Patient Information

Name: ____ **What do you prefer to be called?** ___________

Birthdate: ________ **Age:** _____ **Home Phone:** ___________________ **Cell Phone:** _________________

Work Phone: _____________________**SSN #:** __________________ **E-mail:** ________________________

Address: ______________________________ **City:** _______________ **State:** _______ **Zip Code:**________

Employer: _________________________________ **Occupation:** _____________________

Emergency Contact: Name: _____________________ **Phone:** _________________________

Marital Status: M S D W **Spouses Name:** _________________ **Spouses DOB:** ______

Gender: M F **Primary Care Physician:** _________________

Primary Insurance Company: _______________________**Policy Holder DOB:** _________________

Secondary Insurance Company: _____________________ **Policy Holder DOB:** ________________

- Are your present symptoms or conditions related to, or the result of an **auto collision**, **work-related** or other **personal injury**? Yes No
- Have you ever been under Chiropractic Care: Yes No
  If so, when? _____________ why? ____
- Have you had any SPINAL imaging taken in the last year? Yes No
  If so, where? ____
- How did you hear about our office? ______________________________

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to 1st Choice Chiropractic, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Furthermore, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/ or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but not such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

X ___________________________________ ____________________

Signature of insured/ guardian Date

Case History

Name: ______________________________

A. What is your present complaint? __________________________________

B. Rate your pain from 0 to 10: 0 being no pain, 10 being severe: _________

C. When did your symptoms begin? __________________________________

D. How did your symptoms begin? ___________________________________

E. How often do you experience symptoms? ______________________________

F. Describe the feeling of your symptoms:

___Sharp ___Dull ___Burning ___Aching ___Throbbing ____Numbness ___Tingling

G. Have you experienced these symptoms before? Yes No

H. Have you been treated for these symptoms before? Yes No

- If yes, where and when? _____________________________________
- What treatment did you receive? ______________________________
- Was it helpful? ____

I. What makes your symptoms worse? ______________________________

J. Has anything relieved your pain? _________________________________

K. Has your condition: _____Improved_____ Worsened_____Stayed the same

L. Does this condition interfere with:

____Work ____Sleep ____Social life ____Recreation ____Daily Routine

M. List other major injuries you have had: ____________________________

____

N. Any other musculoskeletal problems? ____________________________

O. Any neurological problems? _____________________________________

P. What is your height? _______ Weight? _______

Q. Do you smoke? Yes No How many packs? ____ per ____day ___week

R. Are you pregnant? Yes No How many weeks along? __________

S. Do you have any hobbies that interfere with your condition? _______________

I certify that the above information is accurate to the best of my knowledge.

X _________________________ ____________________

Signature of insured/ guardian Date

HIPPA / Terms of Acceptance

Patient Name: ___________________________

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand, and we hope this document will clarify those issues for you. Please read below and if you have any questions please feel free to ask one of our staff members.

Informed Consent

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at 1st Choice Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Communications

If we would need to communicate your healthcare information, to whom may we do so?

Spouse: _________________________________ Phone # _____________________________

Children: _________________________________ Phone # _____________________________

Others: _________________________________ Phone # _____________________________

No One: ______

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes No

Consent & Missed Appointments

I hereby authorize payment of benefits directly to 1st Choice Chiropractic. Our policy requires payment in full for all services rendered at the time of visit. If my account is not paid within 60 days of the date of service and no financial arrangements have been made, I will be responsible for all legal fees, collection agency fees, and any other expenses incurred in collecting my payment**. A $20.00 fee will be charged if I fail to show for scheduled appointments and do not call to cancel prior to the scheduled appointment. If my account is turned over to a collection agency, I understand that a $50.00 collection fee will be added.**

I authorize the staff to perform any necessary services for the diagnosis and treatment of my condition and I authorize the provider to release any information required to process my insurance claims. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Consent to Evaluate and Treat a Minor

I ______________________ being the parent or legal guardian of __________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

X ___________________________________ __________________

Signature of insured/ guardian Date

Health History

PATIENT NAME: ______________________________________ DATE: ___________

Please check the box to indicate whether you have had any of the following:

ADDICTIONS
AIDS/HIV
ALCOHOLISM
ALLERGIES
ANOREXIA/BULIMIA
APPENDICITIS
ARTHRITIS
BLEEDING DISORDERS
BLOOD PRESSURE (HIGH/ LOW)
BRONCHITIS
CANCER
CARPAL TUNNEL SYNDROME
CATARACTS
CHOLESTEROL ELEVATION
DEPRESSION
DIABETES
EPILEPSY
FRACTURES
GI ISSUES (STOMACH/S1/L1)
GLAUCOMA
GOITER
GOUT
HEADACHES
HEARING ABNORMALITY
HEART DISEASE
HERNIA
HERNIATED DISC
HORMONE REPLACEMENTS
HYSTERECTOMY
JOINT REPLACEMENTS
KIDNEY OR BLADDER DISEASE
LIVER DISEASE (HEPATITIS, ETC.)
LUNG ISSUES (BRONCHITIS, ASTHMA, ETC.)
MEASLES
METAL IMPLANTS
MISCARRIAGE
MONONUCLEOSIS OR MUMPS
MULTIPLE SCLEROSIS
ORTHOPEDIC PROBLEMS (SHOULDER, KNEE, HIP, ETC)
OSTEOPOROSIS
PANCREATITIS
PARKINSON'S DISEASE
PINCHED NERVES
POLIO
PREGNANCIES
PROSTATE PROBLEMS
PROTHESIS
PSYCHIATRIC CARE
RHEUMATOID ARTHRITIS
SCARLET FEVER
SCOLIOSIS
SHINGLES
SINUS ISSUES
SPINAL STENOSIS
STROKE
SUICIDE ATTEMPT
THYROID PROBLEMS
TINNITUS/ VERTIGO
ULCERS
VAGINAL INFECTIONS
VASCULAR (BLOOD CLOTS, ANEMIA, ETC.)
VENEREAL DISEASE (HERPES/STD)
OTHER:__________________________

LIST ALL OF THE SURGERIES YOU HAVE HAD:
____
____

LIST ALL OF THE MEDICATIONS YOU CURRENTLY ARE ON:
____
____

FAMILY MEDICAL HISTORY:
____
____

DO YOU HAVE A PACEMAKER OR DEFIBRILLATOR: YES NO

OTHER:____

SIGNATURE: ____