What's New!?

Date:_____ E-Mail:_____ Cell Phone: (____)_____

Name _____ Home Phone:(____)_____

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

Occupation:_____ Employer:_____Work Phone: (____)_____

Occupation Address:_____
Street City State Zip

[ ] Single [ ] Married [ ] Other Spouses Name:_____

___ I am interested in a no-interest payment plan to cover any costs associated with treatment.

Insurance Information

Name of Health Insurance Company:_____

Subscriber # _____ Group # _____

Insurance Holder's Name:_____ Date of Birth:__/__/____. SSN:_____

Insured's Employer_____

Relationship to You: [ ] Self [ ] Spouse [ ] Mother [ ] Father

Is this complaint due to a work related or auto accident: YES / NO

Any time lost from work due to this illness or accident: YES / NO From:_____ To:_____

Signing below verifies your consent to the rendering of care including treatment and performance of diagnostic procedures.

Patient Signature:_____ Date:_____

If Minor, Parent/Guardian Signature of Consent:_____ Date:_____

Office Witness:_____ Date:_____ Acct:_____

CASE HISTORY FORM

CONSTITUTIONAL

- ☐ DENY ALL
- ☐ CHILLS
- ☐ FAINTING
- ☐ FATIGUE
- ☐ FEVER
- ☐ NIGHT SWEATS
- ☐ WEAKNESS
- ☐ WEIGHT GAIN
- ☐ WEIGHT LOSS

INTEGUMENTARY

- ☐ DENY ALL
- ☐ ECZEMA
- ☐ HAIR GROWTH
- ☐ HAIR LOSS
- ☐ HIVES
- ☐ ITCHING
- ☐ PARESTHESIA
- ☐ RASH
- ☐ SKIN LESIONS

PSYCHIATRIC

- ☐ DENY ALL
- ☐ AGITATION
- ☐ ANXIETY
- ☐ APPETITE CHANGES
- ☐ BEHAVIORAL CHANGES
- ☐ BIPOLAR DISORDER
- ☐ CONFUSION
- ☐ DEPRESSION
- ☐ HOMICIDAL INDICATION
- ☐ INSOMNIA
- ☐ MEMORY LOSS
- ☐ SUBSTANCE ABUSE
- ☐ SUICIDAL INDICATION

EYES

- ☐ DENY ALL
- ☐ BLURRED VISION
- ☐ CATARACTS
- ☐ CHANGE IN VISION
- ☐ DOUBLE VISION
- ☐ DRY EYES
- ☐ GLAUCOMA
- ☐ SENSITIVITY TO LIGHT
- ☐ TEARING

GASTROINTESTINAL

- ☐ DENY ALL
- ☐ ABDOMINAL PAIN
- ☐ BLACK, TARRY STOOLS
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ HEARTBURN
- ☐ HEMORRHOIDS
- ☐ INDIGESTION
- ☐ NAUSEA
- ☐ RECTAL BLEEDING
- ☐ VOMITING

ALLERGIC/IMMUNOLOGIC

- ☐ DENY ALL
- ☐ HISTORY OF ANAPHYLAXIS
- ☐ ITCHY EYES
- ☐ SNEEZING

HEMATOLOGIC/LYMPHATIC

- ☐ DENY ALL
- ☐ ANEMIA
- ☐ BLEEDING
- ☐ BLOOD CLOTTING
- ☐ BLOOD TRANSFUSIONS
- ☐ BRUISE EASILY
- ☐ LYMPH NODE SWELLING

MUSCULOSKELETAL

- ☐ DENY ALL
- ☐ ARTHRITIS
- ☐ NECK PAIN
- ☐ DECREASED MOTION
- ☐ GOUT
- ☐ INJURIES
- ☐ JOINT PAIN
- ☐ BACK PAIN
- ☐ MUSCLE CRAMPS
- ☐ MUSCLE PAN
- ☐ MUSCLE WEAKNESS
- ☐ SWELLING

CARDIOVASCULAR

- ☐ DENY ALL
- ☐ ANGINA
- ☐ CHEST PAIN
- ☐ HEART MURMUR
- ☐ HEART PROBLEMS
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ PALPITATIONS
- ☐ SHORTNESS OF BREATH
- ☐ SWELLING OF LEGS
- ☐ VARICOSE VEINS

GENITOURINARY

- ☐ DENY ALL
- ☐ BURNING URINATION
- ☐ CRAMPS
- ☐ FREQUENT URINATION
- ☐ HESITANCY/DRIBBLING
- ☐ HORMONE THERAPY
- ☐ IRREGULAR MENSTRUATION
- ☐ LACK OF BLADDER CONTROL
- ☐ PROSTATE PROBLEMS
- ☐ URINE RETENTION
- ☐ VAGINAL BLEEDING
- ☐ VAGINAL DISCHARGE

ENDOCRINE

- ☐ DENY ALL
- ☐ DIABETES
- ☐ EXCESSIVE APPETITE
- ☐ EXCESSIVE HUNGER
- ☐ EXCESSIVE THIRST
- ☐ GOITER
- ☐ HAIR LOSS

NEUROLOGICAL

- ☐ DENY ALL
- ☐ CHANGE IN CONCENTRATION
- ☐ CHANGE IN MEMORY
- ☐ DIZZINESS
- ☐ HEADACHE
- ☐ IMBALANCE
- ☐ LOSS OF CONSCIOUSNESS
- ☐ LOSS OF MEMORY
- ☐ NUMBNESS/TINGLING
- ☐ SEIZURES
- ☐ SLEEP DISTURBANCE
- ☐ SLURRED SPEECH
- ☐ STRESS
- ☐ STROKES
- ☐ TREMORS

RESPIRATORY

- ☐ DENY ALL
- ☐ ASTHMA
- ☐ BRONCHITIS
- ☐ DRY COUGH
- ☐ PRODUCTIVE COUGH
- ☐ COUGHING UP BLOOD
- ☐ DIFFICULTY BREATHING
- ☐ PNEUMONIA
- ☐ SPUTUM PRODUCTION
- ☐ WHEEZING

ENMT

- ☐ DENY ALL
- ☐ BAD BREATH
- ☐ DENTURES
- ☐ DIFFICULTY SWALLOWING
- ☐ EAR DRAINAGE
- ☐ EAR PAIN
- ☐ FREQUENT SORE THROATS
- ☐ HEAD INJURY
- ☐ HEARING LOSS
- ☐ HOARSENESS
- ☐ LOSS OF SMELL
- ☐ LOSS OF TASTE
- ☐ NASAL CONGESTION
- ☐ NOSE BLEEDS
- ☐ SINUS INFECTIONS
- ☐ RUNNY NOSE
- ☐ SNORING
- ☐ SORE THROAT
- ☐ RINGING IN EARS

PATIENT NAME: DOB: ACCT #:

DOCTOR SIGNATURE: _____

PERSONAL HISTORY FORM

1. Do you smoke? Yes No How much? _____
2. Do you drink alcohol? Yes No How much? _____
3. Do you do any recreational drugs? Yes No How much? _____
4. Do you exercise? Yes No How much? _____
5. Are you pregnant, or any chance of being pregnant? (Female Only) Yes No How far along? _____

Who have you seen as your primary care/medical doctor?
_____

Location: _____Telephone: _____

Past Hospitalizations: (list date and reason)
___/___/___/ _____
___/___/___ _____
___/___/___ _____

Past Surgeries: (list date and reason)
___/___/___ _____
___/___/___ _____
___/___/___ _____

Past Fractures: (list date and reason)
___/___/___ _____
___/___/___ _____
___/___/___ _____

List any chronic diseases you may have: _____
_____

Are you currently taking any prescription drugs? [ ] Y [ ] N
Please list:
_____ _____
_____ _____

Dr. Signature: _____ Date: _____

Patient Name: _____ DoB: _____ Pt. Acct #:_____

Patient Health Questionnaire - PHQ

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

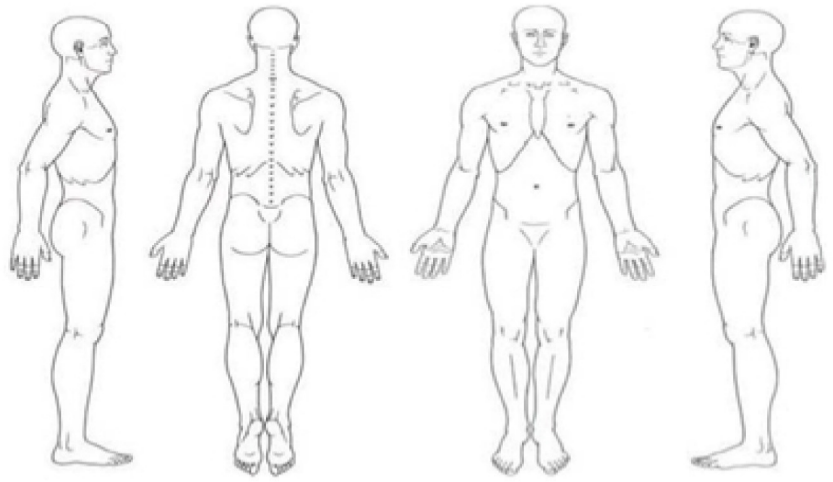
3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

Indicate where you have pain or other symptoms



5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

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8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past?

① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ ***Date*** _____

PATIENT WAIVER FOR NON-COVERED SERVICES

Patient's Name: _____ ACCT #: _____

Your insurance does not pay for all your healthcare costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services.

Your physician believes that the following service(s), although not covered by your health insurance, are an important part of your chiropractic care and recommends that you receive these services as part of your current treatment plan. However, since the services listed here are not considered to be a covered benefit under your health insurance, should you choose to receive these services; you will be personally responsible for the payment of such services. The purpose of this notice is to help you make an informed choice about whether you want to receive these items or services.

The services recommended by your physician are listed below:

☐	X-Rays	$60.00
☐	Decompression Therapy	$65.00 / $45.00
☐	Dry Needling	$50.00 / $35.00
☐	Laser Treatment	$15.00
☐	Cupping Treatment	$15.00
☐	Shockwave Package (6 Treatments)	$600.00

I acknowledge that I have been informed in advance of receiving these services, that these services are not covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges indicated above.

Print Patient Name _____

Patient Signature _____

Name of Parent or Legal Guardian (if applicable) _____

Signature of Parent or Legal Guardian (if applicable) _____

Date_____

This form must be signed by the patient or legal guardian PRIOR to receiving any non-covered services or items and *must be maintained in the patient's medical record.*