

Thompson Chiropractic-Dr. Scot

Today's Date: _____

How did you hear about our office? _____

PATIENT DEMOGRAPHICS

Name: _____ Birthdate: ____-____-____ Age: _____ Male Female

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

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

E-mail Address: _____ Marital Status: Single Married Do you have insurance? Yes No

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number**:

Primary or chief complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Second complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Third complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Fourth complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ When is the problem at its worst? AM PM mid-day late PM

How long does it last? It is constant **OR** I experience it on and off during the day **OR** It comes and goes throughout the week

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? No Yes **If yes**, when? _____ by whom? _____

How long were you under care? _____ What were the results? _____

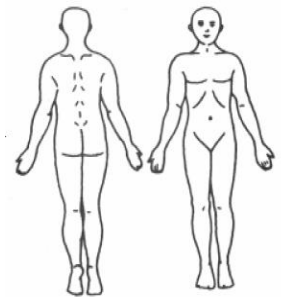
Name of previous chiropractor: _____ N/A

PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/Stabbing **T** = Tingling

What relieves your symptoms? _____

What makes your symptoms feel worse? _____



LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is your problem the result of ANY type of accident? No Yes

PATIENT'S NAME: _____ HR#: _____ DATE: _____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? No Yes **If yes**, how many times? _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: No Yes **If yes**, please state what type of treatment: _____, and who provided it? _____, how long ago? _____, what were the results? Favorable Unfavorable
Please explain: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

Have you had the COVID-19 infection? No Yes **If yes**, how many times have you been infected? _____

Have you been diagnosed with Long COVID? No Yes

Have you had the COVID-19 vaccination? No Yes **If yes**, how many booster shots? _____

If you have ever been diagnosed with any of the following conditions, please indicate with:

P for in the **Past** **C** for **Currently** have **N** for **Never** have had

Broken Bone Dislocations Tumors Rheumatoid Arthritis Fracture Disability Cancer
 Heart Attack Osteo Arthritis Diabetes Cerebral Vascular Other serious conditions: _____

PLEASE IDENTIFY ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE	PROVIDED BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? No Yes **If yes**, whom?
 grandmother grandfather mother father sister(s) brother(s) son(s) daughter(s)
Have they ever been treated for their condition? No Yes I don't know

2. Any other hereditary conditions the doctor should be aware of? No Yes: _____

SOCIAL HISTORY

1. **Smoking:** cigars pipe cigarettes How often? Daily Weekends Occasionally Never
2. **Alcoholic Beverage:** consumption occurs Daily Weekends Occasionally Never
3. **Recreational Drug use:** Daily Weekends Occasionally Never
4. **Hobbies - Recreational Activities - Exercise Regime:** How does your present problem affect? (See Activities of Life form)

I hereby authorize payment to be made directly to Thompson Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Thompson Chiropractic for any and all services I receive at this office.

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

PLEASE COMPLETE THIS FORM ONLY IF YOU HAVE

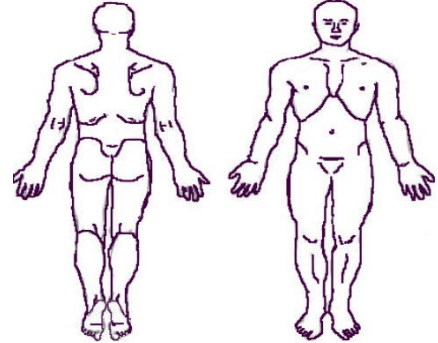
UHC (UNITED HEALTHCARE) INSURANCE:

(Please fill in selections completely)

Indicate where you have pain or other symptoms

Symptoms began on:

--	--	--



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

4. How often do you experience your symptoms?

- Constantly (76%-100% of the time) Frequently (51%-75% of the time)
 Occasionally (26%-50% of the time) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities?

(including both work outside the home and housework)

- Not at all A little bit Moderately Quite a bit Extremely

6. How is your condition changing, since care began at *this* facility?

- N/A This is the initial visit Much Worse Worse A little worse
 No change A little better Better Much better

7. In general, would you say your overall health right now is...

- Excellent Very good Good Fair Poor

Patient Signature: X _____

Date: _____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:

EFFECT:

Carry Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sit to Stand	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Climb Stairs	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Pet Care	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Extended Computer Use	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Lift Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Read/Concentrate	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Getting Dressed	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Shaving	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sexual Activities	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sleep	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Sitting	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Standing	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Yard work	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Walking	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Washing/Bathing	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sweeping/Vacuuming	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Dishes	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Laundry	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Garbage	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Driving	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Other: _____	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

REVIEW OF SYSTEMS

Please mark: **P** for in the **Past** **C** for **Currently** have **N** for **Never**

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pregnant (Now) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Jaw Pain, TMJ | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Heart Problem |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Tremors | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Pain w/Cough/Sneeze | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menopausal Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Foot or Knee Problems | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Menstrual Problem | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression | <input type="checkbox"/> PMS | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers | | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes | | <input type="checkbox"/> Allergies | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Hepatitis (A,B,C) |

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: _____

Date: _____

Instructions:

Please answer each question based on your chief complaint. Indicate your pain level right now, on average, at its best, & at its worst.

Example:

No pain _____ Neck _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

1 – What is your pain RIGHT NOW?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Thompson Chiropractic- Dr. Scot Thompson

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, complications such as sprain/strain injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in one in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Thompson Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____	_____	____/____/____
Patient Name (print)	Patient Signature	Date
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

The first day of my last menstrual cycle was on ____ - ____ - ____ (Date)

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____	_____	____/____/____
Patient Name (print)	Patient Signature	Date
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date

[Dr. Scot Thompson]
 [101 Hidden Glen Way Dothan, AL 36303]
 [drscotthompson.com]

[Thompson Chiropractic]
 [334-803-0803]
 [truth@drscotthompson.com]

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff. **Keep this page for your records.**

YOUR RIGHTS:

1. To inspect or obtain a copy of your records within 15 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
2. To ask for amendments to your health information you think is incomplete or incorrect. We may say “no” to your request, but we’ll tell you why in writing within 60 days.
3. To request confidential communications (contact you in a specific way or send mail to a different address).
4. To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction.
5. To receive an accounting of disclosures (those with whom we’ve shared your information).
6. To receive a paper copy of the extended detail Notice of Privacy Practices.
7. To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
8. To file a complaint if you feel your rights are violated

USES AND DISCLOSURES:

1. Treatment purposes - use your health information and share it with other health care providers who are treating you.
2. Run our organization - use and share your health information to run our practice, improve your care, and contact you when necessary.
3. Bill for your services - use and share your health information to bill and get payment from health plans or other entities.
4. Inadvertent disclosures – an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
5. Help with public health and safety issues - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
6. For health research purposes.
7. Comply with the law - share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.
8. Work with a medical examiner or funeral director - share health information with a coroner, medical examiner, or funeral director in the event of a patient’s death.
9. For workers’ compensation claims, law enforcement purposes or with a law enforcement official, and other government requests – including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
10. Respond to lawsuits and legal actions - share health information about you in response to a court or administrative order, or in response to a subpoena.
11. Emergency – in the event of a medical emergency we may notify a family member.
12. Phone calls and/or emails – we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
13. Change of ownership - in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

COMPLAINT:

If you wish to make a complaint about how we handle your health information, please contact our privacy official using the information noted above. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

U.S. Dept. of Health and Human Services, Office of Civil Rights
 200 Independence Avenue, SW, Washington DC 20201
 877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued ...

Please complete the following where indicated and return to our front desk staff.

I hereby acknowledge I have read and received a copy of **Thompson Chiropractic** Privacy Practices Notice.

I understand my rights as well as the practice’s duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this “Notice of Privacy Practices” at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice.

I am aware an extended detail version of this “Notice” is available to me upon request.

At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature: _____

Date: _____

Print Name: _____

Telephone: _____

If not signed by the patient, please indicate relationship:

_____ Parent or guardian of minor patient

_____ Guardian or conservator of an incompetent patient

_____ Beneficiary or personal representative of deceased patient

Name of Patient: _____

PATIENT'S NAME: _____ HR#: _____ DATE: _____

HIPAA Personal Health Information Release

I, _____, hereby authorize **Thompson Chiropractic** to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- Spouse Name: _____
- Significant Other Name: _____
- Parent/Legal Guardian Name: _____
- Child(ren) Name(s): _____
- Any Specified Person Name: _____
- Information is not to be discussed with or released to anyone.

Restrictions:

- No Restrictions
- Only discuss my appointment time with the above-named individual(s).
- Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

Please call my home my work my cell phone

Phone Number: _____ - _____ - _____

If unable to reach me:

- you may leave a detailed message
- please leave a message asking me to return your call
- _____

I understand I may terminate this consent at any time by giving written notice to Thompson Chiropractic . Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: _____ Date: _____



THOMPSON CHIROPRACTIC/DR. SCOT THOMPSON

PATIENT TESTIMONIAL AND PHOTO RELEASE CONSENT

Purpose of this Consent: By signing this form, you are hereby consenting to allow THOMPSON CHIROPRACTIC and/or any of its associated staff members to use and distribute your photo, video and/or the information in your testimonial to the public.

I hereby grant permission to THOMPSON CHIROPRACTIC and/or staff to allow the use of my photograph, video and/or the information in my testimonial to be used in its public relations that may be distributed to the public. By granting this permission, I hereby agree and acknowledge that my photo, video and/or my testimonial may be released to the public via public relation efforts of THOMPSON CHIROPRACTIC. I further acknowledge and agree that my photo, video and/or my testimonial may be used by the media.

I understand and approve the disclosure of testimonial information to the media and other individuals and entities that may be involved in the public relations efforts of THOMPSON CHIROPRACTIC. I understand and acknowledge that the media may be interested in telling my story, and I am willing to cooperate and participate in media interviews as they arise.

I understand that I am providing my photo, video and/or my testimonial information to THOMPSON CHIROPRACTIC and that my treating healthcare provider will not be providing any information in my media records, the confidentiality of which may be protected by the federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

I hereby waive the right of prior approval and hereby release THOMPSON CHIROPRACTIC from any and all claims for damages of any kind based on the use of my photo, video and/or my testimonial or information in my photo, video and/or the information in my testimonial. By signing below, I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Consent to Release my photo, video and/or my testimonial.

Right to Revoke: You have the right to revoke this Release at any time by providing written notice of your revocation and submitting it to THOMPSON CHIROPRACTIC. Please understand that revocation of this Release will not affect any action THOMPSON CHIROPRACTIC and/or staff took in reliance on this Release before receiving your revocation.

Signature: _____

Date: _____

Printed Name: _____

What are your life goals and where do you see yourself in the next 10 to 20 years?

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____