PRO ADJUSTER CHIROPRACTIC CLINIC

Dr. Nicholas J. Senuta & Associates

Today's Date_____

How did you hear about us? *family___*friend ___*dr. ___*ins. co. ___*yellow pages__
*drive-by ____*hospital ____Whom may we thank for referring you?_____
Name: _____
Address: _____
City: _____ State: _____ Zip: _____Age:_____ DOB:_____
Email Address: _____
Home Phone: _____ Cell: _____
Sex: M F M S W D Occupation: _____
Employer: _____ Employers Address: _____
Spouse's Name: _____ Employer: _____

What is the reason for your visit? _____
How long have you had this condition? _____What activities aggravate your condition? _____
Have you had this condition in the past? Y N Is this condition progressively getting worse? Y N
Does your condition interfere with your Work☐ Sleep☐ Daily Routine☐ Other _____
How long has it been since you felt good? _____
Have you seen any other chiropractors this year? Y N How many visits?_____
What other treatments have you had for this condition? Physical therapy? Medications? Surgery?

Insurance Information

Who is responsible for this account? _____
Who is the Health Insurance Carrier? _____
ID card # _____ Group # _____
Policy holder's name: _____Relationship: _____
DOB of policy holder: _____

Emergency Contact Information

Name: _____Address:_____
Home Phone: _____Work Phone: _____Cell Phone: _____
Relationship to patient: _____

Date of last:

Physical Exam	_____	Spinal x-ray	_____	Blood Test	_____
Spinal Exam	_____	Chest x-ray	_____	Urine Test	_____
Dental x-ray	_____	MRI, CT-Scan, Bone Scan		_____	

Injuries/Surgeries you have had:	**Description**	**Date**
Fall		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? Place a check mark by conditions that apply to you.

__Broken or fractured bones
__Circulatory Problems
__Rheumatoid Arthritis
__Seizures/convulsions
__Congenital Disease
__Excessive Bleeding
__High/Low Blood Pressure
__Osteoarthritis
__Epilepsy
__Pace maker
__Strokes
__Cancer
__Ruptures
__Coughing Blood
__Eating Disorder
__Alcoholism
__Drug Addiction
__HIV Positive
__Gall Bladder
__Depression
__Ulcers

Please circle all the activities that you find difficult to do <u>now</u> due to your discomfort?

*Sleep through the night
*Get out of bed
*Make your bed
*Bathe yourself
*Wash, comb or dry hair
*Go to the bathroom
*Put on socks, shoes or clothing
*Walk up one flight of stairs
*Walk down one flight of stairs
*Bend over sink for 10 minutes
*Crawl on all fours
*Carry laundry, groceries or child
*Open heavy door
*Sit in a chair for 30 min.
*Sit and work at a desk for one hour
*Use pencil, scissors, screwdriver or pliers
*Cross legs
*Reach in front or overhead to high shelves
*Stand for 30 minutes
*Travel on journeys that take over one hour
*Push or pull vacuum or lawn mower
*Turn door knob
*Wash windows or walls
*Shovel snow or dirt
*Bend over to clean bathtub
*Get up from low seat
*Lift heavy suitcase (40Lbs.)
*Walk one mile
*Enjoy hobbies or social activities
*Enjoy sexual activities

Did you have difficulty with any of the above activities **<u>before</u>** you had this condition? Y N
What activities? _____

FAMILY DISEASES (check if applicable and indicate whether family member is <u>F</u>ather, <u>M</u>other, <u>S</u>ister, <u>B</u>rother)

Tuberculosis _____
Diabetes_____
Stroke _____
Arthritis_____
Cancer _____
Asthma _____
Kidney Disease _____
Liver Disease _____
Mental Illness_____
Heart Disease _____
Lung Disease _____

Medications	Allergies	Vitamins/Herbs Minerals

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and the patient. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company that any amount authorized to be paid directly to Chiropractic Clinic will be credited to my account upon receipt. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agree the amount paid the doctor, x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: _____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal: to eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Chiropractors provide a unique service that other healthcare providers do not offer: the location and correction of vertebral subluxations (spinal nerve stress) in your body.

Vertebral Subluxation Complex (VSC): a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Chiropractors spend years studying how to locate and correct this destructive condition, first by analyzing your body structure (especially your spine) using various methods. Second, we correct or adjust your subluxation by using specialized techniques (spinal adjustment). When your spine and nervous system are free from the deep stress of vertebral subluxations you function more efficiently and your natural health ability, your inner healer, will better communicate through your body.

Informed Consent for Chiropractic Care

A patient, in coming to the Chiropractor, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic examinations, diagnosis and analysis. The chiropractic adjustment or other clinical procedures is usually beneficial and seldom cause a problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The

doctor, of course will not give a chiropractic adjustment, or health care, if he is aware that such care may be contradicted.
Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, ilness, or deformities which would otherwise not come to the attention of the Chirpractor. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Chiropractor provides a specialized, non-duplicating health service. The doctor of Chiropractic is licensed in a special practice of health care and is available to work with other types of providers in your health care regiment.

RESULTS

The purpose of Chiropractic services is to promote natural health through the reduction of the VSC (defined earlier). Since there are so many variables, it is difficult to predict the time schedule of efficiency of the Chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions, which do not respond chiropractically, may come under control or be helped through medical science. The fact that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

The patient should discuss any questions or problems with the doctor before signing this statement of policy.

I have read the foregoing and understand it.

_____

Signature Date

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NO INSURANCE PAYS 100% OF EVERYTHING

Insurance information is the responsibility of the patient. A phone number is located on the back of your card. They will tell you if you have chiropractic coverage. They will also tell you what your deductible is, if any. Also what coinsurance you may be responsible for.

If you prefer you may ask our insurance department to check this information for you. But please be advised, most insurance companies will not disclose deductible information to an outside source. It is considered confidential, and they will discuss it only with the patient.

Any information given to you by our insurance department is what they were told at the time of their conversation with your insurance company. It is not a guarantee of payment or amount. This will only be confirmed when an Explanation of Benefits is received.

If you paid any co pay or deductible that was not charged by your insurance on the explanation of benefits, it will be promptly refunded.

PATIENT SIGNATURE _____ DATE _____

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