Signature Chiropractic

8345 W Thunderbird Rd. B103 Peoria, Az 85381
623-334-4114 Phone 623-334-4117 Fax

Name: _____ Age: _____ DOB: _____

Address: _____ City _____ State____Zip _____

Home Telephone ( )_____ Work ( ) _____ Cell ( ) _____

Can you receive text messages on you cell number? Y/N Email Address: _____

Social Security # _____ Male _____ Female _____ Married/Divorced/Single

Spouse's Name _____ Children Y/N Please list their ages _____

Emergency Contact Name and Contact info: _____ Relationship: _____

Occupation:_____ Employer Name: _____

Have you seen a Chiropractor before? Y/N If yes, when?_____

Whom may we thank for referring you to our office? _____

Your Health Summary

Please ✓ all symptoms you have ever had, even if they do not seem related to your current problem.

◊ Headaches	◊ Pins and Needles in legs	◊ Fainting	◊ Neck Pain
◊ Pins and Needles in arms	◊ Loss of smell	◊ Back Pain	◊ Loss of balance
◊ Dizziness	◊ Buzzing in ears	◊ Ringing in ears	◊ Nervousness
◊ Numbness in Fingers	◊ Numbness in toes	◊ Loss of taste	◊ Stomach upset
◊ Fatigue	◊ Depression	◊ Irritability	◊ Tension
◊ Sleeping Problems	◊ Neck Stiff	◊ Cold hands	◊ Cold feet
◊ Diarrhea	◊ Constipation	◊ Fever	◊ Hot flashes
◊ Cold sweats	◊ Light bothers eyes	◊ Problem urinating	◊ Heartburn
◊ Mood swings	◊ Menstrual pain	◊ Menstrual irregularity	◊ Ulcers

List any medications you are taking _____

_____

This office conforms to the current HIPPA guidelines. You may request a copy of our HIPPA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____.
The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature _____ Date signed: _____

Guardian Signature _____ Date signed: _____

Staff Signature: _____ Date: _____HRN _____

Functional Rating Index

For use with Neck and /or Back Problems only.
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity

No Pain	Mild pain	Moderate pain	Severe Pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild Pain No restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No Pain	Mild pain	Moderate pain	Severe Pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Patient Name _____

Signature_____ .Date:_____

Staff _____ HRN _____

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We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. In addition to how your PHI will be used, office policies regarding payment and collections, and consent to treat are listed below. By signing at the end of these policies, you agree to all stipulations.

The patient understands and agrees to allow Signature Chiropractic to use their PHI for the purpose of treatment, payment, health care operations, and coordination of care.

1. The patient has the right to obtain a copy of his/her own health records with a written request. Fulfillment of request may take up to 10 days. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
2. A Patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
3. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
4. We reserve the right to destroy all patient records after the allowed 6 years of inactivity without notice.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Signature Chiropractic to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

AUTHORIZATIONS, ASSIGNMENTS OF BENEFITS AND CONSENT TO TREAT

To: Signature Chiropractic, hereafter referred to as OFFICE

1. I authorize, assign and direct my insurance carrier, to pay directly to said OFFICE such sums as may be due and owing the OFFICE of services rendered me, now or hereafter, which are payable under my insurance contract, or contractual agreement.
2. Patient agrees, that in the event patient receives any checks, drafts or other payment subject to this agreement, patient agrees to act as fiduciary agent to the OFFICE. The OFFICE agrees to apply any proceeds to the patient's debt for services rendered.
3. I fully understand and agree insurance policies are an arrangement between the insurance carrier and myself. I will be responsible for expenses not paid by insurance. I understand and agree that either health insurance or automobile insurance may not pay all of the charges of the OFFICE for my treatment. I understand and agree to pay the customary charges of the OFFICE and agree that if my health insurance or automobile insurance does not pay for my treatment in full, I will be responsible for the remaining balance. I understand and agree that I will be charged for missed appointments and that it may be necessary for OFFICE to record a lien on my case to ensure payment. I agree to pay the charges associated with filing of the lien.
4. I understand that if necessary of OFFICE to employ collection counsel and/or an attorney on my bill, I the patient will be responsible for any said collection and/or attorney fees.
5. I understand that if I do not cancel a scheduled appointment 24 hours in advance of the appointment I may be charged a $25.00 cancellation fee. This includes both Massage and Chiropractic.
6. I agree the OFFICE has the right to call my home or place of employment regarding appointment or insurance issues.
7. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, nutritional assessment, and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or licensed doctors of chiropractic who now or in the future treat me while employed by, or are associated with or serving as back-up for the doctor of chiropractic, including those working at the clinic or office or any other office or clinic.
8. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interests.
9. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) I seek treatment.
10. A photocopy of this form shall be as valid as original

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's signature	**Date**	**HRN** _____ **Office use only**
Legal guardian if patient is a minor		**Relationship to minor**