ROYBAL CHIROPRACTIC
CONFIDENTIAL PATIENT INFORMATION

Last Name __________________ First Name __________________ Initial ____ Date ______________

Address ____ Zip ______________

Home Phone ______________________________ Cell Phone __________________________________

Email ____________________________________ Date of Birth ___________________ Sex: M / F

Social Security ___________________ Marital Status: S/ M/ D/ W Spouse name________________

Do you have children? Y / N If yes, list names & ages_________________________________

____

Occupation _______________________________ Employer ____________________________________

Employer Address/Phone ____

Number of hours worked per week ____________ Supervisor __________________________________

Emergency Contact #1 ____

Emergency Contact #2 ____

Primary Care Physician ____________________________ Phone # ____________________________

Insurance Information

Work Injury? Y / N Motor Vehicle Collision Y / N

Primary Insurance (to be billed): ____

Secondary Insurance (if applicable): ____

The next questions will help Dr. Mario understand your lifestyle so that he can develop a treatment plan specific to your personal needs.

Current Exercises ____

Performed __________________________ times per week for ___________________________ minutes

Hobbies ____

Sleep Position _______________________________ Type of Pillow used _________________________

Daily water intake ____________________________ Do you take vitamins? _______________________

Vitamin brand and daily dosage ____

The 10 foods you most commonly eat ____

Who may we thank for referring you to our office? ____

Roybal Chiropractic, P.S.
Patient Name:________________________
Date of Injury:_______________________

Health Information Form
Date:________________________
Insurance ID#________________

Have you had any recent injuries or illnesses?
____
____
____
____

Have you had any surgeries?
____
____
____
____

Do you have or suffer from any of the following?

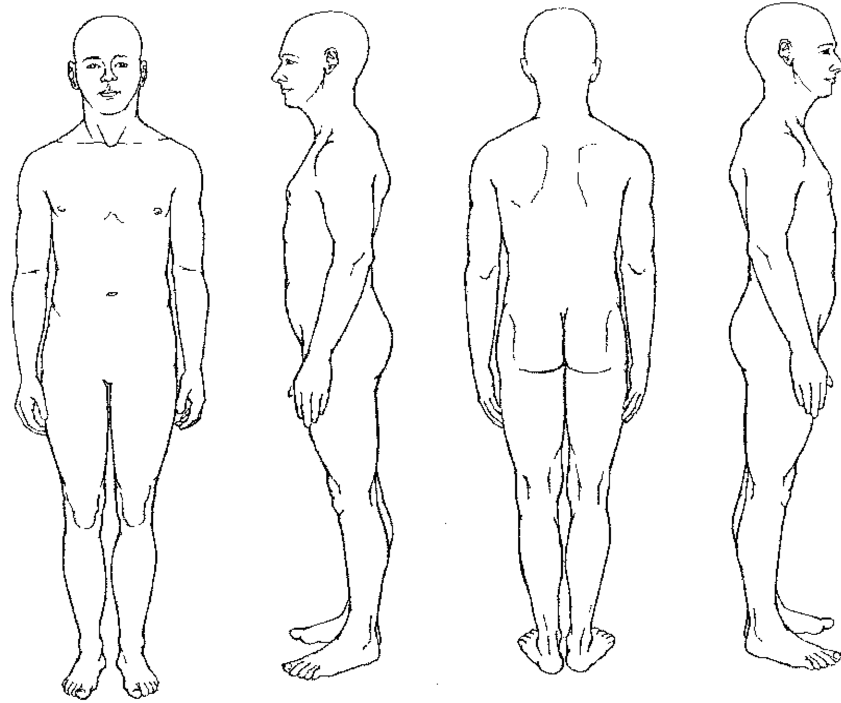
Allergies	( )	Lupus	( )
Arthritis	( )	Numbness	( )
Asthma	( )	Osteoarthritis	( )
Blood Clots	( )	Osteoporosis	( )
Broken Bones	( )	Scoliosis	( )
Depression	( )	Spasms	( )
Diabetes	( )	Tingling	( )
Disk Problems	( )	Varicose Veins	( )
Headaches	( )	GI Problems	( )
High/Low BP	( )	Pancreatitis	( )
Jaw pain	( )	Epilepsy/Seizures	( )

Current Health Information
Are you pregnant?____________________________
Date of last menstrual period?____________________
Do you wear contacts?_________________________
Do you smoke?_______________________________
Do you drink coffee or soda?____________________
If so, how much?_____________________________
Have you ever had a massage before?_______________
Have you had any type of cancer?_________________
Are you allergic to any medication?_______________
Are you taking any medication___________________
Other symptoms than those above?________________

Draw today's symptoms on the figures.

1. Identify CURRENT symptomatic areas in your body by making letters on the figures below. (Use the letters provided in the key to identify the symptoms you are feeling today.)
2. Circle the area around each letter, representing the size and shape of each symptom location.

Key
P= pain or tenderness
S= joint or muscle stiffness
N= Numbness or tingling



“Revised” **Oswestry Disability Index**

Section 1 – Pain Intensity

- ❑ The pain comes and goes and is very mild
- ❑ The pain is mild and does not vary much
- ❑ The pain is comes and goes and is moderate
- ❑ The pain is moderate and does not vary much
- ❑ The pain comes and goes and is severe
- ❑ The pain is severe and does not vary much

Section 2 – Personal Care (washing, dressing, etc.)

- ❑ I would not have to change my way of washing or dressing in order to avoid pain
- ❑ I do not normally change my way of washing or dressing even though it causes some pain
- ❑ Washing and dressing increases the pain, but I manage not to change my way of dressing
- ❑ Washing and dressing increases the pain and I find it necessary to change my way of doing it
- ❑ Because of the pain, I am unable to do some washing and dressing without help
- ❑ Because of the pain, I am unable to do any washing or dressing without help

Section 3 - Lifting

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it causes extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift only very light weights.

Section 4 – Walking

- ❑ Pain does not prevent me walking any distance.
- ❑ Pain prevents me walking more than 1mile.
- ❑ Pain prevents me walking more than1/2 of a mile.
- ❑ Pain prevents me walking more than 1/4 yards.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ❑ I can sit in any chair as long as I like without pain
- ❑ I can sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than ½ hour.
- ❑ Pain prevents me from sitting for more than 10 minutes.
- ❑ Pain prevents me from sitting at all.

Section 6 – Standing

- ❑ I can stand as long as I want without extra pain.
- ❑ I have some pain while standing, but it does not increase with time
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing for more than ½ an hour.
- ❑ I cannot stand for longer than ten minutes without increasing pain.
- ❑ I avoid standing because it increases the pain straight away

Section 7 – Sleeping

- ❑ I get no pain in bed.
- ❑ I get pain in bed, but it does not prevent me from sleeping well
- ❑ Because of pain, my normal night’s sleep is reduced by less than one-quarter
- ❑ Because of pain, my normal night’s sleep is reduced by less than one-half
- ❑ Because of pain, my normal night’s sleep is reduced by less than three-quarters
- ❑ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ❑ My social life is normal and gives me no pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limitingmy more energetic interests, i.e. sports, dancing.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted social life to my home.
- ❑ I have hardly any social life because of pain.

Section 9 – Traveling

- ❑ I get no pain while traveling.
- ❑ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ❑ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that done by lying down.

Section 10 – Changing Degree of pain

- ❑ My pain is rapidly getting better
- ❑ My pain fluctuates, but overall is definitely getting better.
- ❑ My pain seems to be getting better, but improvement is slow at present.
- ❑ My pain is neither getting better nor worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

ROYBAL CHIROPRACTIC, P.S.

INFORMED CONSENT ACKNOWLEDGEMENT

I___________________________________, patient, hereby request and consent to the performance of chiropractic spinal adjustments and other chiropractic procedures by Mario D. Roybal, B.S., D.C.

The following points have been explained to me, to my satisfaction, and I have had the opportunity to discuss them with the doctors of chiropractic.

1. Chiropractic care is the science, philosophy and art of locating and correcting spinal sublaxation (misalignments) and as such, is oriented toward improvement of spinal function, relative range-of-motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptoms, disease or condition, as a result of treatment in this clinic.
2. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint which may cause an audible “pop” or “click”.
3. It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he/she feels at the time to be in my best interest.
4. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related to the patient, information gathered during examination, and the doctor’s interpretation thereof, as well as the doctor’s judgment and expertise in working with like cases.
5. It is not reasonable to expect the doctor to be able to anticipate, or explain, all possible risks and complications of a given procedure on any particular visit.
6. An undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment.
7. As with any health care professionals, there are certain complications which may arise during a chiropractic adjustment. Those complications include strain/sprains, dislocations, fractures, disc injuries, CVA’s (cerebral-vascular accidents), or strokes. These complications are rare occurrences.
8. We acknowledge the new HIPAA laws and must have your permission to release any medical information.

In certain instances, additional information or precautions may be necessary for Chiropractic or Massage care. Please inform the doctor if you have any of the following conditions:

Active Cancer	Cardiac Problems	Use of Contacts
Severe Injuries	Chronic Illness	Recent Surgery
Arthritis	Phlebitis	Bursitis
High-Risk Pregnancies		

****Massage Clients****
A massage provides pain and tension relief by stretching and working the muscles. Please remove whatever clothing you feel comfortable removing or wear loose fitting clothing ands lay face down under the covers. You are covered at all times with a sheet except for the area being worked on. There is relaxing music that you can choose from to listen to during your massage.

***A $25 FEE WILL BE REQUIRED FOR MISSED MASSAGE THERAPY APPOINTMENTS IF WE ARE NOT NOTIFIED 24 HOURS IN ADVANCE OF THE CANCELLATION.

After an adjustment or massage you may feel achy, experience a sore throat or other flu like symptoms. It is important to drink plenty of water before and after to help eliminate the above symptoms.

I have read the above consent, or had it read to me, have had the opportunity to ask questions and receive answers and I am comfortable with the information provided. I hereby request and consent to the performance of massage, chiropractic adjustments and other chiropractic procedures, including various modes of therapy and diagnostic x-rays, on me (or on ____________________________, patient for whom I am legally responsible) by Dr. Mario Roybal, B.S., D.C., Brandy Schlegel LLC, LMT, Felicia Heinz, LMT or Katie Davis, LMT.

___________________________________	___________________________________
Print Patient Name	Print Parent/Legal Guardian Name
___________________________________	___________________________________
Signature of Patient or Parent/Guardian	Date signed
___________________________________	___________________________________
Witness	Date signed

HIPPAA Privacy Practice Notice

My signature below acknowledges that I have had an opportunity to view and / or receive a copy of the Provider's Notice of Privacy Practice. I acknowledge that I have the right to request a restriction of my protected health information.

Patient Signature_________________________ **Date**__________________

NOTICE OF RELEASE OF INFORMATION

I, ____________________ authorize Roybal Chiropractic to discuss and/or release my health care information to the following people.

NAME	Relationship to patient
_________________________	_________________________
_________________________	_________________________
_________________________	_________________________
_________________________	_________________________

Patient Signature______________________ **Date** ___________________

Please include names of spouses, parents, guardians etc.