Welcome to THE CHIROPRACTIC PLACE

Please be sure to fill out all information. If you have any questions, do not hesitate to ask for assistance.

PERSONAL INFORMATION (*Please Print*)

Name_____ Home Phone _____ Cell Phone _____

Address_____ City_____ State_____ Zip_____

Date of Birth_____ Sex _____ Social Security_____-_____-_____ Email _____

Occupation_____ Employer_____ Work Phone (____) _____ _____

Are You: o Minor o Married o Single o Widowed o Divorced o Separated

Spouse/Parent Name_____ Cell Phone (____) _____

Name of Insured_____ Insured DOB_____ Relationship to insured _____

Emergency Contact_____ Relationship_____ Phone (____) _____

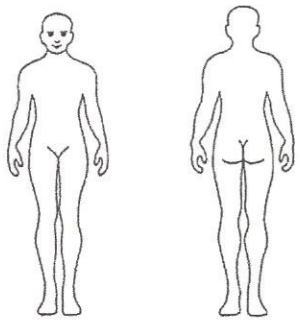
How did you learn about our office? _____

Children in family (Please list names and ages) _____

_____

CURRENT CONDITION

Please identify the condition(s) that brought you to this office: #1 _____ #2 _____ #3 _____



Rate the severity of each complaint on a scale from 1 (minor) to 10 (severe): #1 ____ #2 ____ #3____

When and how did each condition begin? #1 _____ #2 _____ #3 _____

Mark an **X** on the picture above where you are experiencing pain, numbness or tingling:

Mark the number corresponding with each condition next to the word that best describes the quality of that pain:

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting
☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other _____

Daily frequency of discomfort (0%-100%) #1 _____ #2 _____ #3 _____

When in the day does it feel the worst? #1 _____ #2 _____ #3 _____

Is this condition getting better/worse/same? #1 _____ #2 _____ #3 _____

What relieves your symptoms? #1 _____ #2 _____ #3 _____

What makes you feel worse? #1 _____ #2 _____ #3 _____

When have you had this problem before? #1 _____ #2 _____ #3 _____

Who else have you seen for this condition?_____

Last visit and results? _____

What diagnostic tests have you had <u>for this condition</u>? o X-ray o CT Scan o Bone Scan o MRI o Ultrasound o Other: _____

What diagnostic tests have you <u>ever had</u>? o X-ray o CT Scan o Bone Scan o MRI o Ultrasound o Other: _____

What food supplements/herbs/vitamins are you taking? How many a day? A month?_____

What non-prescription drug(s) are you taking? _____

What prescription drug(s) are you taking?_____

Any changes in functional systems in the past 5 years (headaches, sinus problems, allergies, asthma, bowel, bladder, digestion, etc)?

_____

PAST HISTORY

Please identify ALL PAST and CURRENT conditions you feel may be contributing to your present problem:

Yes	No		When?	What was injured?	Did you recover?	Any residuals?
o	o	**Injury(s)?**				
o	o	**Fractured Bone(s)?**				
o	o	**Surgery(s)?**				
o	o	**Hospitalization(s)?**				
o	o	**Any serious illnesses?**				
o	o	**Unexplained symptoms?**				

If you or your family have ever experienced or have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the Past, or **C** for Currently experiencing or diagnosed.

SELF	FAMILY		SELF	FAMILY	
☐	☐	Stroke	☐	☐	Sinus Issues
☐	☐	ADD/ADHD	☐	☐	Asthma
☐	☐	High blood pressure	☐	☐	Bed Wetting
☐	☐	High cholesterol	☐	☐	Trouble Sleeping
☐	☐	Nausea	☐	☐	Depression
☐	☐	Diabetes	☐	☐	Gout
☐	☐	Headache	☐	☐	Allergies _____
☐	☐	Disorientation/ Slurred speech	☐	☐	Cancer _____
☐	☐	Tremors	☐	☐	Arthritis _____
☐	☐	Numbness, Tingling or paralysis	☐	☐	Heart problems _____
☐	☐	Neck Pain	☐	☐	Liver Disease _____
☐	☐	Shoulder Pain	☐	☐	Lung/Breathing _____
☐	☐	Jaw/TMJ Pain	☐	☐	Digestive _____
☐	☐	Upper/Mid/Lower Back Pain	☐	☐	Kidney/Urinary _____
☐	☐	Hip Pain	☐	☐	Other: _____
☐	☐	Scoliosis			**LIFESTYLE**
☐	☐	Joint Pain	☐	☐	Do you smoke?
☐	☐	Menstrual Problems	☐	☐	Do you use alcohol?
☐	☐	Convulsions/Epilepsy	☐	☐	Do you consume caffeine?
☐	☐	Dizziness/Fainting	☐	☐	Do you drive more than 1 hour a day?
☐	☐	Ringing in the ears	☐	☐	Do you exercise regularly?

Please identify any and all types jobs or repetitive activities you have done in the past that have imposed any physical stress on your body:

_____

Have you had previous chiropractic care? o Yes o No Doctors name: _____ Duration of care: _____

Frequency of Care: _____ Date of last visit: _____ Where you satisfied with your experience: o Yes o No

Reason for seeking care at that time: _____

Does anyone in your family suffer with your current condition(s)? o Yes o No If yes, whom? _____

Have they been treated for this condition? o Yes o No o I don't Know

Any other information pertaining to your health that you think we should know: _____

_____

_____

***FEMALE ONLY*: Is there any chance that you may be pregnant? o Yes o No Due Date _____**

ASSIGNMENT & RELEASE

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further, I hereby authorize payment to be made directly to The Chiropractic Place, LLC for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize the utilization and release of this application and all medical records or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to The Chiropractic Place, LLC for any and all services I receive at this office. I understand that I am responsible for all charges, which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

_____ _____

Signature of Patient, Parent, Guardian or Responsible Party (Please print name of Patient, Parent, Guardian or Responsible Party)

_____ _____

Relationship to Patient Date

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

0 1 2 3 4 5 6 7 8 9 10
COMPLETELY ABLE — TOTALLY UNABLE TO FUNCTION TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0 1 2 3 4 5 6 7 8 9 10
COMPLETELY ABLE — TOTALLY UNABLE TO FUNCTION TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

0 1 2 3 4 5 6 7 8 9 10
COMPLETELY ABLE — TOTALLY UNABLE TO FUNCTION TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS –

0 1 2 3 4 5 6 7 8 9 10
COMPLETELY ABLE — TOTALLY UNABLE TO FUNCTION TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED –

0 1 2 3 4 5 6 7 8 9 10
COMPLETELY ABLE — TOTALLY UNABLE TO FUNCTION TO FUNCTION

6. **LIFE –SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

0 1 2 3 4 5 6 7 8 9 10
COMPLETELY ABLE — TOTALLY UNABLE TO FUNCTION TO FUNCTION

PATIENT NAME_____ DATE_____ SCORE _____ [60] BENCHMARK = 5_____

TERMS OF ACCEPTANCE

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

Chiropractic care, like all forms of healthcare, offers considerable benefits and may also carry some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments, may be a vertebral artery injury that could lead to stroke. Prior to receiving chiropractic care from The Chiropractic Place, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another healthcare provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

It is important to note that we do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxation or neuromusculoskeletal conditions. However, if during the course of a 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 healthcare 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 maintain the adjustments.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the chiropractor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

PREGNANCY RELEASE

This is to certify that, to the best of my knowledge, I am not pregnant and the above practice and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: ___/___/____

INSURANCE PLANS

For our patients with insurance benefits, please note that although we are happy to bill your insurance carrier as a courtesy, the insurance contract exists between the carrier and the insured. We will accept insurance assignment, but cannot guarantee payment of benefits. **Any questions regarding your benefits should be directed to your insurance carrier directly.**

PAYMENT

Payment is due in full at each appointment for chiropractic services provided. We accept Visa, MasterCard, American Express, Discover, Cash, and Personal Checks. As a courtesy to patients with chiropractic insurance, we electronically submit insurance claims. Payment is due at the time of service for all estimated portions of charges, deductible, co-pay amounts, and non-covered services. If your insurance company has not paid within 45 days, your balance is due in full.

A statement of services rendered will be mailed at the end of each month. Receipt of payment is expected within 30 days from the time of service for any outstanding balance. Your account will be considered delinquent if payment is not received within 60 days from the time of service; a late fee of 1.5% per month will be assessed and will appear on any subsequent statements. Delinquent accounts will be sent to a collection agency, and collections fees will be added to your account. If the balance is deemed uncollectible by the collection agency after 30 days, a report will be filed with the national credit reporting agencies, which will adversely affect your credit rating.

HIPAA

I have been shown a copy of The Chiropractic Place's Patient Privacy Notice for my review. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies are kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

I, _____ have read and fully understand the above statements.

_____ _____

Signature of Patient, Parent, Guardian or Responsible Part Date