

The Karel Lewit Clinic

List all prior injuries for which you received any medical or chiropractic evaluation or treatment.

- | | |
|----|----|
| 1. | 3. |
| 2. | 4. |

List date and reason for any prior hospitalizations.

- | | | |
|----|----|----|
| 1. | 3. | 5. |
| 2. | 4. | 6. |

List the symptoms or condition(s) for which you are seeking this evaluation and treatment and what event caused the condition.

How long have you been having pain?

- 1 week or less
- 1-6 weeks
- > 6 weeks but < 3 months
- 3 months – 1 year
- Over 1 year

How many times have you had this problem in the past?

- Never
- 1-3 episodes
- 4 or more episodes

When did you first have these or similar symptoms?

- Never
- < 6 months
- 6 months – 1 year
- More than 1 year

Motor Vehicle Accident

Is your pain the result of a motor vehicle accident? Yes No

Location of impact?

- Rear end
- Frontal
- Side
- Both front and rear
- Both front and side
- Both side and rear

Job Injury

Is your pain the result of a work related injury? Yes No

Have you filed a workman's compensation claim? Yes No

Disabled from _____
To _____

Personal Injury

Is your pain the result of a personal injury outside of work or a motor vehicle accident? Yes No

Have you filed a legal suit? Yes No

**Please write in a number: 1. PRESENTLY HAVE; 2. PREVIOUSLY HAD;
3. RELATED TO ACCIDENT (DATE: _____)**

GENERAL

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Sleep loss
- Weight loss
- Nervousness/depression
- Neuralgia
- Numbness
- Sweats
- Tremors

EYES,EARS,NOSE,THROAT

- Asthma
- Colds
- Sore throat
- Deafness
- Dental decay
- Earache/noises
- Ear discharge
- Sinus infection
- Enlarged glands
- Enlarged thyroid
- Nose bleeds
- Failing vision
- Far sightedness
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness

MUSCULOSKELETAL

- Arthritis
- Bursitis
- Foot Trouble
- Hernia
- Low back pain
- Lumbago
- Neck pain/stiffness
- Shoulder blade pain
- Pain or numbness in:
 - Shoulders
 - Arms
 - Elbows
 - Hands
 - Hips
 - Legs
 - Knees
 - Feet
- Painful tailbone
- Poor posture
- Sciatica
- Spinal curvature

GENITO-URINARY

- Bedwetting
- Blood in urine
- Frequent urination
- Inability to control bladder
- Kidney infection or stones
- Painful urination
- Prostrate trouble
- Pus in urine
- Painful menstruation
- Hot flashes
- Irregular cycle
- Lumps in breasts

CARDIOVASCULAR

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

RESPIARTORY

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

GASTROINTESTINAL

- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Abdominal distention
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting blood

Have you had any x-rays, MRI's or CT scans? Date and place: _____

Prior physicians that have evaluated/treated you for this injury?

(name) (date) (specialty) (Recommendation)

(name) (date) (specialty) (Recommendation)

(name) (date) (specialty) (Recommendation)

Have you ever had surgery for this injury? _____

(type) (date) (surgeon)

Was the surgery helpful? _____

Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful.

THE FOLLOWING IS OUR FINANCIAL POLICY WHICH WE REQUIRE YOU READ AND SIGN PRIOR TO ANY TREATMENT.

PAYMENT TERMS

FEEES FOR SERVICES RENDERED ARE DUE AT TIME OF SERVICE. DOCTOR SERVICES THAT ARE IN NETWORK WILL REQUIRE PAYMENT AS NEGOTIATED WITH EACH INDIVIDUAL CONTRACT.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of patient or responsible party

Date: _____

Signature of co-responsible party

Date: _____

Certain services provided by the doctors and therapists at The Karel Lewit Clinic are not reimbursable by your insurance company. The charges for these services will be your responsibility. I understand that certain services are not reimbursable by my insurance and that I will pay for such services as rendered.

Signature

Date

I, _____, hereby authorize Dr. Clayton Skaggs, and/or such associates or assistants as may be selected by him, to treat me by means of the following procedure:

Manipulation and/or Physical Therapy

I consent to the performance of procedures in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions which the above named doctor or associates or assistants may consider necessary or advisable in the course of the procedure.

For the purpose of advancing medical education, I consent to the admittance of observers to the treatment room.

The nature and purpose of the procedure, possible alternative methods of treatment, the risks involved and the possibility of complications have been fully explained to me. No guarantee or assurance has been given by anyone as to the results that may be obtained.

I HAVE READ THIS CONSENT AND ITS CONTENTS HAVE BEEN FULLY EXPLAINED TO ME. I CERTIFY THAT I UNDERSTAND THE CONTENTS OF THIS CONSENT AND THAT I AM SIGNING IT VOLUNTARILY AS MY OWN ACT AND DEED.

Patient Signature

Date Time AM/PM

Witness

If patient is unable to sign, or is a minor, the following is to be completed by an individual legally authorized to consent for the patient:

Patient is a minor _____ years of age, or is unable to sign because:

Witness

Signature of one legally authorized to consent

Date

_____ AM/PM
Time

Relationship to Patient

Clayton D. Skaggs, D.C.
Consent to Medical Procedure

ADDRESSOGRAPH