Patient Information:

Date: _______________ How did you hear about us ______________________________

First Name: __________________________ MI: __ Last Name: ________________________________

SSN # _________________________ D.O.B. ____________________ Sex: ____________________

Address: ____

City: _____________________________ State: _________________ Zip: ______________________

Home Phone: ____________________ Cell: ____________________ Work: ____________________

Marital Status: (Circle) Single Married Divorced Separated Widowed

Email: ____

Emergency Contact: _______________________________ Phone: ____________________________

Do you have X-Rays or MRI's for this problem area? ____

If you do have films, where did you get them done? ____

Did a Physician refer you here for today's visit? ____

If so, Physician's name: ____

Referring Physician's Address/City/Phone: ____

INSURANCE INFORMATION:

Primary Insurance: _____________________________________ Effective Date: ________________

Policy #_________________________________ Group #_______________ HSA/HRA: (Circle) Yes No

Policy Holder ___ ____________________________ Policy Holder Employer ______________________

Secondary Insurance: ____________________________ Effective Date: _________________________

Policy # ____ Group # __________________________

<u>Acceptance as Patient:</u>

I understand and agree that the doctors of Advanced Chiropractic have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a medical history and the conduction of a physical exam are not considered treatment, but are part of the process of information gathering concerning my or my child's healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

____ ____________________

Signature of patient (parent if minor) Date

Questionnaire

Occupation____
1.**When did your pain start?** ____
2**. Have you been hospitalized for your pain?** YES NO If yes how many times_________
3. Have you had surgery for this issue? YES NO

Previous Hospitalizations and or Operations

Date	**Hospital**	**Reason**
_______________	____________________________	___________________________________
_______________	____________________________	___________________________________
_______________	____________________________	___________________________________
_______________	____________________________	___________________________________
_______________	____________________________	___________________________________

Please circle what type of pain you are experiencing at this time.

Leg Pain Right or Left	**Buttocks** Right or Left	**Thigh** Right or Left	**Forearm** Right or Left
Shoulder Right or Left	**Low Back**	**Mid Back**	**Upper Back**
Headaches	**Foot** Right or Left	**Neck**	

OTHER_________________________

When did the pain start? Please circle all that apply

Suddenly Gradually Lifting Twisting Fall Turning Sleeping Injured at work Hit from behind

During sports No apparent cause

Other____

What makes the pain worse? Please circle all that apply

During exercise After exercise Sitting Turning Lying down Morning Evening Looking downward

Looking upward Coughing Sneezing Rising (from sitting) Walking Running
Other_________________________

What makes the pain better? Please circle all that apply

Exercise Sitting Walking Standing Manipulation Nothing Bending forward Bending Backward
Mornings Evenings Aspirin/Anti-Inflammatory Physical Therapy
Other____

How long have you had this pain? Years_____ Months_____ Days_____ **How many episodes have you had?**_____

Have you had any diagnostic studies for this issue?

Diagnostic X-Ray	YES	NO	Date __________	Discography	YES	NO	Date__________
CT Scan	YES	NO	Date__________	MRI	YES	NO	Date__________
Myelogram	YES	NO	Date__________	Sonogram	YES	NO	Date__________
Electrogram	YES	NO	Date__________	Injections	YES	NO	Date__________

Have you received treatment for this pain from anyone?

Massage Manipulation Braces/Supports Medication Physical Therapy Acupuncture Injections

Psychological Support

Other____

What medications are you currently taking?____
____
____

Do you smoke? YES NO If so how much per day?_____ **Do you drink?** YES NO If so how much per day? ______

Do you have problems with or have you had recently any of the following? Please circle all that apply

Head/Ears/Eyes Problems	**Respiratory Problems**	**Metabolic Problems**	**Neck/Throat/Nose**
Glaucoma	Asthma	Diabetes	Hoarseness
Cataracts	Shortness of breath	Low blood sugar	Changes in voice
Glasses/Contacts	Pain when breathing	High blood sugar	Nose bleeds
Loss of hearing	Coughing up blood	Appetite changes	Thyroid Problems
Painful chewing	Lung problems		Difficulty swallowing
Ringing in ears			

Gastrointestinal	**Neurological**	**Cardiovascular**	**Urinary**
Stomach problems	Headaches	Chest pains	Bloody urine
Gallbladder problems	Fainting	Irregular heartbeats	Frequent urine
Pancreatitis	Blackouts	Low blood pressure	Night time urine
Constipation	Seizures/Epilepsy	High blood pressure	Trouble starting
Diarrhea	Strokes	Swollen extremities	Trouble stopping
Blood in stool	Paralysis		Pain with urination
Liver/Kidney issues	Numbness		

Skin Problems	**Genital Problems**	**Bleeding Disorders**	**General Problems**
Infections	Infections	Anemia	Fever/Chills
Psoriasis	Herpes	Bleeding problems	Swollen ankles
Skin cancer	AIDS		Anxiety
Rashes			Toothaches
			Gout
			Depression

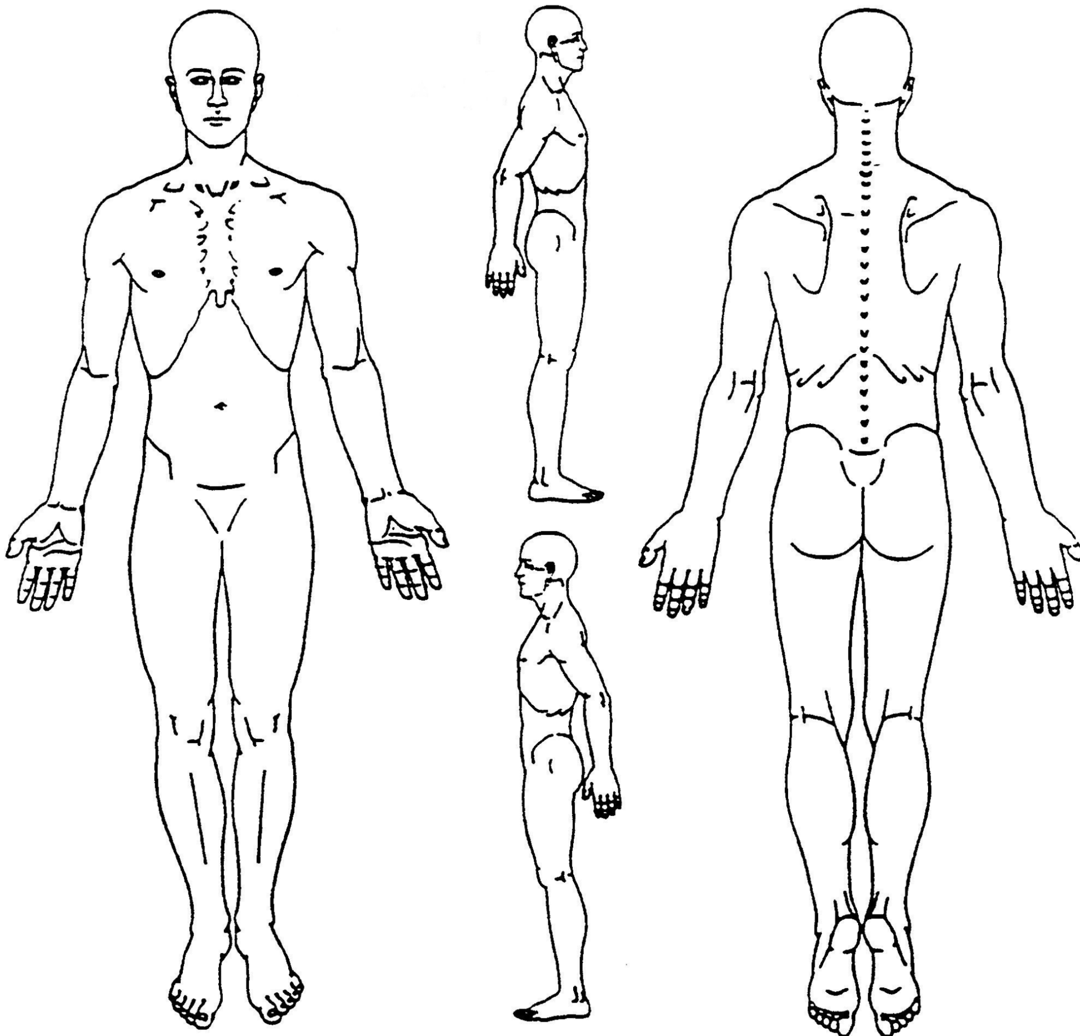
____
Patient Name

____ _________________________
Patient Signature / Parent if Minor DATE

PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: **A** – ACHE **B** – BURNING **N** – NUMBNESS P – PINS & NEEDLES
S – STABBING **O** - OTHER



PAIN SCALE

Rate the severity of your pain by checking one box on the following scale.

No Pain | Worst Possible Pain

0	1	2	3	4	5	6	7	8	9	10

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and/or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments

I have read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare options. I also understand you are not required to agree to my restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient: (Printed) Name:

____

Signature:

____

Relationship to patient:

____

Date:

____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the *Notice of Privacy Practices,* but was unable to do so as documented below:

Date: ________________ Initials: _____________________ Reason: __________________________

FINANCIAL STATEMENT

You are receiving important forms that must be completed prior to seeing our doctors. In order to provide you with the highest level of care, please complete these forms as accurately as you can.

We will make every effort to verify your coverage and benefits prior to you seeing the doctor. This information is provided as a courtesy. **It remains the full responsibility of the insured to know and understand their policy and benefits.**

We require the payment of either the co-payment amount or the percentage of coverage for which you are responsible. If your insurance plan has a deductible, and it has not been met, then your current charges will be applied toward the deductible until that amount has been fulfilled. If the primary and/or secondary insurance company reduces or denies any billed claim(s), the patient will be responsible for paying the remaining balance. If the insurance company has not paid a claim within sixty 60 days of submission, we require the patient to pay the balance with one of the approved payment methods. The patient is ultimately responsible for the bill.

The required payment, which is the amount the patient is responsible for, must be paid at the time of service. You may use cash, and/or credit card (Visa, Master Card, & AMEX). If a check is returned for insufficient funds, a charge of $40.00 will be applied to the account.

If circumstances arise, and you need to reschedule an appointment, we require a 24 hour notice. There is a $25.00 charge for missed appointments effective February 1, 2018. In the event of an emergency (medical emergency, death in family or extreme inclement weather), this fee will not be charged.

Thank you for trusting us with your healthcare; if you have any questions about the financial policy, please feel free to ask.

By signing the policy below, I am acknowledging that I have read, understand, and agree to the provisions of this financial policy.

Signed:____

Printed: ____

Informed Consent For Chiropractic Treatment

Please read this consent form, discuss it with your clinician if you would like to, and then sign where indicated at the bottom. Clinicians are required to inform patients that there may be some risks associated with such treatment. In particular:

a) While rare, some patients have experienced muscle and ligament sprains or strains, bruising, burns, spinal disc damage, or bone fractures following spinal or soft tissue manual therapy, therapeutic exercise, spinal decompression therapy, or electrical stimulation therapy.
b) There have been reported cases of injury to a vertebral artery following neck adjustment, manipulation. Such vertebral artery injuries may on rare occasion cause stroke, which may result in serious neurological injury and/or physical impairment. This form of complication is an extremely rare event, occurring about 1 time per 1 million treatments.
c) There have been reported cases of disc injuries following spinal manual therapy, although no scientific study has ever demonstrated that such injuries are caused, or may be caused, by adjustment or manipulative techniques and such cases are also very rare. Treatments provided at this clinic, including spinal adjustment and manipulation, have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders/arms/legs, headaches and other similar symptoms. Treatment provided at this clinic may also contribute to your overall well being. The risk of injury or complication from manual treatment is substantially lower than the risk associated with many medications, other treatments and procedures frequently given as alternative treatments for the same forms of musculoskeletal pain and other associated syndromes. Your clinician will evaluate your individual case; provide an explanation of care and a suggested treatment plan, or alternatively a referral for consultation and/or further evaluation if deemed necessary.
d)Some supplements contain allergens that may not be safe or recommended for everyone. These can cause severe reactions that can include but are not limited to: death(rare occasion), allergic reactions, and organ damage.
Consent: I consent to the chiropractic treatment(s) offered or recommended to me by my clinician, including x-rays, therapeutic exercise, spinal decompression, joint adjustment or manipulation to the joints of my spine (neck and back), pelvis and extremities (shoulder, upper limbs and lower limbs) and manual soft tissue therapies, and nutritional supplementation. This consent applies to all my present and future treatments at this clinic.

Acknowledgement: I acknowledge I have discussed, or have been given the opportunity to discuss, with my clinician the nature of chiropractic treatment in general and my treatment in particular as well as the contents of this consent. I understand that the practice of chiropractic, like other methods of medical treatment, cannot guarantee any results or outcome of my care.

Print Name_______________________________ Date___________________________

Signature_________________________________