# IMPACT CLINIC

**Dr. Timothy Tregoning**
**10115 E. 80th St. Ste. B**
**Tulsa, OK 74133**
**918-893-6400**

## PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip _____ Email: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Social Security # _____ Driver's License #: _____

Date of Birth: _____ Age: _____ Sex ___Male ___ Female

Employer: _____ Occupation: _____

Marital Status: Single Married Divorced Widowed # of children: _____

Spouse Name _____ Spouse Date of Birth _____

Spouse Employer: _____

Primary Care Physician: _____Phone#:_____

How were you referred to Impact Chiropractic Clinic? _____

## Emergency Contact

Name: _____ Relationship _____

Home Phone: _____ Cell: _____ Work#_____

Address_____ City _____ State ____ Zip _____

## Insurance Information

Insurance Company: _____Phone #: _____

Insured Name: _____ Insured Date of Birth: _____

ID# _____ Group #: _____

Secondary Insurance: _____

Insured Name:_____ Insured Date of Birth _____

ID#: _____ Group #: _____

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# INFORMED CONSENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself: I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

I hereby authorize physicians and staff at Impact Chiropractic Clinic to treat my condition as deemed appropriate. It is understood and agreed the amount paid the doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Impact Chiropractic Clinic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

**Specific Risk Possibilities Associated with Chiropractic Care.**

**Soreness-** Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

**Soft Tissue Injury-** Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

**Rib Injury-** Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

**Physical Therapy Burns-** Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but if it occurs you should report it to your doctor, or a staff member at Impact Chiropractic Clinic.

**Stroke-** Stroke is the most serious complication of chiropractic treatment. The most recent studies ( Journal of the CAA, Vol. 37 No. 2, June, 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

**Other Problems-** There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, **I** hereby give my informed consent to have chiropractic treatment administered

_____

Patient Name  Patient Signature  Date

_____

Parent/Legal Guardian Signature  Date

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# PATIENT HISTORY FORM

Patient Name _____ Date of Birth _____

## MAJOR COMPLAINT INFORMATION

What is your major complaint? _____

_____

When did symptom(s) begin? _____

Have you experienced these symptoms before? ☐ Yes ☐No When? _____

These symptoms developed from? ☐ Auto Accident ☐ Work related ☐ Other: _____

Have you reported this to your: Insurance Company ☐Yes ☐No Employer ☐Yes ☐No

What aggravates this condition? _____

What decreases the symptoms/pain? _____

Have you seen a doctor for this condition? _____Doctor's Name:_____

Does this condition interfere with your sleep? ☐ Yes ☐ No, If Yes, how many times do you wake up in pain per night? _____

Does it cause pain to cough, grunt or sneeze? ☐Yes ☐No If Yes, Explain:_____

**CHECK THOSE ACTIVITIES BELOW IN WHICH YOU EXPERIENCE DIFFICULTY OR PAIN:**

| | | | | |
|---|---|---|---|---|
| ☐Lying on Back | ☐Getting in/out of car | ☐Sleeping | ☐ Stooping | ☐Standing for over 1 hour |
| ☐ Lying on side with legs bent | ☐ Gripping | ☐Pushing | ☐ Sitting | ☐Sneezing |
| | ☐Climbing | ☐Pulling | ☐ Bending Forward | ☐Coughing |
| ☐Turning over in bed | ☐ Dressing self | ☐Reaching | ☐ Bending backward | ☐Walking |
| ☐Lying flat on stomach | ☐Sexual Activity | ☐Kneeling | Other: _____ | |

**COMPLETE THE NEXT SECTIONS AS THEY PERTAIN TO YOU:**

**HEADACHES**
Do you get headaches? ☐Yes ☐No Frequency _____
Do you experience the following with your headaches: Pain or cracking in your jaw? ☐ Yes ☐ No
Abnormal Blood Pressure? ☐ Yes ☐ No High or Low? Nausea/Vomiting or Visual Disturbance? ☐ Yes ☐ No

**LOWER BACK PAIN**
Do you ever experience ripping/tearing sensations in your back? ☐Yes ☐No If Yes, Where: _____
Does the pain radiate to the abdomen? ☐Yes ☐No
Do you ever have impairment of bowel or bladder function? ☐Yes ☐No Explain: _____
_____

**NECK PAIN**
If you have a neck injury does it affect: ☐Hearing ☐Vision ☐Balance ☐Cause ringing in the ears
Do you hear grating sounds? ☐Yes ☐No Do you feel pressure or pain behind your eyes? ☐Yes ☐No
Do you feel ripping or tearing? ☐Yes ☐No

Patient Name: _____ Date of Birth: _____

**CHECK ALL COMPLAINTS THAT YOU HAVE HAD OR ARE CURRENTLY EXPERIENCING**:

| | | | | |
|---|---|---|---|---|
| ☐Headache | ☐Neck Stiffness | ☐Loss of Consciousness | ☐Cold Feet | ☐Arthritis |
| ☐Irritable | ☐Jaw Pain | ☐Loss of Concentration | ☐Memory Loss | ☐HIV/Aids |
| ☐Anxiety | ☐Dizziness | ☐Eyes sensitive to light | ☐ Depression | ☐Cancer |
| ☐Hypertension | ☐Insomnia | ☐Heavy feeling in head | ☐Diabetes | ☐Hepatitis |
| ☐Fatigue | ☐Ringing in Ears | ☐Flushed Face | ☐Convulsions | ☐ Allergies |
| ☐Fainting | ☐Loss of Balance | ☐Excessive Perspiration | ☐Nausea | ☐Vomiting |
| ☐Diarrhea | ☐Loss of Smell | ☐Vision Problems | ☐Digestive Trouble | ☐Constipation |
| ☐Palpitation | ☐Loss of Taste | ☐Sinus Trouble | ☐Cold Hands | ☐Heart Disease |
| ☐Anemia | ☐Neck Pain | ☐Neck Motion restricted | ☐Nervousness | ☐Chest Pain |
| ☐Pain Behind Eyes | | ☐Shortness of Breath | | |

Please Specify Location:

☐Numbness _____ ☐Swelling _____ ☐Bleeding _____

☐Broken Bones _____ ☐Bruising _____

Do you have or have you ever had any diseases or medical problems not listed? ☐Yes ☐No

If YES, Please list: _____

_____

If Female, are you pregnant? ☐Yes ☐No ☐Not Sure If Yes, What is your due date? _____

**MEDICATIONS**

List all medications you are currently taking, including over the counter medications and supplements:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you Allergic to any medications? ☐Yes ☐No Please list: _____

Have you ever had any surgeries or hospitalizations? Please List:

Type of Hospitalization/Surgery: Date: Type of Hospitalization/Surgery: Date:

_____ _____

_____ _____

_____ _____

Have you had X-rays taken in the last 12 months? ☐Yes ☐No When/Where?_____

_____

Have you had any MRI's or CT scans performed? ☐Yes ☐NO If Yes, When/Where? _____

_____

Have you ever seen a chiropractor before? ☐Yes ☐No If Yes, Name of Chiropractor_____

_____