PATIENT HISTORY

Name _____ Date _____

Date of Birth _____ Referred by _____

Address _____ City _____ State _____ Zip _____

Phone: (H) _____ Cell _____ Work _____

Sex _____ Age _____ Marital Status _____ Number of Children _____

Occupation _____ Place of Employment _____

SS # _____ Email _____

Chief Complaint #1

How did it start? _____ Date of onset? _____

Condition related to ☐ work ☐ auto ☐ chronic ☐ other _____

Dates of similar symptoms: _____

Condition is ☐ same ☐ better ☐ worse ☐ comes & goes

Provoked by: ☐ sitting ☐ standing ☐ laying ☐ reaching ☐ bending ☐ walking ☐ other _____

Relieved by: ☐ Ice ☐ heat ☐ sitting ☐ standing ☐ sleep ☐ walking ☐ laying ☐ pain killers, muscle relaxants, anti-inflammatories ☐ other _____

Quality is: ☐ sharp ☐ shooting ☐ aching ☐ cramping ☐ stiffness ☐ spasms ☐ swelling ☐ burning ☐ numbness ☐ tingling ☐ stabbing ☐ other

Intensity: Absent 0 1 2 3 4 5 6 7 8 9 10 severe

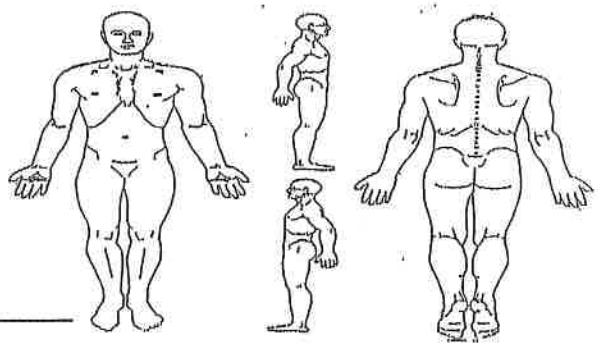
Pain Radiates Into: _____

Is complaint worse in: ☐ morning ☐ afternoon ☐ evening ☐ same all day

Other treatment/diagnosis/results: _____

Symptoms last: ☐ hours ☐ days ☐ weeks ☐ constant ☐ other

Shade the area where you are having symptoms



Chief Complaint #2

How did it start? _____ Date of onset? _____

Condition related to ☐ work ☐ auto ☐ chronic ☐ other _____

Dates of similar symptoms: _____

Condition is ☐ same ☐ better ☐ worse ☐ comes & goes

Provoked by: ☐ sitting ☐ standing ☐ laying ☐ reaching ☐ bending ☐ walking ☐ other _____

Relieved by: ☐ Ice ☐ heat ☐ sitting ☐ standing ☐ sleep ☐ walking ☐ laying ☐ pain killers, muscle relaxants, anti-inflammatories ☐ other _____

Quality is: ☐ sharp ☐ shooting ☐ aching ☐ cramping ☐ stiffness ☐ spasms ☐ swelling ☐ burning ☐ numbness ☐ tingling ☐ stabbing ☐ other

Intensity: Absent 0 1 2 3 4 5 6 7 8 9 10 severe

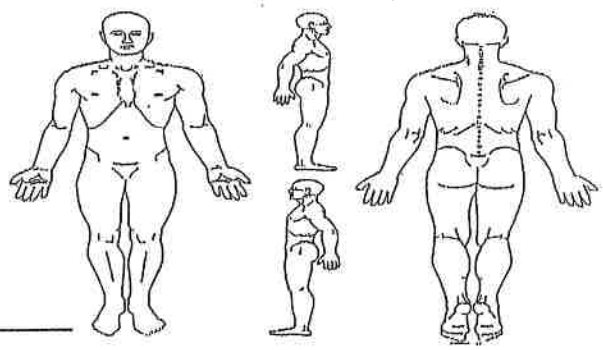
Pain Radiates Into: _____

Is complaint worse in: ☐ morning ☐ afternoon ☐ evening ☐ same all day

Other treatment/diagnosis/results: _____

Symptoms last: ☐ hours ☐ days ☐ weeks ☐ constant ☐ other

Shade the area where you are having symptoms



Past Health History

1) Please list any hospitalizations, operations and work, auto or personal accidents you've had. Be as specific as possible and include dates, injuries involved and treatment you received.

2) Please list any significant illnesses you have had, and treatment you have received.

3) Do you have any allergies?

4) Prescription medications:

Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____
Medication: _____ Dosage: _____ Frequency: _____

Review of System

General	Yes	No
Are you in good general health	☐Y	☐N
Recent weight change	☐Y	☐N
Fever	☐Y	☐N
Fatigue	☐Y	☐N
Are you out of shape	☐Y	☐N
Eyes and Vision		
Eye disease or injury	☐Y	☐N
Wear glasses / contact lenses	☐Y	☐N
Blurred or double vision	☐Y	☐N
Ears, nose, and throat		
Hearing loss	☐Y	☐N
Ringing in the ears	☐Y	☐N
Earaches or drainage	☐Y	☐N
Sinus problems	☐Y	☐N
Swollen glands in neck	☐Y	☐N
Nose bleeds	☐Y	☐N
Bleeding gums	☐Y	☐N
Sore throat or voice change	☐Y	☐N
Heart Cardiovascular		
Do you have a pacemaker	☐Y	☐N
Swelling of feet, ankles, hands	☐Y	☐N
Heart trouble	☐Y	☐N
Chest pains	☐Y	☐N
Sudden heartbeat changes	☐Y	☐N
Respiratory		
Spitting up blood	☐Y	☐N
Frequent coughing	☐Y	☐N
Shortness of breath	☐Y	☐N
Asthma or wheezing	☐Y	☐N
Gastrointestinal		
Frequent diarrhea	☐Y	☐N
Painful bowel movements	☐Y	☐N
Blood in stool	☐Y	☐N
Loss of appetite	☐Y	☐N
Loss of Bowel/Bladder control	☐Y	☐N
Stomach pain	☐Y	☐N
Nausea or vomiting	☐Y	☐N
Genitourinary		
Burning or painful urination	☐Y	☐N
Irregular periods	☐Y	☐N
Kidney stones	☐Y	☐N
Frequent urination	☐Y	☐N
Incontinence or dribbling	☐Y	☐N
Blood in urine	☐Y	☐N

Musculosketelal	Yes	No
Muscle pain or cramps	☐Y	☐N
Joint swelling	☐Y	☐N
Weakness of muscles/joints	☐Y	☐N
Cold hands or feet	☐Y	☐N
One leg shorter than the other	☐Y	☐N
Difficulty in walking	☐Y	☐N
Foot/Ankle/Knee/Hip pain	☐Y	☐N
Orthotics	☐Y	☐N
Skin and breasts		
Rash or itching	☐Y	☐N
Change in skin color	☐Y	☐N
Breast lump	☐Y	☐N
Breast pain	☐Y	☐N
Breast discharge	☐Y	☐N
Neurological		
Paralysis	☐Y	☐N
Frequent/recurrent headache	☐Y	☐N
Light headed or dizzy	☐Y	☐N
Head injury	☐Y	☐N
Stroke	☐Y	☐N
Tremors	☐Y	☐N
Numbness or tingling	☐Y	☐N
Convulsions or seizures	☐Y	☐N
Endocrine		
Dry skin	☐Y	☐N
Heat/cold intolerance	☐Y	☐N
Glandular/hormone problem	☐Y	☐N
Change in hat/glove size	☐Y	☐N
Thyroid disease	☐Y	☐N
Diabetes	☐Y	☐N
Excessive thirst/urination	☐Y	☐N
Hematologic/Lymphatic		
Anemia	☐Y	☐N
Transfusion	☐Y	☐N
Swollen glands	☐Y	☐N
Psychiatric		
Memory loss or confusion	☐Y	☐N
Sleep problems	☐Y	☐N
Depression	☐Y	☐N
Anxiety	☐Y	☐N

Last Date of Menstrual Cycle _____

Last Prostate Exam _____

Additional Explanation if required _____

SOCIAL HISTORY

0-None 1-Mild 2-Moderate 3-Excessive

_____ Tobacco _____ Alcohol _____Coffee _____ Soft Drinks
_____ Diet Soft Drinks _____ Exercise _____Water

FAMILY HISTORY

Mark any family members who have had the following health conditions

_____ Alzheimer's
_____ Arthritis
_____ Asthma
_____ Back Problems
_____ Cancer
_____ Cardiovascular
_____ Depression/Anxiety
_____ Diabetes
_____ Digestive
_____ Disc Problems
_____ Emphysema
_____ Endocrine
_____ Epilepsy
_____ Eyes/Ears/Nose/Throat
_____ Gastrointestinal
_____ Genitourinary
_____ Headaches
_____ Heart Problems
_____ High Blood Pressure
_____ High Cholesterol/Triglycerides
_____ Immune
_____ Insomnia
_____ Kidney
_____ Liver/Gal Bladder
_____ Musculoskeletal
_____ Neurological
_____ Psychological/Emotional
_____ Respiratory
_____ Scoliosis
_____ Senility

CHIROPRACTIC HISTORY

When did you last see a Chiropractor? _____ Dr. _____
Why did you see the Chiropractor? _____ Were you helped? _____
What spinal maintenance programs were you given to follow to maximize the future stability of your spine?

_____

Did you follow it? _____ If not, why? _____

Why are you changing Chiropractors? _____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

_____ Temporary Relief (Help the symptoms but do not fix the cause of the problem)
_____ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

WHAT IS YOUR HEALTH PHILOSOPHY? (What should you do to be healthy)

_____

WHAT ARE YOUR EXPECTIONS OF US?

_____

WELLNESS COMMITMENT

At our Chiropractic office our goal is to help you achieve your maximum health potential and wellness. Therefore, we need to understand your commitment toward this as well. We do not ask for financial commitment, but we do ask for a cooperative commitment. On a scale of 1 (least) to 10 (most):

_____ How committed are you to being at your maximum health potential and wellness?
_____ How important is it to you for your family to be at their maximum health potential and wellness?
_____ How committed are you to preventing arthritis and maximizing your spinal stability?
_____ If we find your problem, how committed are you to correcting it?

The information I have supplied is complete and truthful.

_____
Patient Signature

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustment to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I Agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

☐ PATIENT ☐ SPOUSE ☐ PARENT ☐ WORKERS COMP ☐ AUTO INSURANCE ☐ MEDICARE ☐ HEALTH INSURANCE

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

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 adjustment to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, 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 see the services of a health care provider who specializes in that area. 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 subluxation.

I have read and fully understand the above statement. Any question regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

SIGNATURE:	DATE:
WITNESS SIGNATURE	DATE:

OVER

Acknowledgement of Receiptof Privacy Practices

Seim Chiropractic and Wellness

A **NOTICE OF PRIVACY PRACTICES** is provided to all patients on the date of their first service with our practice. This Notice of Privacy Practices identifies how medical information about you may be used or disclosed. It explains your rights to access your medical information; to request an accounting of disclosures of your medical information and to request addition restrictions on our uses and disclosures of that information. It explains your rights to complain if you believe your privacy rights have been violated, and our responsibilities for maintain the privacy of your medical information, and letting you know if that privacy is breached.

The undersigned has been offered a copy of the **NOTICE OF PRIVACY PRACTICES** and is the patient or the patient's personal representative.

Name of Patient and Personal Representative (if applicable)

Signature

Date

Staff Notes (Staff – please make every reasonable effort to obtain patient's written acknowledgement before first service, however if unable, i.e. -patient refuses to sign, etc., please describe the interaction below):

Seim Chiropractic and Wellness • 50 Centre on the Lake
Lake St. Louis, MO. 63367 • Tel. (636) 625-4448

Patient Acknowledgement Form for Non-Covered Services, Products and Supplies

Your health insurance plan requires you to be responsible for co-payments, co-insurance and deductibles for covered services. You are also financially responsible for all non-covered services, products and supplies (e.g., vitamins, durable medical equipment, home therapy supplies, nutritional products, analysis and testing, maintenance care, services that exceed your insurance coverage limits, etc.).

Maintenance care usually begins once you have reached maximum improvement for the active problem you presently have. If during maintenance care, you develop a new condition or an acute exacerbation of your previous condition, your care may then be covered again by your health insurance plan.

The services, products and supplies listed below are not covered according to your health insurance plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay this office for the below listed products, services or supplies.

Non-Covered Products*				
Pillows	Foam Rollers	Muscle Gel/Cream	Nutritional Products	Weight Loss Products
Essential Oils	Spa Oil Diffusers	Hair Analysis	Saliva Analysis	Hormone Testing
Ice Packs/Wraps	Other Analysis	Books	Home Cervical Traction	Vitamins
T.E.N.S. Device				

* Retail Prices of non-covered products are readily available from HCWC Staff, and are always discussed before purchase.

Non-Covered Services
Nutritional Consult - $50 regular fee
Visits that exceed insurance coverage limitations / Maintenance Care / Services excluded from insurance plan – *These services are offered at usual and customary fees.*

Patient Acknowledgement:

I_____(patient name), acknowledge that I have been told in advance by this office that the types of services, products and supplies listed above are not covered by my health insurance plan and I agree to pay usual and customary fees, for these non-covered services, products and supplies at the time the service, supply or product is provided.

_____ _____

Patient Signature Date