums / mouth sores
- ☐ Bad Breath or bad taste
- ☐ Dental Problems
- ☐ Swollen throat or voice change
- ☐ Swollen glands in neck
- ☐ Ringing in the ears
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Sinus / Allergy problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other: _____
- ☐ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive Thirst or urination
- ☐ Cold Extremities
- ☐ Heat or Cold intolerance
- ☐ Change in hat or glove size
- ☐ Dry skin
- ☐ Glandular or hormone problem
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other: _____
- ☐ *None in this Category*

Skin and Breasts:
- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change of appearance of a mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other: _____
- ☐ *None in this Category*

Women Only:

Are you pregnant?
- ☐ **Yes -** ***Due Date*** __/__/____
- ☐ **No -** ***Last Menstrual Period*** __/__/____
- ☐ Infertility
- ☐ Painful or Irregular periods
- ☐ Vaginal Discharge
- ☐ Other: _____
- ☐ *None in this Category*

Pregnancies:

Date	Outcome

Comments: _____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date_____

Treating Doctor Signature _____ Date_____

Patient No: _____

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Informed Consent and Permission Form

When you give your permission to have chiropractic spinal adjustments and physical medicine modalities performed, you or your guardian should understand the most common risks and hazards we are required to disclose of these procedures. These are all rather infrequent but may occur:

1. Post treatment discomfort, or soreness or stiffness, which may persist 12 to 24 hours after treatment.

2. Transient lightheadedness or dizziness following chiropractic adjustments of the neck. Please alert Dr. Snyder should this reaction occur.

3. Aggravation of acute intervertebral disc bulge or herniation. Please be advised that Dr. Snyder will make reasonable efforts to determine the possibility of an underlying disc problem and modify your treatment recommendations accordingly.

4. Spontaneous vertebral body or rib fracture in an osteoporotic patient. Please be advised that Dr. Snyder will make every reasonable effort to diagnose this preexisting condition and modify your treatment recommendations accordingly.

5. Acute onset of muscle spasms alongside the spine in the area being treated or in an adjacent area. These muscle spasm reactions are commonly present, even before treatment, in the acute patient and every effort will be made to reduce them prior to spinal adjustments.

I understand that no guarantee had been made and that the procedures may not cure my condition.

Authorization To Release Information: Assignment of Benefits

I hereby authorize assignee to release information, or grant release from other parties solely related to my health and treatment, to secure payment for my care at this facility and act as my legal representative regarding any matters, including appeals, relating to health care received at this office or medical bills incurred at this office. I hereby assign payment of my benefits, including major medical benefits to which I am entitled, private insurance or any other health plan to:

Dr. Justin G. Snyder D.C.
4146 S. Harvard Ave. Suite F-5
Tulsa, OK 74135

I also request insurance payments be sent direct to his office and NOT to the policy holders address. A photocopy of this assignment is to be considered as valid as an original. This assignment remains in effect until revoked by me in writing.
I understand that I am financially responsible for all charges whether or not paid by insurance. If the account is placed in collections, additional charges equal to the cost of collections including *agency* and attorney fees and court cost incurred and permitted by law governing these transactions will be added to the amount due. These services and this agreement were entered into the City of Tulsa.

Date_____ _____

Signature

_____

Printed Name

DOCTOR'S STATEMENT: The patient (guardian) and I have discussed the procedures to be preformed. To the best of my knowledge, the patient (guardian) understands the procedures and consents to it.

Dr. Justin G. Snyder D.C.

Snyder Chiropractic
4146 S. Harvard Ave. Suite F-5
Tulsa, OK 74114

Notice of Privacy Practice Summary

This summary discloses how health information about you may be used. A full notice of the privacy rights has also been provided to you.

Snyder Chiropractic uses health information about you for treatment, to obtain payment for treatment with your authorization as required, for administrative purposes, and to evaluate the quality of your care that you receive.

Snyder Chiropractic will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Snyder Chiropractic may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Snyder Chiropractic may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, government function in order to comply with workers compensation laws and regulations. A right to request restriction, report and retain a copy of your health records, request communication authorization and request any accounting of your health records.

You may complain to Dr. Snyder and the Department of Health and Human services if you believe your privacy rights have been violated. You will not be retaliated against for filling a complaint.

Dr. Snyder must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restrictions on how your information is used and disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any other questions or complaints please contact Dr. Snyder D.C. at 918-749-7772.

Patient Signature_____Date_____