



First Name: _____ M.I.: _____ Last Name: _____

Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home #: _____ Cell #: _____

Work #: _____ Age: _____ DOB: ____ / ____ / ____ Male / Female

Primary Care Physician: _____

Do we have permission to contact your doctor regarding your care in our office? ____ Yes ____ No

Occupation: _____

Employer: _____

Marital Status: Single Married Divorced Widowed Separated Minor

Spouse's Name: _____ # of Children? _____

Emergency Contact Name: _____ Relation: _____

Phone #: _____

Smoking Status: Never smoked / Former Smoker / Occasional Smoker / Daily Smoker

Are you pregnant? _____ If yes what is your due date: _____

Have you had an auto accident? (X if applies): 0-6mo 6 mo-1 yr 1-3yrs 3+yrs Never

Had a recent fall/other accident? (X if applies): 0-6mo 6 mo-1 yr 1-3yrs 3+yrs Never

Have You Ever Received: Physical Therapy Chiropractic Care Pain Management

Last Visit: _____

How Did You Hear About This Office?

Existing Patient: _____ Walk-In/Drive-By Ad _____

Massage Therapist : _____ internet: _____

Payment is due at the time of services. If any payment arrangements need to be made, please speak with Dr. Timothy Nix. Please sign and date that you understand and agree to our policy. If there are any questions please ask us before signing. Thank You!

Print Name:

Signature:

Date:



PRIMARY COMPLAINTS: Please list in order of most severe (#1) to least severe (#4).

	MOST SEVERE		LEAST SEVERE	
	1.	2.	3.	4.
Complaints (examples: Low Back, Left Knee, Neck)				
Circle the word that best describes this complaint.	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other
How often do you feel this complaint?	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"
How long have you had this complaint?	___ Days / Weeks / Months / Years	___ Days / Weeks / Months / Years	___ Days / Weeks / Months / Years	___ Days / Weeks / Months / Years
Is it getting better, worse, or staying the same?	Better Worse Same	Better Worse Same	Better Worse Same	Better Worse Same
What makes it better, if anything?				
What makes it worse, if anything?				
On a scale of 0 – 10, rate your discomfort. (0 = no pain, 10 = excruciating)	Circle response 0 1 2 3 4 5 6 7 8 9 10	Circle response 0 1 2 3 4 5 6 7 8 9 10	Circle response 0 1 2 3 4 5 6 7 8 9 10	Circle response 0 1 2 3 4 5 6 7 8 9 10
How have you taken care of this in the past? Has that worked for you?				
Circle the ways this issue is affecting your life. (all that apply)	job children sex marriage hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity
Improving this issue in my life would improve my quality of life by: (Circle best response)	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%
Date problem began:				
How the problem began:				

Have you taken any of the following for the above complaints in the last 6 months? Tylenol Ibuprofen/NSAIDs Aspirin

Have you tried any of the following? Physical Therapy/Rehab Occupational Therapy Chiropractic Ice/Heat

Pain Management How long ago or how often did you attempt the selected therapies? _____

 Name (Print)

 Signature

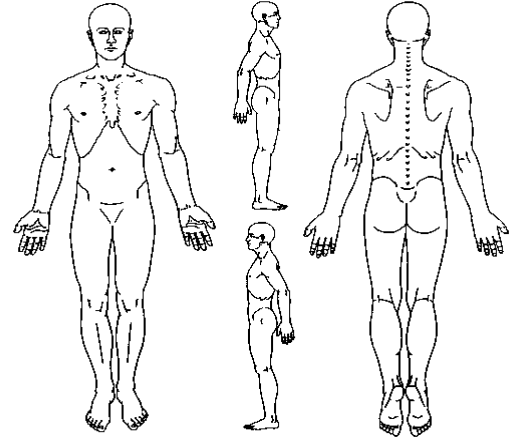
 Date

Mark the body where pain is.

PATIENT HEALTH HISTORY

Please check if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:

- | | | |
|--|--|---|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Night Pain |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Recent Weight Change | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Cold Extremities | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Bowel/Bladder Changes | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Blurred/Double Vision | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Trouble Concentrating | <input type="checkbox"/> Foot Trouble |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Shortness of Breath | |



ALLERGIES: (Please place a checkmark next to any known allergies that you have.)

Milk Eggs Peanuts Almonds Cashews Walnuts Fish Shellfish Soy Wheat
 Gluten Penicillin Sulfa Drugs Tetracycline Codeine NSAIDS Phenytoin Carbamazepine Mildew
 Mold Dust Fungus Mites Tree Pollen Grass Pollen Weed Pollen Insects Dog Dander Cat
 Dander Latex Other Animal Dander OTHER: _____ (please fill in)

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Are you currently under drug and/or medical care? Yes No If yes, explain _____

Please list any and all medications you are currently taking: _____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

Is there a family history of any of the following conditions? (indicate family members including parents, grandparents & siblings)

- | | | |
|--|------------------------------------|---|
| <input type="checkbox"/> Heart Problems/Stroke _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure ____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Other |

Do you exercise: 5-7x/week 3-4x/week 1-2x/week Occasionally None

Do your work activities mostly involve: Sitting Standing Light Labor Heavy Labor

Do you sleep on your: Back Side Stomach How old is your mattress? _____

What is your daily/weekly intake of the following: Caffeine ____ cups/day Alcohol ____ drinks/week Cigarettes ____ pks/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will give complete & accurate information during my exam.

Name (Print)

Signature

Date



TERMS OF ACCEPTANCE AND CONSENT FOR CARE

The clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific health care, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc).

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also understand that the fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are taken, they cannot be released, but may be checked out.

I have read and I accept the terms above and understand them fully. I hereby give consent to the clinic to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

I, _____ have read and fully understand the above statements.
(PRINT NAME)

(SIGNATURE)

(DATE)

FOR MINORS: I, _____ being the parent or legal guardian of
(Print Guardian Name)

(Print Minor's Name)

have read and fully understand the above terms of acceptance & grant permission for my child to receive treatment.

(SIGNATURE)

(DATE)

X-ray Questionnaire: For women only Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____ Date of last menstrual period: _____

There is a possibility that I may be pregnant at this time? ___ Yes, I am definitely pregnant.
___ No, I am definitely not pregnant at this time. ___ I request that x-ray films not be taken because:

Patient's Signature:

Date:



PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient Oasis Chiropractic and Laser Center, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Timothy Nix. If you would like further information about our privacy policies and practices please contact: Dr. Timothy Nix. This notice is effective as of January 1, 2025, and any alterations or amendments made herein will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Print)

Signature

Date