APPLICATION FOR CARE AT AGAN CHIROPRACTIC

Acct. #:_____

Today's date:_____

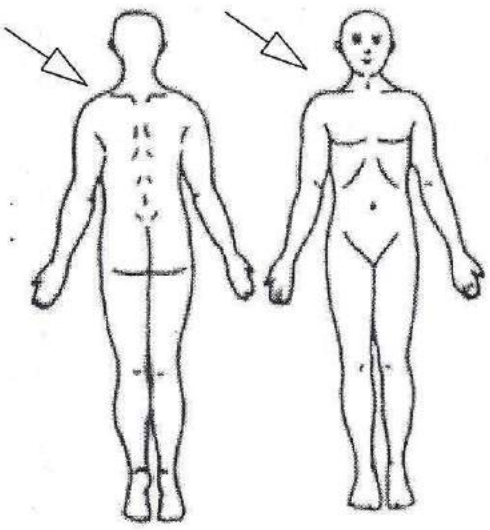
Name: _____ Birth Date: ____-____-____ Age: _____ ☐ Male ☐ Female
Name you wish to be called in our office: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Home Phone: _____
Mobile Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Name of Spouse: _____ Spouse's Employer: _____
Occupation: _____
Names and Ages of your children: _____
Name & Number of Emergency Contact: _____ Relationship: _____

History of Complaint(s)

Primary Problem: _____ **When did problem begin?** _____
What relieves your symptom? Rest Ice Heat Movement Stretching Other: _____
What makes your symptom worse? Sitting Standing Walking Sleeping Overuse Other _____
Frequency: Off & On / Constant **Does the pain radiate?** No / Yes **Where?** _____
How long does this problem last? _____ **# of prior episodes?** _____
Type of Pain: Sharp Stabbing Dull Achy Burning Stiff Sore
On a scale of **0 to 10** with **10** being the worst and **0** being pain free, rate how you feel today:
(Circle the number): 0 1 2 3 4 5 6 7 8 9 10

Secondary Problem: _____ **When did problem begin?** _____
What relieves your symptom? Rest Ice Heat Movement Stretching Other: _____
What makes your symptom worse? Sitting Standing Walking Sleeping Overuse Other _____
Frequency: Off & On / Constant **Does the pain radiate?** No / Yes **Where?** _____
How long does this problem last? _____ **# of prior episodes?** _____
Type of Pain: Sharp Stabbing Dull Achy Burning Stiff Sore
On a scale of **0 to 10** with **10** being the worst and **0** being pain free, rate how you feel today:
(Circle the number): 0 1 2 3 4 5 6 7 8 9 10

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms: **R = Radiating B = Burning D = Dull**
A = Aching N = Numbness S = Sharp/ Stabbing T= Tingling



Do your symptoms cause you to feel worse in the ☐AM ☐PM ☐ mid-day ☐ late PM
Have these Problems ever been treated by anyone in the past? ☐No ☐Yes
If yes, Who provided: _____
How long ago? _____ What **type** of treatment did you receive? _____
What were the **results?** ☐ Favorable ☐ Unfavorable → **If unfavorable** please explain: _____
List any **medications** taken to treat these conditions: _____
Did they help? ☐ No ☐ Yes If you still take them how often? _____
Have you ever been under chiropractic care? ☐ No ☐ Yes
If yes, how long ago: _____ Name of Previous Chiropractor: _____
Are any of your problem(s) today the result of ANY **recent accident?** ☐ No ☐ Yes
If yes, How long ago? _____ Please explain what type of accident: _____

PAST HISTORY

1. If you have ever been diagnosed with any of the following conditions please indicate with a P for the Past, C for Currently have and N for Never have had:

___ Heart Attack ___ Dislocations ___ Tumors ___ Stroke ___ Seizure
___ Broken Bone ___ Concussion ___ Disability ___ Cancer ___ Rheumatoid Arthritis
___ Osteo Arthritis ___ Fracture ___ Diabetes ___ Other _____

2. PLEASE, identify ALL PAST and any unrelated current condition you feel may be contributing your present problem

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
PREVIOUS ACCIDENTS			
ADULT DISEASES			
SURGERIES			
CHILDHOOD DISEASES			

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes **If yes whom:**
❑ Grandmother ❑ Grandfather ❑ Mother ❑ Father ❑ Sister(s) ❑ Brother(s) ❑ Son(s) ❑ Daughter(s)
2. Have they ever been treated for their condition? ❑ No ❑ Yes ❑I don't know
3. **Any** other hereditary conditions the doctor should be aware of ❑ No ❑Yes _____

What health goals do you hope to accomplish in our office?
Short Term: _____
Long Term: _____

Whom may we thank for referring you into our office today? _____

How do you plan to take care of your charges today? ❑ Cash ❑ Check ❑ Credit Card

For Women Only: Are you pregnant? (circle one) **Yes** **No**

Reserved for doctor's use only → Systems reviewed with patient:
❑Musculoskeletal
❑Neurological

Informed Consent

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. The types of complications that have been reported secondary to chiropractic care include, sprain/strain injuries, irritation of a disc condition, and - although rare- minor fractures. One of the rarest complications associated with Chiropractic cares (occurring at a rate between one instance per one million to one instance per two million) is a cervical spine (neck) adjustment causing injury to a vertebral artery which could lead to a stroke.

I understand the risks associated with chiropractic spinal adjustments, and the other therapeutic procedures enlisted by the doctor(s) in practice. This form was not signed until all my questions regarding treatment were answered to my complete satisfaction, and I conveyed my understanding of all risks to the doctor. After careful consideration, I do hereby consent to chiropractic care by any means, methods, and or techniques the doctor discussed with me that he/she deems necessary to treat my condition(s) at any time throughout the entire clinical course of my care.

_____ _____-_____-_____
Patient or Authorized Person's Signature Date Completed

Reviewed by: _____ _____
Reviewer Initials Doctors Initials

NAME_____ DATE_____ ACCT.#_____

Rand 36-Item Health Survey 1.0

1. In general, would you say your health is: ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

2. **Compared to 1 year ago**, how would you rate your health in general **now**?

☐ Much better now than 1 year ago ☐ Somewhat better now than 1 year ago ☐ About the same
☐ Somewhat worse now than 1 year ago ☐ Much worse now than 1 year ago

The following items are about activities you might do during a typical day. **Does your health now limit you** in these activities? If so, how much?

CIRCLE ONE ON EACH LINE

	Yes, Limited a lot	Yes, limited a little	No, not limited at all
3. **Vigorous activities**, such as running, lifting heavy Objects, participating in strenuous sports	1	2	3
4. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	1	2	3
5. Lifting or carrying groceries	1	2	3
6. Climbing **several** flights of stairs	1	2	3
7. Climbing **one** flight of stairs	1	2	3
8. Bending, kneeling or stooping	1	2	3
9. Walking **more than a mile**	1	2	3
10. Walking **several blocks**	1	2	3
11. Walking **one block**	1	2	3
12. Bathing or dressing yourself	1	2	3

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health?**

13. Cut down the **amount of time** you spend on work or other activities	Yes	No
14. **Accomplished less** than you would like	Yes	No
15. Were limited in the **kind** of work or other activities	Yes	No
16. Had **difficulty** performing the work or other activities (i.e. it took extra effort)	Yes	No

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)

17. Cut down the **amount of time** you spend on work or other activities	Yes	No
18. **Accomplished less** than you would like	Yes	No
19. Didn't do work or other activities as **carefully** as usual	Yes	No

20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups? **(Check One)**

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

21. How much **bodily** pain have you had in the **past 4 weeks? (Check One)**

☐ None ☐Very mild ☐Mild ☐ Moderate ☐Severe ☐ Very severe

22. During the **past 4 weeks**, how much did **pain** interfere with your normal work (Including work outside the house **and** housework) **(Check One)**

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

These questions are about how you feel and how things have been with you **during the last 4 weeks.** For each question, please give the 1 answer that comes closest to the way you have been feeling. **How much of the time during the last 4 weeks...**

CIRCLE ONE ON EACH LINE

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a very nervous person?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26. Have you felt calm and peaceful?	1	2	3	4	5	6
27. Did you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6
31. Did you feel tired?	1	2	3	4	5	6

32. During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

How TRUE or FALSE is *each* of the following statements for you?

CIRCLE ONE ON EACH LINE

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33. I seem to get sick a lot easier than other people	1	2	3	4	5
34. I am as healthy as anybody I know	1	2	3	4	5
35. I expect my health to get worse.	1	2	3	4	5
36. My health is excellent	1	2	3	4	5

Patient Signature: _____ Date: _____

Notice of Privacy Practices-HIPAA

Agan Chiropractic
1297 Bryan Rd.
O'Fallon, MO 63366

Patient Name: _____ Date: _____

May we leave personal medical information on your answering machine or cell phone?
YES NO

Who do you give us permission to discuss your medical information with?

No one _____ (please initial)

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES
My signature below indicates that I have read and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Privacy Practices).
Pamphlets available in reception area.

Patient or Responsible Party Signature: _____ Date: _____

AGAN CHIROPRACTIC OFFICE POLICY

The best doctor/patient relationship is when there is complete understanding of the treatment and financial responsibilities between the doctor and the patient. Our primary concern is being able to schedule you as required without creating a problem for you in keeping your account up-to-date. This will allow you to obtain the health care you need and handle your fees in a convenient manner.

Insurance

We shall assist in all possible ways in helping you process and obtain all of the benefit for which you are eligible; but financial obligation is yours. For your own information, please check with your insurance company as to the policy benefits for which you are eligible. We will advise you to pay any amount due for the "deductable" or any other "non-covered" charges.

Personal Payment

For your convenience, we accept: cash, personal checks, ApplePay, MasterCard, Visa, and Discover. We will be happy to discuss your financial charges. Please remember that insurance is considered a method of reimbursing the patient for the fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay for any deductible amount, co-insurance or any other balance not paid by your insurance. **IN ORDER TO CONTROL YOUR COST OF COPAYS AND COINSURANCE, ALL SERVICES MUST BE PAID AT THE TIME OF SERVICE.**

No Show Policy

Your health is important to us and it is important for you to keep your scheduled appointments. When patients miss appointments without calling the office to cancel, we lose the ability to offer those appointment times to other patients. We require a 24 hour notice to change or cancel a scheduled appointment. **If you fail to show or cancel your appointment without a 24 hour notice you will be charged $40.00.** These charges will be the **patient's responsibility** and cannot be billed to you insurance company.

Payment Agreement

I have read and understand the Office Policy as it pertains to my financial responsibility. I understand that I am responsible for any balance due at the time that services are rendered. I am aware that if my account is past due by 30 days, there will be a 1.5% finance charge added to my balance monthly. Should collection of services be required, fees for those services will be added to my balance and will be my responsibility. I also understand that I am responsible for all court costs and attorney fees should legal action be required.

Consent

I hereby authorize and release the doctor and whomever he may designate as his assistant to administer treatments, physical examinations, x-ray studies, chiropractic care, or any clinic services that he deems necessary in my case.

I agree that if I discontinue my care for any reason: 1) Any time of service or other house discounts will be voided. 2) I will pay the balance in full at the time.

_____ _____

Patient/Guardian Signature Date