

Patient Application for Treatment

Name _____ Date _____ Acct # _____

Date of Birth _____ Age _____ Gender _____ SS # _____

Address _____

City _____ State _____ Zip _____ Email _____

Home # _____ Cell # _____ Occupation _____

Emergency Contact _____ Phone # _____ Marital Status S M W D

How many children do you have? _____ What are their ages? _____

Have they or any other members of your family received chiropractic care? Yes No

Have you ever had chiropractic care? Yes No How long has it been? _____

Do you drink alcoholic beverages? Yes No How often? _____

Do you smoke? Yes No How often? _____

Do you exercise? Yes No How often? _____ Type _____

Do you have any allergies? (Specify) _____

The purpose or reason for today's appointment? _____

When was your last physical exam? _____

When was the last time you were involved in an accident of any kind? _____

Have you ever suffered from or been diagnosed as having: (Circle Yes or No)

- | | |
|--------------------------------|---------------------|
| Y N *Broken or Fractured Bones | Y N *Osteoarthritis |
| Y N Circulatory Problems | Y N Epilepsy |
| Y N *Rheumatoid Arthritis | Y N Pacemaker |
| Y N Seizures/Convulsions | Y N Strokes |
| Y N A Congenital Disease | Y N *Cancer |
| Y N Excessive Bleeding | Y N Ulcers |
| Y N High/Low Blood Pressure | Y N Ruptures |
| Y N *Diabetes | Y N Coughing Blood |
| Y N Eating Disorder | Y N Alcoholism |
| Y N Drug Addiction | Y N HIV Positive |
| Y N Gall Bladder | Y N *Head Problems |
| Y N Depression | Y N Tumors |

*Explanation _____

For Doctor's Use Only

General

Injury Type

NDRA

Drug Allergies

See Meds

MEDICATION LIST

Names of Medication	Names of Vitamins	Non Rx Strength	Rx Strength	Date Started	Date Stopped	Who Prescribed	
						Dr	Self
						Dr	Self
						Dr	Self
						Dr	Self
						Dr	Self
						Dr	Self

Name _____ Date _____ Acct # _____

Systems Review

On the line next to each condition, please indicate with a (C) Conditions you have Now or with a (P) Conditions you have had in the Past. If neither applies, mark (NA), don't leave any blanks.

<p>High Blood Pressure _____</p> <p>Dizziness/Fainting _____</p> <p>Insomnia _____</p> <p>Low Resistance _____</p> <p>Tension _____</p> <p>Confusion _____</p> <p>Fatigue _____</p> <p>Ulcers _____</p> <p>Eye/Vision Problems _____</p> <p>Ear/Hearing Problems _____</p> <p>Difficulty Breathing _____</p> <p>Heart Problems _____</p> <p>Loss of Bladder Control _____</p> <p>Constipation _____</p> <p>Diarrhea _____</p> <p>Digestion Problems _____</p> <p>Nausea _____</p> <p>Female Problems _____</p> <p>Prostate Problems _____</p> <p>Diabetes _____</p> <p>Hands/Feet Cold _____</p> <p>Hand Tremors _____</p> <p>Loss of Memory _____</p> <p>Nervousness _____</p> <p>Sweaty Palms _____</p> <p>Speech Difficulty _____</p> <p>Anxiety _____</p> <p>Depression _____</p> <p>Irritability _____</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3" style="text-align: center; padding: 5px;">FOR DOCTOR'S USE ONLY</th> </tr> <tr> <th style="width: 10%; padding: 5px;">Dr. Reviewed</th> <th style="width: 45%; 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Please identify all facilities/providers you have seen for these conditions and those you are currently seeing, if any, for your presenting problem(s).

PROBLEM LIST

Dr Name/ Facility	Problem	Type of Treatment Received	From When to When

FOR DOCTOR'S USE ONLY

- | | | |
|--|---|---|
| <input type="checkbox"/> Reviewed External | H | P |
| <input type="checkbox"/> Release Records | H | P |
| <input type="checkbox"/> Request Records | H | P |

External DXd _____

Disabilities

Impairments

Patient History

Name _____ Date _____ Acct # _____

1. What is your main complaint? _____

2. On the scale below, please circle the **severity** of your main complaint (at its worst).

None	Slight		Mild		Moderate		Severe		
1	2	3	4	5	6	7	8	9	10

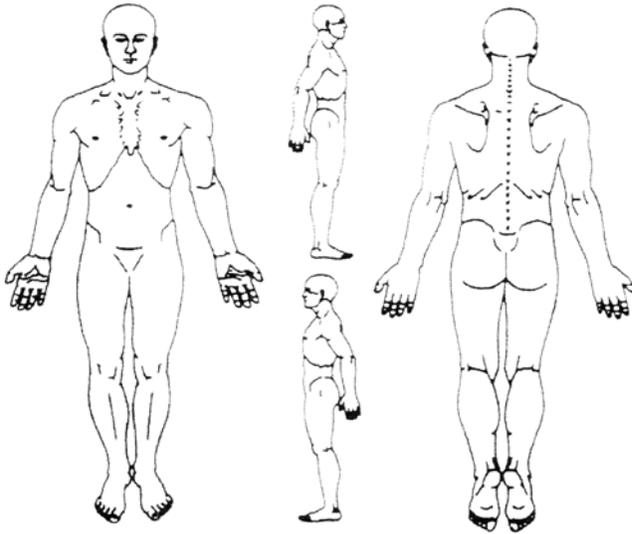
3. On the scale below please circle the **percentage of time** you experience your main complaint.

Occasional			Intermittent			Frequent			Constant	
0	10	20	30	40	50	60	70	80	90	100

4. How **long** have you been experiencing your main complaint? _____

5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache B: burning pain C: cramping D: dull pain R: throbbing pain N: numbness T: tingling



Do you have **pain** and/or **difficulty** performing any of the following activities: (check those that apply)

- personal care _____
- lifting _____
- reading _____
- concentrating _____
- work _____
- driving _____
- sleeping _____
- recreation _____
- walking _____
- sitting _____
- standing _____
- social life _____

6. When do you notice it most? Morning Evening
 How long does it last? _____ minutes _____ hours

7. What makes it feel better? _____

8. What makes it feel worse? _____

9. Have you ever had this problem in the past? Yes No

10. I have been hospitalized been treated by another chiropractor
 been treated by another specialty provider never received care for this problem.

11. Have you lost time from work because of it? Yes No Dates _____ to _____

12. Are you pregnant? Yes No

13. Number of pregnancies? _____ Miscarriages? _____

14. What was the first day of your last menstrual cycle? _____

Patient's Signature _____ Date _____

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.

B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.

C. The chiropractic adjustment process involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one-million times each day by doctors of chiropractic in the United States.

D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.

E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.

G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration or cost, in what we work to maintain as a supporting, open environment.

I, _____ have read and fully understand the above statements.
Print Name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

Patient's Signature

Date

Financial Agreement Cash or Insurance

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial policies of our office, we would like to explain how your medical bill will be handled.

Payment Arrangements

It is our policy to maintain your account on a current basis. On this, your first visit to our office, charges are due at the time of service rendered.

Insurance and Cash

If you have insurance that you would like to utilize, please bring your insurance card to the front desk at this time. We will make a copy of it so we can verify your benefits. Although we may utilize your insurance, charges may still be applied.

Your insurance is a contract between you and your insurance company. While we will make every effort to assist you in collecting, you are ultimately responsible for your account. We do not base your adjustment program on your insurance coverage and neither should you. There are limits as to what your insurance company will cover. We will work with any insurance that has chiropractic coverage.

It must be understood that our office does not guarantee that your insurance will pay for your care. We will make every attempt to obtain verification of your policy coverage if you so choose. However, if for any reason your insurance claim is denied, you are responsible for the full amount of your bill.

It's not only important to get yourself adjusted but your family members should also be taking advantage of chiropractic and having their subluxations corrected. For this reason, affordable family plans are available. Please see the front desk. Family, Corrective and Wellness Plans are available for everyone.

Voluntary Termination of Care

- It is not uncommon for insurance coverage to stop and/or become maxed out in the middle of the adjustment plan. However, if you discontinue your treatment plan, you will not reach your maximum improvement. For this reason, if you choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable at our normal office fee schedule.
- We will expect you to honor the financial agreement you make with our office. If you find that you cannot fulfill the agreement you have made with us, please advise us immediately so new arrangements may be made. Any overdue balance is subject to fees.
- All nutritional products, orthopedic support, spinal pillows, as well as foot orthotics are taxable. Items must be paid the same day the order is placed. All products are non-refundable due to the Federal Health & Safety standards.

Payment Policies

1. We do not bill our patients. If we are forced to bill you, there will be an additional service charge.
2. If a check is returned to our office it will be subject to a \$35.00 charge. All payments, accounts past 30 days will be subject to collection fees, interest and processing fees.
3. All payments are expected at time of service. If an adjustment is paid for at the time of service you will receive our time of service discount of \$35.00. Our normal fee for an adjustment is \$50.00.

Patient's Signature: _____

Date: _____