PARENT CHIROPRACTIC CENTER

Today's Date: _____ ***How did you hear about our office?*** _____
(patient referral, website, google, Facebook etc., doctor)

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ Legal sex: ☐ Male ☐ Female

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

E-mail Address: _____
(we use e-mail to keep you updated about office closures, change in hours due to holidays and weather, etc.)

Home Phone: _____ Mobile Phone:_____ Work Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Number of children and ages: _____

Employer: _____ Occupation: _____

Spouse's Name _____Spouse's Phone: _____

Name & Number of Emergency Contact: _____Relationship: _____

REASON FOR VISIT

Please answer all questions related to your current condition. This information is required in medically necessary documentation that is regulated by insurance carriers and federal Centers for Medical Services (CMS) guidelines for contracted provider documentation.

Please explain the condition(s) that brought you to this office today: _____

_____

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

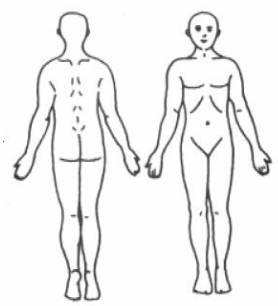
How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ ☐ **N/A**

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching
N = Numbness **S = S**harp/**S**tabbing **T = T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Is your condition the result of an Auto Accident? ☐ Yes ☐ No Workman Comp Injury? ☐ Yes ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about: _____

_____

List any medications/supplements that you are currently taking_____

_____

ACTIVITIES of DAILY LIVING ASSESSMENT

Rate your current difficulties with Daily Activities, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale

CHECK THE APPROPRIATE BOX that most closely describes your current degree of difficulty:

1 = "I can do it "no difficulty",
2 = "I can do it without much difficulty, despite some pain"
3 = "I manage to do it by myself, despite marked pain"
4 = "I manage to do it, despite the pain, but only if I have help"
5 = "I cannot do it at all, because of the pain".

Activities	#1 No difficulty	#2 Some pain	#3 Difficult/ Marked pain	#4 Painful but need help	#5 Unable to perform
Bathing					
Dressing					
Shaving					
Washing hair					
Preparing meals					
Household chores					
Standing					
Sitting					
Walking					
Bending-forward/backwards					
Twisting – right/left					
Leaning – forward/backward					
Carrying small objects					
Carrying large objects					
Climbing stairs					
Exercising					
Driving a car					
Driving for long distances					
Riding as a passenger					
Riding for long distances					
Riding in airplane/train					

PAIN ASSESSMENT

Instructions: Please circle the number that best describes your pain level now and your pain level on average. If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint.

1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

PAST HISTORY

If you have ever been diagnosed with any of the following conditions, please place checkmark in appropriate column:

C for ***CURRENTLY*** have **P** for conditions in the ***PAST*** **N** for ***NEVER*** have had

	C	P	N		C	P	N
Broken bones				Cancer			
Dislocations				Diabetes			
Fractures				Cardiac conditions			
Arthritis				Cerebral Vascular issues			
Rheumatoid Arthritis				Tumors			
Osteo Arthritis				Disability			
Asthma				Auto Immune disorder			
Crohn's / Colitis / IBS				Frequent ear/respiratory infections			

Please explain Current condition(s) checked above and list any conditions/ surgeries that are not listed above:

_____

_____

SOCIAL HISTORY

1. Smoking: ☐cigars ☐ pipe ☐ cigarettes / e-cigarettes ☐ vaping

How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. Alcoholic Beverage: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No

If yes whom: _____

Have they ever been treated for their condition? ☐ Yes ☐ No ☐ I don't know

2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

_____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Parent Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Parent Chiropractic Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Parent Chiropractic Center requires a credit card to be kept on file in the event your account has an outstanding balance in excess of 90 days. In the event that this should happen, we will process a payment for the outstanding balance on your account with the credit card listed below.

Card # _____ Exp.Date:_____ CVC code: _____

VISA / MC / Discover / AMEX

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

PARENT CHIROPRACTIC CENTER

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. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra 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.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

Pregnancy Release (if applicable)
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Signature: _____ Date of last menstrual period: _____

I authorize **Parent Chiropractic Center** to speak to person(s) listed below regarding any treatments, concerns, financial matters, appointments related to my healthcare.

_____
(Relationship to patient)

I have read and fully understand the above statements and accept chiropractic care on this basis.

Signature: _____ Date: _____

Billing, Insurance and Financial Policies

At Parent Chiropractic Center we are committed to providing you and your family with the best chiropractic care possible in a caring environment, and have established our financial and health insurance policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered.

Health Insurance: We accept and participate in many plans. Our office is happy to file insurance for you, however, it is important to know that all insurance companies state the disclaimer:

"**VERIFICATION IS NOT A GUARANTEE OF PAYMENT**."

We verify insurance as a courtesy; this is not a guarantee of benefits. We ask that you contact your insurance company to verify your chiropractic coverage as well. It is your responsibility to thoroughly understand your insurance benefits. You are ultimately responsible for any co-payments, deductibles, and portion of care that is not covered by your health insurance. We strongly advise you to maintain contact with your insurer in order to confirm coverage and benefits to prevent problems with billing and reimbursement. Should your insurance coverage change, it is your responsibility to inform us immediately. You will be responsible for any balance due that insurance does not pay for.

Medicare patients – we are providers for Medicare, however, Medicare does not cover the initial exam, x-rays, or scans for Medicare patients. These fees are the responsibility of the patient. Please call our office for rates and we will be happy to help you with any questions you may have.

Past Due Accounts - We make every effort to avoid using a collection agency to settle an account. However, In the event that an account is over 90 days past due, and all attempts to collect the debt have gone unanswered, you will be responsible for the outstanding amount due in addition to any fees that the collection agency charges to collect the outstanding debt. There is a $35.00 fee in the event of a returned check from the bank due to insufficient funds.

Release of Medical Records – I give permission for Dr. Parent to request medical information from other medical facilities that may help the doctor to accurately assess and treat my condition.

HIPPA / Privacy Practices – I acknowledge that I have been given the opportunity to view the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Our office will use e-mail to inform you of any changes in our office hours, closings, education etc. In the event of a missed appointment, we will call the phone number provided to us.

I have read and understand each of the above mentioned office policies:

Patient signature Date