PATIENT INFORMATION FORM
Hawaii Sports Chiropractic, LLC
328 Uluniu St. Ste.103, Kailua, HI 96734
808-295-9939

Patient Name:____________________ Birthdate:__________ Sex: M/F

Address:____________________ City: ________ State:_____ Zip: _____

Home ph#:____________ Work#: ____________ Cell#:____________

Age:_____ SS#:__________ Email:________________ May we send newsletter? Y/N
☐Married ☐Single ☐Widow ☐Other Spouse Name:____________ Ages of Children________

Occupation: ________________ Employers Name: ________________
Referred by: ________________

Insurance: ☐ HMSA ☐ Kaiser ☐ Medicare ☐ UHA ☐ HMAA ☐ Summerlin ☐Other ________
Do you have insurance that covers chiropractic? ☐ Yes ☐ No ☐ Unsure

Name of Insurance: ____________ Policy Number: ____________ Group #: ________
Subscriber Name: ____________ Relationship: ________ Primary Care Physician________
2nd HealthPlan Name: ____________ Member ID#: ____________ Group #________
Is your condition due to an Auto Accident? ☐ Yes ☐ No Work Related? ☐ Yes ☐ No
Are you employed by the City & County or State? ☐ Yes ☐ No
Have you had Chiropractic before? ☐ Yes ☐ No. If yes, how long ago?____________

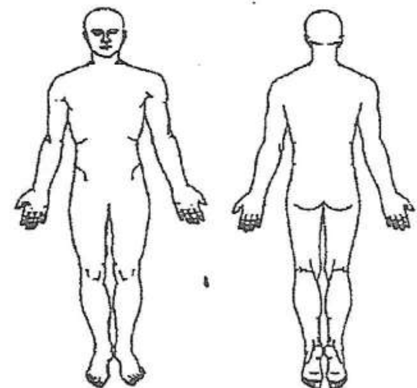
Current Symptoms or Complaints

Please list reasons for this visit:	Date first noticed	Please circle severity of symptom. 0 = none and 10= Severe	Please circle how often this symptom is present:
1.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%
2.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%
3.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%

How problem(s) began: ________________
Is it getting: ☐ Better ☐ Worse ☐ Staying the same
In the past week, how much has your pain interfered with:

	0 = no interference 10 = severely limits
Sleep	0 1 2 3 4 5 6 7 8 9 10
Work	0 1 2 3 4 5 6 7 8 9 10
Exercise/Sports	0 1 2 3 4 5 6 7 8 9 10
Household chores	0 1 2 3 4 5 6 7 8 9 10
Other ________	0 1 2 3 4 5 6 7 8 9 10

Please Mark Areas of Complaints



What time of the day do you feel worse? ________________
What types of exercises do you do? ________________
What kinds of therapy have you tried? ________________
Most comfortable sleeping position? ☐ Side ☐ Stomach ☐ Back
Main hobbies and sports? ________________
Have you had spinal X-rays, MRI, CT scan for your area(s) of complaint? ☐ Yes ☐ No
Dates(s) taken:____________ What areas were taken? ________________

Please check all of the following that apply to you:

- ☐ Recent Fever
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke (date)__________
- ☐ Corticosteroid Use (cortisone, prednisone, etc.)
- ☐ Taking Birth Control Pills
- ☐ Dizziness/Fainting
- ☐ Numbness in Groin/Buttocks
- ☐ Cancer/Tumor (explain__________________
  ____
- ☐ Osteoporosis
- ☐ Epilepsy/Seizures
- ☐ Other Health Problems (explain)____________
  ____
- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Urinary Problems
- ☐ Currently Pregnant, # of weeks _______
- ☐ Abnormal Weight Gain Loss
- ☐ Marked Morning Pain/Stiffness
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Visual Disturbances
- ☐ Surgeries______________________________
  ____
  ____
- ☐ Medications___________________________
  ____

Family History: ☐ Cancer ☐ Heart Problems/Stroke ☐ Diabetes ☐ Rheumatoid Arthritis ☐ High Blood Pressure ☐ Other __________

Current Health Habits:

Yes	No	
☐	☐	Do you have good posture?
☐	☐	Did/do you smoke?
☐	☐	Did/do you drink alcohol?
☐	☐	Do you eat healthy?
☐	☐	Do you take supplements?
☐	☐	Do you exercise regularly?
☐	☐	Did/do you have occupational stress?
☐	☐	High level of physical stress?
☐	☐	High level of mental stress?

Have you been in any accidents? If yes, how many?____

What type(s) of service do you desire?

- ☐ Temporary relief of symptoms/pain control
- ☐ Elimination of cause of problem, if possible
- ☐ Maintenance/regular care to help maintain good health

Insurance Certification: I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services received. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that a quote of benefits is NOT a guarantee of payment and benefits are subject to change at any time. I understand that co-payments are to be paid at time of service. ________ **(INITIAL)**

I understand that my chiropractor or Clinical Services Manager may need to contact my Primary Care Physician if my conditions need to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician, if necessary. ________ **(INITIAL)**

Financial Policy: I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Hawaii Sports Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if my insurance carrier refuses to pay for services rendered to me for any reason, any balance on my account will be immediately due and payable. ________ **(INITIAL)**

For the safety and security of your account, we will be taking your photo. This will help prevent fraudulent activities and help us to identify our patient. Please initial here, allowing us to take your photo. ________ **(INITIAL).**

I understand that this clinic has a **24 Hour Cancellation Policy** and that I may be charged a $25 fee for any appointments that are either missed or canceled without 24 hours notice. ________ **(INITIAL)**

Consent for Chiropractic: I hereby request and consent to chiropractic adjustments and/or other chiropractic procedures by Dr. Aren Viveiros and/or anyone working in this office authorized by him to perform such. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment that include but are not limited to fractures, dislocations, and sprains. I do not expect the chiropractor to be able to anticipate and explain all risks and complications. I understand that results are not guaranteed. Further, I wish to rely on the chiropractor to exercise judgment during the course of the procedure which the chiropractor deems are in my best interests at the time, based upon the facts then known. I hereby give my consent for treatment.

Patient Name ______________________________________

Patient (or Guardian) Signature ______________________________ **Date**____________