Dr. Samantha Jennings & Associates

Whom may we thank for referring you to this office _____?

APPLICATION FOR CARE WITH DR. SAMANTHA JENNINGS, DC AND ASSOCIATES

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ⬜ Male ⬜ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Marital Status: Single⬜ Married⬜ Widowed⬜Divorced ⬜Separated ⬜ Driver's License #:_____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and Ages:_____

Name & Number of Emergency Contact: _____Relationship:_____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office:

Primarily: _____

Secondarily: _____

Third: _____

Fourth: _____

From **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*:**

Primary or complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Are you on worker's compensation? _____

Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Have you had any car crashes in the last two years? ___

Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____

When is the problem at its worst? ⬜ AM ⬜ PM ⬜Mid-day ⬜ Late PM

How long does it last? ⬜ It is constant **OR** ⬜Periodic during the day **OR** ⬜Periodic throughout the week

How did the injury happen? _____

Has the condition(s) ever been treated by anyone in the past? ⬜ No ⬜ Yes

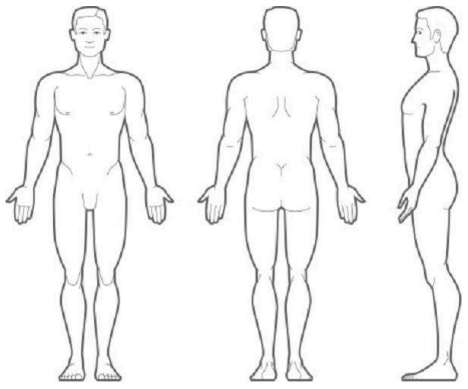
If yes, when: _____ by whom? _____

How long were you under care: _____

What were the results _____

Name of Previous Chiropractor: _____ ⬜ **N/A**

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:**R = R**adiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T=T**ingling



What relieves your symptoms?_____

_____

What makes them feel worse?_____

_____

_____

Is your problem the result of ANY type of accident? ⬜Yes, ⬜No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ⬜No ⬜Yes **If yes** how many times? _____

When was the last episode? _____

How did the injury happen? _____

_____

Other forms of treatment tried: ⬜No ⬜Yes **If yes,** please state **what** type of treatment:_____

Who provided it: _____ **How long ago?** _____**What were the results?** ⬜Favorable ⬜ Unfavorable

Please explain: _____

Please identify any of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have and **N** for ***Never** have had*:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___ Heart Attack

___Osteoarthritis ___ Diabetes ___Cerebral Vascular/Stroke ___Cancer ___ Other serious conditions:_____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

		HOW LONG AGO	**TYPE OF CARE RECEIVED**
INJURIES:			
SURGERIES:			
DISEASES:			

SOCIAL HISTORY

1. Smoking: ⬜Cigars ⬜Pipe ⬜Cigarettes ⬜E-cig/vape **How often?** ⬜ Daily⬜ Weekends ⬜ Occasionally⬜ Never

2. Alcoholic Beverage: ⬜ Daily ⬜ Weekends ⬜ Occasionally ⬜ Never

3. Recreational Drug use: ⬜ Daily ⬜Weekends ⬜Occasionally ⬜Never

4. Hobbies -Recreational Activities- Exercise Regime:_____

_____

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? No⬜ Yes⬜

If yes whom:_____

Have they ever been treated for their condition?⬜ No ⬜Yes⬜ I don't know

2. Any other hereditary conditions the doctor should be aware of? ⬜ No ⬜ Yes: _____

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/ strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments. Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided by Dr. Samantha Jennings, DC have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____

Patient or Authorized Person's Signature **Date**

PAYMENT AUTHORIZATION

I hereby authorize payment to be made directly to Dr. Samantha Jennings, DC, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Dr. Samantha Jennings, DC for any and all services I receive at this office.

_____ ____/____/_____

Patient or Authorized Person's Signature **Date Completed**

CANCELLATION POLICY

As our practice continues to grow, we have updated our cancellation policy in order to better serve our patients. Your appointment time is reserved especially for you. Please call or text 408-479-2559 at least 24 hours before your scheduled appointment if you will be unable to keep your appointment. This allows the doctors time to offer that appointment to another patient who needs care. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" calendar for the day. **If you do not cancel your appointment at least 24 hours in advance, you will be charged a no-show or late cancellation fee of $85 (or full price of the appointment(s)).** We understand that life gets busy. However, a pattern of missed appointments without proper notice does not show mutual consideration. Patients who fail to provide advanced cancellation for three appointments in the span of one year may be subject to dismissal from the practice.

_____ ____/____/_____

Patient Signature **Today's Date**

CONSENT TO ELECTRONIC COMMUNICATION USE

☐ By checking this box and signing below, I consent that Dr. Samantha Jennings and Associates can provide their services and communicate with me via phone, text message, e-mail and any kind of online communications, provided that these communications comply with privacy regulations. I understand that Dr. Samantha Jennings, DC & Associates can reach me any time to remind me of my appointments or let me know in case of any change about my appointments. And I also understand that Dr. Samantha Jennings, DC & Associates can employ and use a third-party automated system to reach out to me for the purpose of "confirm", "reschedule" or "cancel". I accept that I am responsible for notifying Dr. Samantha Jennings, DC & Associates when my contact information changes. I know that I can revoke this consent at any time by contacting Dr. Samantha Jennings, DC & Associates. I can text Dr. Samantha Jennings, DC & Associates for information regarding services. Reply STOP to opt-out; Reply HELP for support; Message & data rates may apply; Messaging frequency may vary. Visit https://www.drsamanthajennings.com/privacy-policy to see our privacy policy and https://www.drsamanthajennings.com/terms-of-use for our Terms of Service.

_____ ____/____/_____

Patient Signature **Today's Date**

_____	___/___/_____
Doctor's Signature	**Date Reviewed**