ACCOUNT #: _________ CHART: _________

Patient Health History

-PATIENT INFORMATION-

Patient Title: __ Mr. __ Mrs. __ Miss. __ Dr. __ Prof. __ Rev. **Today's Date:** _____________

Patient Name: ____
Last First MI Suffix

Mailing Address: ____ __ Male __ Female
City: ______________________________________ **State:** __________ **Zip Code:** ________________

Cell Phone: ________________ **Other:** ________________ **Work:** _________________ **EXT:** _____

E-mail Address: ____

Birthdate: _________________ **Social Security Number:** ____________________________________

Status: __ Minor __ Single __ Married __ Divorced __ Separated __ Widowed

Patient Employer: ______________________________ **Occupation:** ___________________________

Spouse's Name: _______________________ **Legal Guardian** (for minor): _____________________

-INSURANCE INFORMATION-

Insurance Company Name: ____

Mailing Address: ____

City: ______________________________________ **State:** __________ **Zip Code:** ________________

Phone: ________________________ **Insured's SS#:** ____

Policy #: ___________________________ **Group #:** ____________ **Insured's DOB:** ______________

Insured's Name: ________________________________ **Relation to Patient:** __________________

Secondary **Insurance Company Name:** ____

Mailing Address: ____

City: ______________________________________ **State:** __________ **Zip Code:** ________________

Phone: ________________________ **Insured's SS#:** ____

Policy #: ___________________________ **Group #:** ____________ **Insured's DOB:** ______________

Insured's Name: ________________________________ **Relation to Patient:** __________________

List all prescription and/or over-the-counter medications you are currently taking:

____

What Brings You To Our Office?

If you have NO symptoms/complaints and are here for Wellness, please indicate using NONE.

List of Problems/Concerns: (most important first)

1. ____ 2. ____

Frequency of MAIN problem
- ☐ Constant
- ☐ Frequent
- ☐ Intermittent
- ☐ Occasional

Better
- ☐ in the morning
- ☐ by mid-day
- ☐ by evening
- ☐ at night
- ☐ doesn't change

Relieving Factors
- ☐ sitting
- ☐ standing
- ☐ lying down
- ☐ movement
- ☐ stretching
- ☐ heat
- ☐ ice
- ☐ massage
- ☐ medication

Quality of Pain
- ☐ dull ache
- ☐ sharp
- ☐ burning
- ☐ stiffness
- ☐ numb/tingling
- ☐ radiating

Worse
- ☐ in the morning
- ☐ by mid-day
- ☐ by evening
- ☐ at night
- ☐ doesn't change

Aggravating Factors
- ☐ sitting
- ☐ driving
- ☐ standing
- ☐ bending
- ☐ lifting
- ☐ walking
- ☐ sleeping
- ☐ work activities
- ☐ coughing
- ☐ rest
- ☐ movement
- ☐ exercise
- ☐ stress
- ☐ fatigue
- ☐ household chores

Have you seen other doctors for this problem? ☐No ☐Yes

If yes, what treatment was received and did it help? ____

No Complaints or Problems? Start Here:

Have you seen a chiropractor before ?
- ☐ Yes
- ☐ No

When? ____________

Do you wear orthotics or arch support?
- ☐ Yes
- ☐ No

How would you rate your mattress?
- ☐ Great
- ☐ OK
- ☐ Need a better one

Sleeping position
- ☐ Side
- ☐ Back
- ☐ Stomach
- ☐ Change positions

How many hours do you sleep on average?
- ☐ 6-8 hours
- ☐ 4-5 hours
- ☐ 2-3 hours

Caffeine Used
- ☐ Often
- ☐ Occasionally
- ☐ Never

Exercise
- ☐ Often
- ☐ Occasionally
- ☐ Never

Alcohol
- ☐ Often
- ☐ Occasionally
- ☐ Never

Feel Stressed
- ☐ Often
- ☐ Occasionally
- ☐ Never

Average daily water intake: ______________ oz.

Vitamins/Supplements:

1. ____ 3. ____

2. ____ 4. ____

Your Past Health History

Check all that apply. If you have NO symptoms/complaints please check NONE ☐

Cardiovascular

- ☐ Blood Pressure
- ☐ Cholesterol
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Stroke
- ☐ Pacemaker
- ☐ Congestive Heart Failure
- ☐ Irregular Heartbeat

Genitourinary

- ☐ Frequent Urination
- ☐ Kidney Stones
- ☐ Prostate
- ☐ Frequent Infection
- ☐ Kidney Disease

Blood/Lymph

- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Leukemia
- ☐ Blood Clots
- ☐ Hepatitis

Respiratory

- ☐ Asthma
- ☐ Pneumonia
- ☐ Sleep Apnea
- ☐ COPD
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ TB

Ear/Nose/Throat

- ☐ Hearing Loss
- ☐ Ringing
- ☐ Chronic Sinus
- ☐ Frequent Ear Infections

Eyes

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Double Vision
- ☐ Blindness
- ☐ Detached Retina

Skin

- ☐ Eczema
- ☐ Psoriasis
- ☐ Rashes
- ☐ Shingles

Allergy/Immunity

- ☐ Hives
- ☐ HIV/AIDS
- ☐ Allergy Shots
- ☐ Chronic Allergies

Gastrointestinal

- ☐ Gall Bladder
- ☐ Crohn's Disease
- ☐ Constipation
- ☐ Ulcers
- ☐ Reflux
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Poor Appetite
- ☐ Diverticulitis

Musculoskeletal

- ☐ Gout
- ☐ Arthritis
- ☐ Joint Stiffness
- ☐ Muscle Weakness
- ☐ Osteoporosis

Neurological

- ☐ Seizures
- ☐ Head Injury
- ☐ Multiple Sclerosis
- ☐ Autism
- ☐ Memory Loss
- ☐ Severe Headaches/ Migraines
- ☐ Parkinson's
- ☐ Carpal Tunnel
- ☐ Loss of Balance
- ☐ Dizziness

Endocrine

- ☐ Thyroid
- ☐ Diabetes
- ☐ Menopause
- ☐ Menstrual Problems

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Unusual Stress
- ☐ Bi-Polar Disorder

Constitutional

- ☐ Weight loss/ gain
- ☐ Energy Problem
- ☐ Difficulty Sleeping

Allergies

- ☐ Eggs
- ☐ Shellfish
- ☐ Milk/Lactose
- ☐ Peanuts
- ☐ Soy
- ☐ Pets
- ☐ Sulfa
- ☐ Wheat/Gluten
- ☐ Codeine
- ☐ Chemical
- ☐ Seasonal
- ☐ Latex

Surgery History

List any relevant below.

____

____

____

To be performed by clinic staff:

Height:_____________ inches Weight_____________ pounds BP:______/______

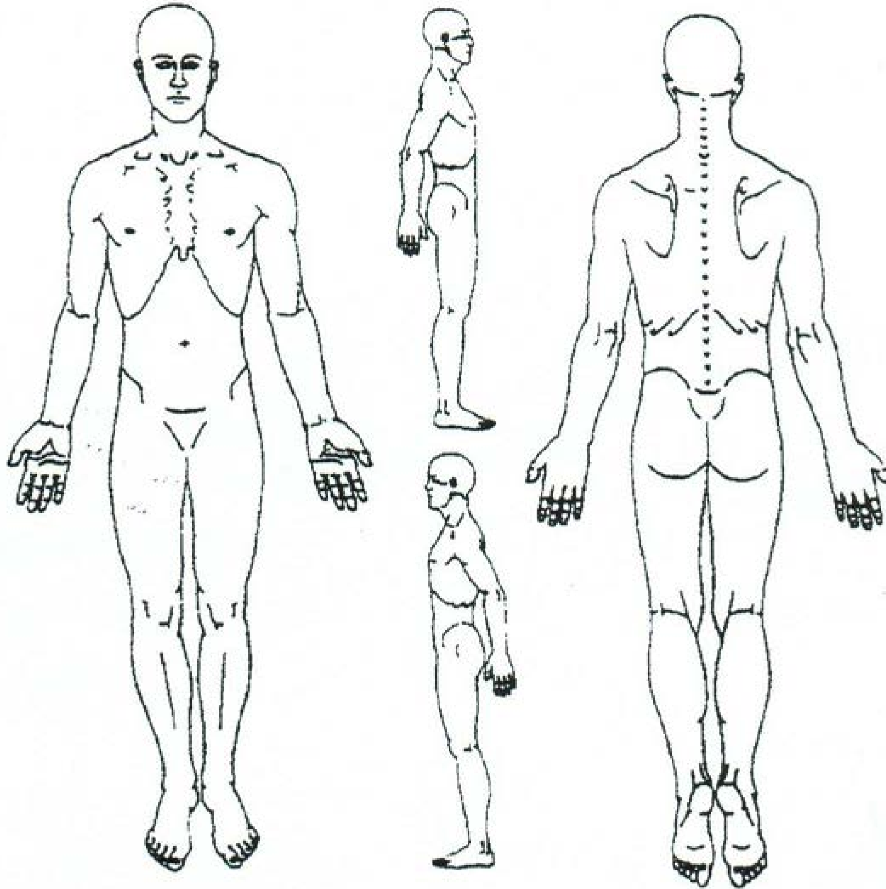
Patient Health History

Please mark areas on the picture below that correspond to the areas of your body where you feel the described sensations. Mark areas of radiation. Include all affected areas.

Use appropriate symbols:

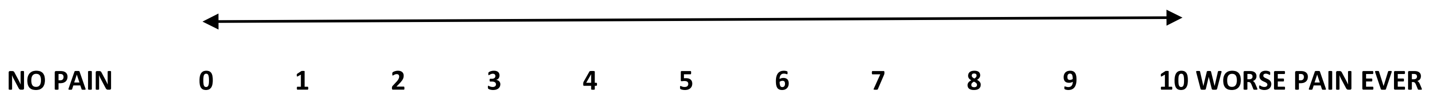
Numbness - - - - - **Pins & Needles ooooo** **Burning xxxxx**

Aching ***** **Stabbing /////**



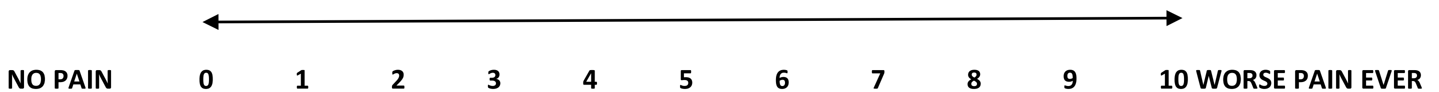
VISUAL ANALOG PAIN SEVERITY SCALE

Please place a mark on the line that corresponds to your ***current*** pain.



NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORSE PAIN EVER

Please place a mark on the line that corresponds to your ***average*** pain



NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORSE PAIN EVER

PLEASE SIGN

Patient Signature:____ **Date:**_________________

Family Health History

*Please review the below listed symptoms and conditions and indicate those that are current health problems of a family member by the designation of a **C** under his or her column. The designation of a **P** should be used to indicate a past problem. Leave blank those spaces that do not apply.*

	Father	Mother	Spouse	Brother(s)	Sister(s)	Children
Allergies						
Anxiety						
Arthritis						
Auto Accident						
Back Pain						
Cancer						
Constipation						
Diabetes						
Disc Problems						
Epilepsy						
Freq. Cold/Flu						
Gassy/Bloating						
Headache						
Heartburn						
Heart Trouble						
High Blood Pressure						
Low Energy						
Migraine						
Neck Pain						
Nervousness						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Sleeping Problems						
Other:						
Other:						
Other:						

The statements made on these forms are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

All fees are payable when services are received unless special arrangements are made in advance.

The purpose of today's visit is to determine if you are a candidate for care in this office.

Patient's Signature:____ Date:___________________________

Informed Consent

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare minor fractures, and possible stroke have been associated with chiropractic adjustments.

Patient Signature____________________________________ Date __________________

X-Ray Consent

By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination if the doctor has deemed necessary in my case.

Patient Signature____________________________________ Date __________________

Office Financial Policy

All services rendered are the responsibility of the patient and said patient is ultimately responsible for all payment on services regardless of whether or not this office accepts insurance assignment. Our office will prequalify your insurance coverage. We will give you the best estimate of your coverage for the recommended services. This is **not a guarantee of benefits.** Should you discontinue care for any reason, other than discharge by the doctor, any and all balances will become due and payable. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero. Any expenses incurred by this office (collections, court fees, etc.)in the effort to obtain payment on unpaid accounts past 90 days will be added to your balance.

Patient Signature____________________________________ Date __________________

Notice of Privacy Practices

The undersigned acknowledges receipt of a copy of the current Notice of Privacy Practices for this health care facility. It describes your rights to the limited use of protected health information, including your demographic information.

You have the right to request a restriction or disclosure on the use of your PHI (Protected Health Information). This office may or may not agree to your request.

This office utilizes open or common areas for treatment, however, private areas are available upon request. You may refuse to sign this acknowledgement and authorization and revoke this consent to use PHI. This must be done in writing.

I authorize contact from this office to confirm my appointments, treatment, and billing information by means:

- ☐ Cell phone
- ☐ Home phone
- ☐ Text message
- ☐ Email
- ☐ All of the above

Patient Signature____________________________________ Date __________________

Witness

CONSENT TO CHIROPRACTIC EXAMINATION AND TREATMENT

Chiropractic is a health care profession that focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. The primary treatment provided by Doctors of Chiropractic is spinal manipulative therapy, also referred to as an adjustment. A Doctor of Chiropractic uses his/her hands and/or a mechanical instrument on the patient's body in such a way as to move the patient's joints. This may cause an audible "pop" or "click", such as when a person "cracks" his knuckles. The patient may feel a sense of movement as well.

Other procedures commonly used by Doctors of Chiropractic include the following:

- physical examination
- postural analysis
- vital signs
- bracing and support applications
- ultrasound therapy
- hot/cold therapy
- diagnostic studies
- manual therapy
- laser therapy
- traction/decompression
- electrical muscle stimulation
- acupuncture/dry needling
- palpation
- rehabilitation

The material risks associated with chiropractic treatment

Chiropractic treatment utilizes very safe, non-invasive procedures performed in chiropractic offices to reduce pain, restore range of motion, and promote overall body wellness, among other various benefits. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Possible complications include but are not limited to the following: muscle strain, dizziness, nausea, flushing, fractures, disc injuries, dislocations, cervical myelopathy, burns, costovertebral strains and separations. It is not uncommon for patients to experience temporary soreness after the first few treatments. In rare cases, manipulation of the neck has been associated with injuries to the arteries in the neck, leading to or contributing to serious complications, including stroke.

The probability of those risks occurring

Fractures are rare occurrences and generally result from underlying weakness of the bone for which the Doctor of Chiropractic checks during the taking of the patient's history, and during examination and X-ray. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options may include the following

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain-killers
- Hospitalization/Surgery

There are risks and benefits associated with all the above treatment options, which the patient may wish to discuss with his/her medical doctor.

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Failure to seek care could result in serious medical conditions going unrecognized. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that Dr. ________________ will advise me of any material risks in this regard.
2. Neither the practice of chiropractic nor the practice of medicine is an exact science, and my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. It is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, and an undesirable result does not necessarily indicate an error in judgment or treatment.
4. Dr. ________________ does not guarantee any results with respect to any course of care or treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. ONCE READ AND UNDERSTOOD, PLEASE CHECK THE APPROPRIATE BLOCK IN THE PARAGRAPH BELOW AND SIGN.

Patient:

I [ ] have read, or [ ] have had read to me, the above explanation of chiropractic adjustment and related treatment. I hereby authorize, Dr. ____________ and his/her assistants, associates and other appropriate persons to render care, to perform an examination and to provide an appropriate evaluation and treatment plan to address the complaints, problems, and medical history I have provided. I have discussed any questions, comments, or concerns with Dr. ______________ and have had my inquiries answered to my satisfaction. By signing below, I state that I have weighed the risks and/or benefits in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

________________________________ Patient's Name	________________________________ Patient's Signature
________________________________ Date	________________________________ Signature of Parent/Guardian (if patient is a minor)

MEDICARE WAIVER

Medicare will only pay for services that are determined to be "Reasonable and Necessary" under section 1862(a) of the Medicare Law.

If the Medicare Carrier determines that a particular service, although it would otherwise be covered, is not "Reasonable and Necessary" under the Medicare program standards, the Medicare Carrier will deny payment for that service.

Medicare is likely to deny all services except the Chiropractic Adjustment, including the Chiropractic X-rays, because they are not a contract benefit.

Likewise, Medicare will not pay for examinations necessary to develop the diagnosis or any other procedure, because those procedures do not fit into their contract benefit.

Further, there is a possibility that Medicare will attempt to impose utilization controls, making the Doctor prove medical necessity of care. If the Doctor does not have "Documentation" to prove medical necessity of care, Medicare will determine the chiropractic care to be "maintenance" which is a non-covered service and does not fit into their contract benefit.

Chastain Family Chiropractic has determined that in my case, the Medicare carrier is likely to deny payment for all or part of the services identified above. If Medicare denies payment, I agree to be personally and fully responsible for payment on all services, except the Chiropractic Adjustment.

_________________________________ _____________________

Signature of Patient Today's Date

____

Witness

EXTENDED PAYMENT REQUEST

Patient's Name: (Please Print) ____

Patient's Medicare Number: ____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Chastain Family Chiropractic for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: _____________________________________ Date ____________________________________

CHASTAIN FAMILY CHIROPRACTIC

(Provider)