FOR OFFICE USE ONLY:

PATIENT NUMBER ____________________ **PI** ____ **ATTORNEY** ___________________________________

CASH _____ **WC** ______ **GI** ______ **MED PAY** ______ **DATE OF ACCIDENT** ___________________

PATIENT INFORMATION (PLEASE PRINT)

NAME ____
(NOMBRE) LAST FIRST MIDDLE

SOCIAL SECURITY NUMBER _____-_____-_______ **DATE OF BIRTH** ____-____-_____ **SEX** M / F
(NUMERO DE SEGURO SOCIAL) (FECHA DE NACIMIENTO)

ADDRESS ____ **APT. #** _______________
(DIRECCION)

CITY ____ **STATE** ________________ **ZIP** ___________________
(CUIDA) (ESTADO) (CODEO POSTAL)

HOME PHONE (_______) ________________________ **CELL PHONE** (______) _______________________
(TELEFONO) (TELEFONO)

EMAIL ADDRESS ____@_____________._________
(DIRECCION ELECTRONICA) (EMAIL ADDRESS WILL NOT BE SOLD OR GIVEN TO 3RD PARTIES, USED BY NBC COMPANY ONLY)

MARITAL STATUS (CIRCLE) SINGLE / MARRIED / DIVORCED / WIDOWED
(SOLTERO(A)) (CASADO(A)) (DIVORCIADO(A)) (VIUDO(A))

EMPLOYMENT (CIRCLE) NONE / FULL-TIME / PART-TIME / STUDENT / RETIRED / DISABLED

EMPLOYER ____ **OCCUPATION** _______________________
(EMPLEO) (TRABAJO)

EMPLOYER ADDRESS ________________________________ **TELEPHONE** _________________________
(EMPLEO DIRECCION) (TELEFONO)

SPOUSE / PARENT INFORMATION

NAME ____ _____________________
(NOMBRE) FIRST LAST RELATIONSHIP

SOCIAL SECURITY NUMBER _____-_____-_______ **DATE OF BIRTH** ____-____-_____ **SEX** M / F
(NUMERO DE SEGOUR SOCIAL) (FECHA DE NACIMIENTO)

HOME PHONE (_______) ________________________ **CELL PHONE** (______) _______________________
(TELEFONO) (TELEFONO)

EMPLOYER ____ **OCCUPATION** _______________________
(EMPLEO) (TRABAJO)

NEAREST RELATIVE NOT LIVING WITH YOU

NAME ____ _____________________
(NOMBRE)

HOME PHONE (_______) ________________________ **CELL PHONE** (______) _______________________
(TELEFONO) (TELEFONO)

PATIENT INITIALS ___________ I acknowledge that the information provided is accurate to the best of my knowledge.

Date (FECHA) ________________________

ACCIDENT / INJURY INFORMATION

WERE YOU IN A CAR ACCIDENT? YES / NO **WERE YOU?** DRIVER / PASSENGER
(ESTUVO EN UN ACCIDENTE)

DO YOU HAVE AN ATTORNEY REPRESENTING YOU REGARDING THIS ACCIDENT / INJURY? YES / NO
(TIENE UN ABOGADO POR ESTE ACCIDENTE)

ATTORNEY NAME ____________________________________ **PHONE NUMBER** _____________________
(ABOGADO) (TELEFONO)

DATE OF ACCIDENT/INJURY_________________ **IS THIS A WORKER'S COMPENSATION CLAIM?** YES / NO
(FECHA DEL ACCIDENTE)

WAS THIS A SLIP AND FALL? YES / NO **IF YES, WHERE DID THIS OCCUR?** ____________________
(SE CALLO?) (SI FUE A SI, DONDE PASO?)

OTHER: __________________________________ **ARE YOU PREGNANT?** YES / NO
(OTRO?) (ESTAS EMBARAZADA?)

WERE YOU TRANSPORTED FROM THE ACCIDENT / INJURY SCENE BY AMBULANCE? YES / NO
(FUE TRANSPORTADO POR AMBULANCIA)

HOSPITAL WHERE YOU WERE TREATED ____
(NOMBRE HOSPITAL QUE FUE)

OTHER DOCTORS THAT HAVE TREATED YOU FOR THIS INJURY ____
(PORFAVOR INDIQUE EL NOMBRE DEL DOCTOR QUE TRADADO DESDE QUE PASO EL ACCIDENTE)

AUTOMOBILE INSURANCE INFORMATION

YOUR CAR INSURANCE _________________________________ **PHONE NUMBER** (_____) _____________
(NOMBE DE SU SEGURO DEL AUTO) (TELEFONO)

POLICY NUMBER ______________________________ **CLAIM NUMBER** ______________________________
(NUMBERO DEL POLICA) (NUMERO DEL RECLAMO)

DO YOU HAVE MEDICAL PAYMENT COVERAGE ON YOUR POLICY? YES / NO AMOUNT $ ___________
(SU ASEGURANZO DE AUTOMOVIL CUBRE MEDICAL) (CANTIDAD)

OTHER DRIVER'S INSURANCE ______________________________ **PHONE NUMBER** (_____) _________________
(THE PERSON THAT HIT YOU/ LA PERSONA A CUPLA) (TELEFONO)

POLICY NUMBER ______________________________ **CLAIM NUMBER** ___________________________________
(NUMBERO DEL POLICA) (NUMERO DEL RECLAMO)

HEALTH INSURANCE INFORMATION

INSURANCE COMPANY ___________________________________ **PHONE NUMBER** (_____) _______________
(ASEGURANZO) (TELEFONO)

ADDRESS ____
(DIRECCION) ADDRESS CITY STATE ZIP

NAME OF INSURED _________________________________ **RELATIONSHIP** ________________________________
(NOMBRE DE EL ASEGURANZO) (RELATION)

ID # ___________________ GROUP # ________________ **EMPLOYER** ____________________________________
(EMPLEO)

SOCIAL SECURITY NUMBER _______-_______-________ **DATE OF BIRTH** ______-_______-________
(NOMBRE DEL SEGURO SOCIAL) (FECHA DE NACIMIENTO)

WORKER'S COMPENSATION INFORMATION

INSURANCE COMPANY NAME ______________________________ **PHONE NUMBER** (_____) _______________
(ASEGURANZO) (TELEFONO)

BILLING ADDRESS ____
ADDRESS CITY STATE ZIP

EMPLOYER _______________________________________ **PHONE NUMBER** (_____) _______________________
(EMPLEO) (TELEFONO)

SUPERVISOR ____________________________________
(MANEGADOR)

CASE MANAGER ___________________________________ **CLAIM NUMBER** ______________________________
(MANEGADOR DE CASO) (NUMERO DEL RECLAMO)

INFORMED CONSENT

Dear New Patient,

Every type of healthcare procedure and/or treatment is associated with some degree of risk. This includes chiropractic care. We want you to be informed about potential problems associated with chiropractic healthcare before consenting to treatment.

Chiropractic adjustments involve the moving of joints in the body with the use of the doctor's hands, use of a machine, use of a mechanical table, or use of a hand held instrument. Frequently, adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office, we use trained staff to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, and other treatment modalities. Occasionally when your doctor is unavailable, another chiropractor will treat you. If you do not want to be treated by another chiropractor in this clinic, please inform the staff immediately and that request will be honored.

NATURE AND PURPOSE OF CHIROPRACTIC PROCEDURES

The practice of chiropractic includes many standard examination and testing procedures. These include physical examination, orthopedic and neurological testing, palpation, specialized instrumentation's, laboratory tests, radiology examinations, physical therapy and rehabilitative procedures.

There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. A chiropractic adjustment is the application of a quick precise movement over a very short distance to a specific segmental contact point of a vertebra.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.
All chiropractic physicians providing care at the **Neck and Back Clinics** are licensed by the Chiropractic Physicians' Board of Nevada in accordance with state laws.

POSSIBLE RISKS ASSOCIATED WITH CHIROPRACTIC PROCEDURES

Not only should you understand the benefits of chiropractic care in restoring and maintaining good health, but also you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care, but should be considered in making the decision to receive chiropractic care. All health care procedures, including those used in varying degrees, have some risks associated with them. Risks associated with some chiropractic adjusting procedures may include:

- Stroke
- Verterbral disc herniation
- Soft tissue injury
- Rib fractures
- Physical therapy burns
- Soreness

I hereby give consent to the **Neck and Back Clinics** and its employees and/or contract personnel to render treatment to myself and/or my child (or child under my guardianship). This includes all necessary examinations, treatment, and any other related procedures necessary to provide chiropractic care. I understand that treatment will be based on the physician's professional judgment.

____
PRINT NAME

____ ____________________
SIGNATURE OF PATIENT / PARENT OR GUARDIAN **DATE**

DAILY ACTIVITY DISCOMFORT / DIFFICULTY CHECKLIST

Patient Name ____ Date ____________
(Nombre) (Fecha)

This checklist is to help us understand how much discomfort, pain, and/or difficulty you are having while doing certain activities. Please check ONE COLUMN for each activity. If a particular activity does not apply to you or you have not yet tried that activity check “not applicable”.

Esta lista es para ayudarnos a comprender cuánto incomodidad, dolor y dificultad tiene al hacer ciertas actividades. Compruebe una columna para cada actividad. Si una determinada actividad no se aplica a usted o todavía no has probado esa verificación de actividad "no aplicable".

ACTIVITY (Actividad)	**NOT APPLICABLE (No Aplicable)**	**NO DISCOMFORT/ DIFFICULTY (No Molesta/ Dificultad)**	**MINIMAL DISCOMFORT/ DIFFICULTY (Molesta/ Dificultad Minima)**	**MODERATE DISCOMFORT/ DIFFICULTY Molesta/ Dificultad Moderada)**	**MAJOR DISCOMFORT/ DIFFICULTY Molesta/ Dificultad Mayor)**	**CAN'T DO THIS ACTIVITY BECAUSE OF DISCOMFORT/ DISABILITY (No puede bacer porque Molesta/ Dificultad)**
SITTING (Sentado)						
STANDING (De pie)						
BENDING (Agachando)						
LIFTING (Levantando)						
WALKING (Caminando)						
LYING DOWN (Acostado)						
SLEEPING (Dormido)						
DRIVING (Manejando)						
WORKING (Trabajando)						
HOUSEWORK (Limpieza)						
PERSONAL CARE / DRESSING (Cuidado Personal/Vestir se)						
CARING FOR CHILDREN (El Cuidado de niños)						
USING THE COMPUTER (Usando la computadora)						
EXERCISING / PLAYING SPORTS (Ejercicios/ Jugando deportes)						
WATCHING TV (Viendo la televisión)						
OTHER (Otra) _______________						

____
PATIENT SIGNATURE/ FIRMA DEL PACIENTE