Today's Date: ____/___/_____

CONFIDENTIAL HEALTH INFORMATION

PATIENT DEMOGRAPHICS

Name:_____ Birth Date:___/___/_____ Age:_____
(Last) (First) (M.I.)

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

E-mail:_____ Home Phone:_____ Cell:_____

Marital Status: Single___ Married___ Divorced ___ Other_____ Sex: Male ___ Female___ Other_____

Spouse's Name: _____ Number of Children:_____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

Whom may we thank for referring you? _____

PAYMENT INFORMATION

Method of Payment: Cash ____ Check ____ Credit/Debit ____ Auto ____ Workers Comp: ____

Insurance Company: _____ Member ID/Claim Number: _____

HISTORY OF COMPLAINT

Why are you here? Please describe your major complaint: _____

_____

_____

_____

_____

Please check if applicable: Work related injury ____ No fault/Auto Injury ____ How did injury happen? _____

_____

Approximate date of when your problem started: _____

Have you had this problem or similar in the past? Yes ____ No ____ If yes, when was last time? _____

Are your complaints affecting your ability to be active? Yes ____ No ____ If yes, explain: _____

_____

Frequency of Pain/Discomfort: Constant (75-100%) ___ Frequent (51-74%) ____ Occasional (26-50%) ___ Intermittent _____

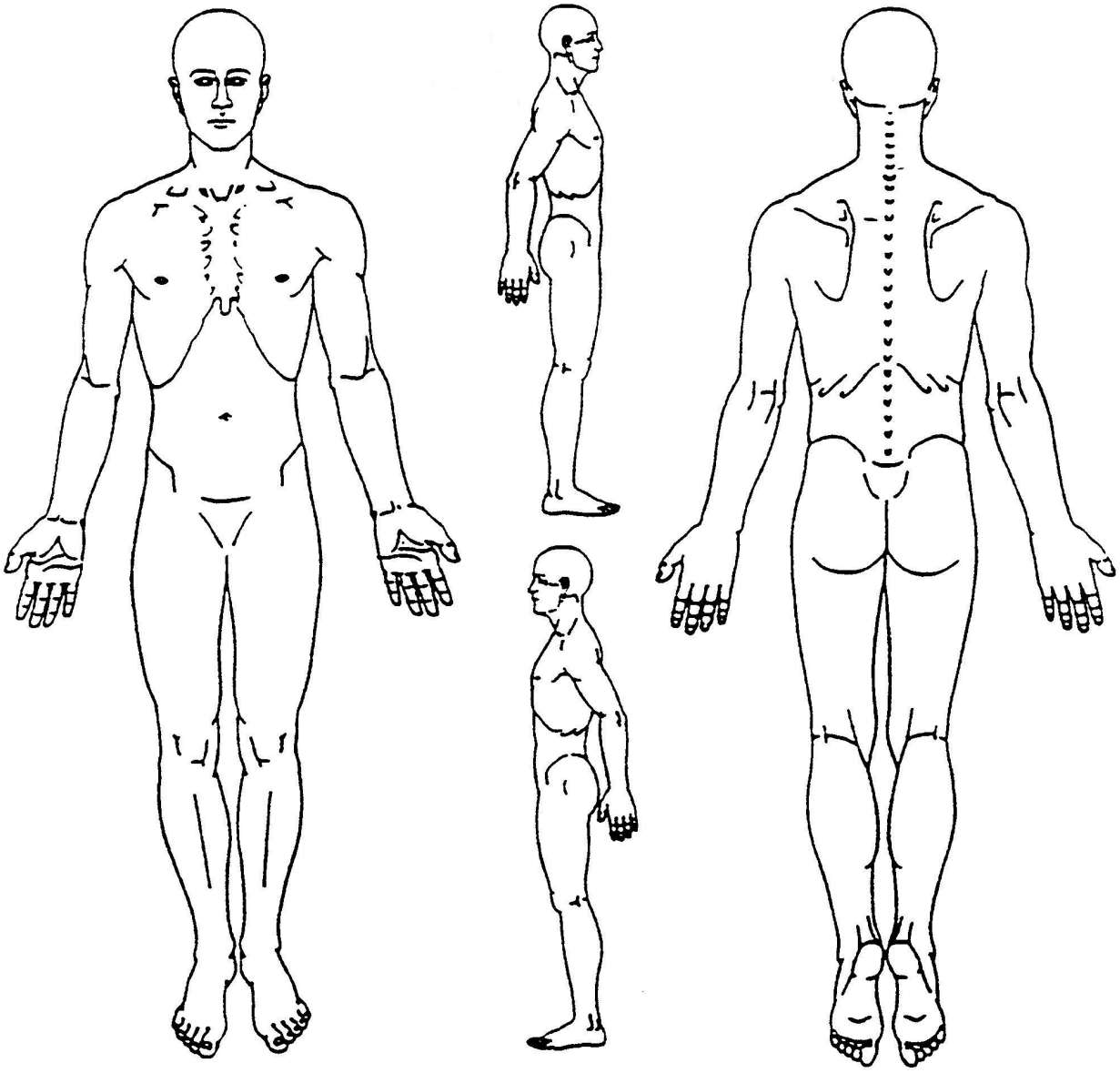
What do you want out of your healthcare experience?

Relief Care (patch the problem) _____ Corrective Care (fix the problem) ____

PAIN DRAWING

Please mark the drawings below according to where you hurt. Indicate which sensations you are currently experiencing by referring to the key below:

SS = Stabbing **BB** = Burning **PP** = Pins & Needles **NN** = Numbness **AA** = Aching **OO** = Other



Current Pain Level (please circle): 0 1 2 3 4 5 6 7 8 9 10

0	No Pain
1	Mild Pain. You are aware of it, but it doesn't bother you.
2	Moderate Pain. You can tolerate without medication.
3	Moderate Pain. It requires medication to tolerate.
4 – 5	More Severe Pain. You begin to feel antisocial.
6	Severe Pain
7-9	Intensely Severe Pain
10	Most Severe/Excruciating Pain

HEALTH HISTORY

Have you had any previous Chiropractic care: Yes ____ No ____ Approximate date of last visit: _____

Dr.'s Name: _____

Have you had any diagnostic studies (X-ray, MRI, CT, Bone Scan, etc.) in the last 2 years? Yes ____ No ____

X-ray ___ MRI ___ CT ___ Other: _____ Approximate date and facility: _____

Please mark any of the conditions that you previously or currently have. Mark current with a C and previous with a P:

Musculoskeletal:

Neck pain ___ Back pain ___ Shoulder pain ___ Elbow /hand pain ___ Hip pain ___ Knee/ ankle pain ___

Arthritis ___ Osteoporosis ___ Scoliosis ___

Neurological:

Headaches ___ Migraines ___ Anxiety ___ Depression ___ Sleep problems ___

Cardiovascular:

High blood pressure ___ Low blood pressure ___ Angina ___ Heart attack ___ Stroke ___ Poor circulation ___

Respiratory :

Asthma ___ Pneumonia ___ Emphysema ___ Sleep apnea ___ Allergies ___

Digestive

Irritable bowel ___ Constipation ___ Diarrhea ___ Ulcers ___ Food sensitivities/allergies ___ Heartburn

Nausea ___ Anorexia/bulimia ___

Sensory

Blurred vision ___ Ringing/buzzing in ears ___ Hearing loss ___ Loss of smell___ Loss of taste ___ Loss of touch ___

Integumentary

Skin cancer ___ Psoriasis ___ Eczema ___ Acne ___ Rashes ___ Hair loss ___

Endocrine

Immune disorders ____ Diabetes ___ Thyroid issues ___ Fatigue ___

Genitourinary

Kidney stones ___ PMS symptoms ___ Prostate issues ___ Bowel/bladder control issues ___

_____

Please list any allergies that you have: _____

_____

_____

Medications you are currently taking:

Drug Name **Frequency**

_____

_____

_____

Present Weight: _____ lbs. Height:____feet _____inches Blood Pressure: High Low Normal? ____ /_____

CONFIDENTIAL HEALTH INFORMATION

Informed Consent

Chiropractic: The science of locating and correcting subluxations

Subluxations: An alteration of normal spinal alignment or aberrant joint motion causing nerve interference, reflex muscle spasm and often pain and disability.

Adjustment: The application of force to bones of the spine (or extremities), which causes a change in alignment towards normal position.

Benefits of Chiropractic Care: Less pain, less disability, increased range of motion, better functioning nervous system.

Risks of Chiropractic Care: Adjustments occasionally cause initial soreness.

The working diagnosis, prognosis, proposed care plan, risks and benefits have been fully explained to me.
I have been given the opportunity to ask questions.

I agree to be examined and I accept care on this basis as explained to me.

_____ _____

Signature Date

_____

Print Name

Billing Policy:

We participate and accept assignment with certain insurance carriers. Please remember, ultimately you are responsible for providing sufficient billing information and determining whether or not our services are covered by your insurance contract.

If we participate with your insurance and a referral is necessary, it is your responsibility to obtain a valid referral at the time of treatment. You are always responsible for applicable co-payments, deductibles, etc. as determined by your insurance company. Co-payments are always expected at the time of service unless prior arrangements have been made with our billing department.

If we do not participate with your insurance, you will be responsible for payment in full at the time of your visit. Our office will bill your insurance carrier on your behalf.

If Workers' Compensation or No Fault/Auto is your primary insurance, you are responsible for providing us with accurate information regarding the date of injury, WCB and Carrier case number as well as your insurance company's name and address. It is also important that you have authorization to be treated. Be aware that if your case is denied, all outstanding balances and future services will be your responsibility unless you have a secondary insurance carrier. In order for our office to bill your private carrier, all information must be provided at your initial visit to insure timely filing of your claim.

I hereby authorize payment of benefits directly to the provider of benefits due me for services rendered. I further authorize the chiropractic physician to release any information required to process my insurance claims. I also understand that I am ultimately responsible for the payment my bill.

I fully understand, accept, and agree to the above policies.

_____ _____

Patient's Signature Date

_____

Print Name

If you have any questions, please do not hesitate to ask at the front desk.

No Show and Cancellation Policy

Resolution of your injury/pain is best achieved when you comply with the treatment plan prescribed by the doctor. Each treatment tends to compliment and build upon the prior visit especially during the initial stages of your treatment regime. If you cancel or no show frequently it will hinder and delay the progress of your recovery as well as negate valuable treatment time that could have been utilized by another patient requiring care.

We understand that life often deals us some unexpected surprises so there are of course legitimate excuses. We are here to serve you and appreciate the confidence you show in us by allowing us to care for you. However, due to the increasing problem of no shows and late cancellations and our desire to schedule others for treatment as soon as possible, we have implemented the following policy:

1. **Two No-Shows:** You may be subject to a **$10.00 charge** (offices typically charge $25.00). This is especially important for those with no-fault or workers' compensation cases.

2. **Same Day Cancellations** (less than 24 hours) may be subject to a **$10.00 charge** if they occur regularly.

3. If you need to cancel or reschedule please call Thorassic Park or after hours you may leave a short message on our answering machine stating:
    a. Your Name and Doctor you were scheduled with
    b. Date and time of your appointment
    c. Best phone # to reach you at
    d. We will call you back to reschedule your appointment
4. If you **arrive 10 minutes or later to your appointment** without a phone call, we may have to reschedule you due to other patient's appointments. If we can work you in we will certainly do so.
5. New patients must arrive early enough to fill out the required paperwork prior to their scheduled appointment time.

6. If you apologize profusely we tend to forgive everyone for their oversight!

All no-show/late cancellation fees will be donated to a non-profit charity of your choice.

_____ _____ _____

Signature ***Date*** ***Choice Charity***