



Dr. J. Scott Gillis
Chiropractic Physician

Please present valid identification and your insurance card to the front desk staff. All questions contained in this questionnaire are strictly confidential and will become a part of your medical record.

PATIENT DEMOGRAPHICS

Today's Date: _____

Patient Name: _____ Male Female

What you prefer to be called: _____

DOB: _____ Age: _____ SSN: _____

Home Address: _____
Street

_____ *City* _____ *State* _____ *Zip Code*

Phone Number: _____ Work Number: _____

Marital Status: Single Married Divorced Separated Widowed

Race: American Indian/Alaska Native Asian African American Native Hawaiian Other Pacific Islander
 White Ethnicity: Hispanic or Latino Not Hispanic or Latino

Occupation: _____

Place of Employment: _____

How did you hear about us? Referred by (Name): _____

Other: _____

INSURANCE INFORMATION

Please present insurance card to the front desk staff.

PATIENT HEALTH HISTORY

Height: _____ Weight: _____

Are you taking any of the following medications? Nerve Pills Pain Killers (Including Aspirin) Muscle Relaxers Stimulants Blood Thinners Tranquilizers Insulin Other: _____

Have you ever had any of the following diseases/medical condition(s)?

<input type="checkbox"/> Heart Attack/Stroke	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Artificial Valves
<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> STD	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> HIV+/AIDS	<input type="checkbox"/> Shingles	<input type="checkbox"/> Cancer
<input type="checkbox"/> Frequent Neck Pain	<input type="checkbox"/> Emphysema/Glaucoma	<input type="checkbox"/> Anemia
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Severe/Frequent Headaches	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Ulcers/Colitis
<input type="checkbox"/> Fainting/Seizures/Epilepsy	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Diabetes/ Tuberculosis	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Lower Back Problems	<input type="checkbox"/> Artificial Bones/Joints	<input type="checkbox"/> Arthritis

Please list any other serious medical condition(s) you have or ever had: _____

Please list anything you may be allergic to: _____

Please list any previous surgeries/treatments with dates: _____

Please list any past serious accidents with dates: _____

Do you smoke? Yes No How much? _____ How Long? _____

Are you wearing any of the following? Heels Lifts Sole lifts Inner Soles Arch Supports

For Women: Are you taking Birth Control? Yes No

Are you pregnant? Yes No How Long? _____

REASON FOR VISIT

Have you ever been treated by a chiropractor before? Yes No

If so, please explain when and why: _____

The reason for this visit is a result of: Work Sports Auto Trauma Chronic

Explain what happened: _____

Describe the pain and location: _____

When did the condition begin? _____

Is the condition getting worse? Yes No Constant Comes and goes

Is the condition interfering with your: Work Sleep Daily Routine

Have you had this or similar conditions in the past? Yes No

If yes, please explain: _____

Have you been treated by a Medical Physician for this condition? Yes No

Indicate your degree of comfort while performing the following activities:

Activity	Comfortable	Uncomfortable	Painful (even if only sometimes)
Lying on Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How many hours are in your normal workday? _____

Please indicate any physical activity you are required to perform:

<input type="checkbox"/> Standing	<input type="checkbox"/> Twisting	<input type="checkbox"/> Lifting
<input type="checkbox"/> Sitting	<input type="checkbox"/> Typing	<input type="checkbox"/> Working w/ arms above head
<input type="checkbox"/> Crawling	<input type="checkbox"/> Stooping	<input type="checkbox"/> Others:
<input type="checkbox"/> Bending	<input type="checkbox"/> Operating Equipment	<input type="checkbox"/>
<input type="checkbox"/> Driving	<input type="checkbox"/> Walking	<input type="checkbox"/>

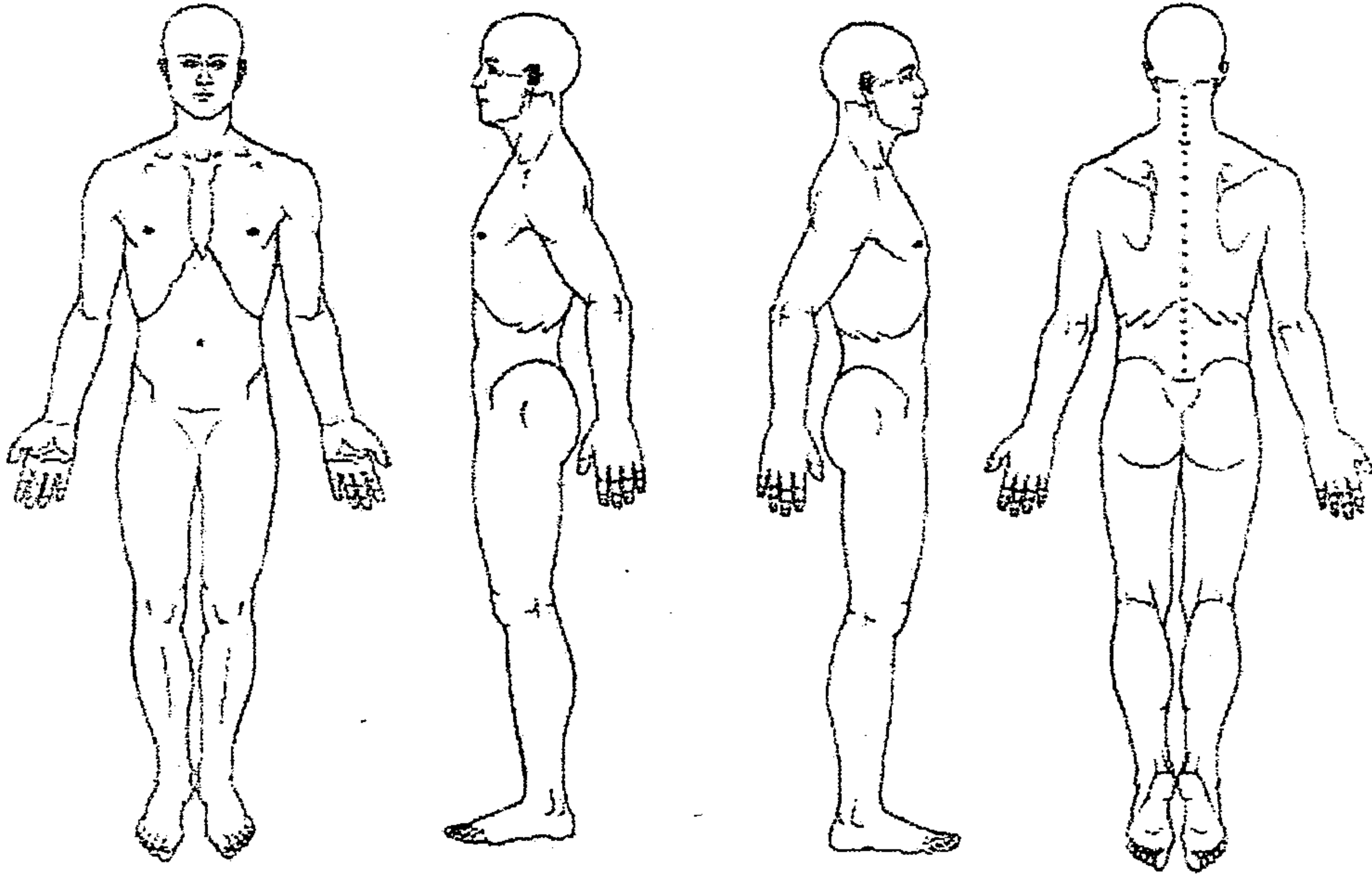
Do you work with others that can help with heavy lifting? Yes No N/A

Is there any light duty work you could request? Yes No N/A

SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description: Numbness Pins & Needles Burning Aching Stabbing
Symbol: (N) (P) (B) (A) (S)
Circle any area of pain not represented by a symbol



Patient Remarks: _____

Doctor's Remarks: _____

Side / Back / Stomach Sleeper Firm / Semi / Soft W/ Pillow Weather Bothers

Heat / Ice Rx: _____ X/Day: _____

Worse Certain Time of Day / AM/PM Positional / Lying / Sit / Stand / Walk

What Relieves Pain if Anything: _____

WORKERS COMPENSATION CASE

Claim Number: _____ Employer Name: _____

Employer Address: _____

Street

City

State

Zip Code

MCO Name: _____

MCO Address: _____

Street

City

State

Zip Code

MCO Phone: _____ Fax: _____

MCO Case Manager Name: _____

Date of Accident: _____ Time of Accident: _____

Was your accident directly related to your work? Yes No

Briefly describe the events that occurred just before and during your accident:

Give the address where the accident occurred (if different from Employer Address):

Was anyone else present during your accident? Yes No

Did you report the accident to your employer? Yes No

What recommendation did your employer make just after your accident?

Has this type of accident happened to you before? Yes No

To the best of your knowledge, has this accident occurred in your workplace before? Yes No

In general:

Is your job physically stressful? Yes No

Is your job mentally stressful? Yes No

Is your workplace noisy? Yes No

Have you changed jobs in the last year? Yes No

PATIENT TREATMENT CONSENT FORM

I authorize Gillis Chiropractic to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, social workers, insurance carriers or attorneys.

I authorize Gillis Chiropractic to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Financial Responsibility / Assignment of Benefits

I understand that I am responsible for paying my co-payments and deductibles at the time of service. I also understand that I am responsible for any balance due after payment by my insurance company.

I, the undersigned, understand that Gillis Chiropractic will bill my insurance company for services rendered upon verification of coverage by my insurance company. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If your insurance company does not remit payment within 60 days, the balance will be due in full from you.

I hereby request that my insurance carrier make payment directly to Gillis Chiropractic for all services rendered by this facility. If my current policy prohibits direct payment to Gillis Chiropractic, I hereby instruct and direct my insurance company to make the check out in my name but send the check to the listed address of Gillis Chiropractic.

If my insurance carrier makes a payment to me, I agree to immediately pay over these funds to Gillis Chiropractic. I also authorize Gillis Chiropractic to deposit checks received on my account when made out to me.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Charges related to Worker's Compensation injury shall be forwarded to the Worker's Compensation Insurance carrier. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered to you.

Charges related to Personal Injury shall be forwarded to my attorney, or my car insurance carrier for payment. However, be advised that if your Personal Injury Claim is denied, you will be held responsible. I direct all payments from my insurance carrier/attorney to pay directly to Gillis Chiropractic for services rendered. Upon settlement of my personal injury claim, Gillis Chiropractic will be paid, or I assume all responsibility on my account.

I, the undersigned, acknowledge that by signing this form I authorize Gillis Chiropractic to submit charges via mail or internet to my insurance carrier. This is a "Signature on File" authorization.

Patient recognizes that Policy quotes are not a guarantee of payment by carrier and the patient is responsible for obtaining actual Policy benefits, limits from the carrier and, if needed, any referrals from primary care physicians or pre-authorization with insurance. All referrals or recommendations from our office have no confirmation of payment or benefits to referring providers.

I authorize my healthcare provider and/or entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by any telephone number, email address and/or mailing address provided. I authorize all my numbers that I have provided to the office in my file be able to accept phone and/or text message. I authorize stating a detailed message to all phone numbers that I have given Gillis Chiropractic.

List of prices (subject to change):

Chiropractic Adjustment: \$55.00, Examinations: \$60.00/\$130.00, Therapy: \$35.00/each, X-rays: \$35-\$100 each

Acknowledgement of Receipt of Notice of Privacy Practices / Patient Consent

I certify that I was offered a copy of Gillis Chiropractic's Notice of Privacy Practices. The Notice of Privacy Practices describes the types and uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Gillis Chiropractic's health care operations. The Notice of Privacy Practices is also posted in the reception area.

Gillis Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requested a revised copy be sent in the mail or asking for one at the time of my next appointment.

I, the undersigned, state that I have read all the above and agree to the terms and conditions set forth.

Patient Name

Date

Patient/Guardian Signature

Date