Sturgis CHIROPRACTIC
Specific Chiropractic

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PATIENT INFORMATION

Patient Name _____ (LAST NAME)
_____ (FIRST NAME) (MIDDLE INITIAL)
Address _____
City _____ State _____ Zip
Home Phone _____
Cell Phone _____ Provider
Email _____
Sex ❑ M ❑ F Age _____ Birthday _____
❑ Married ❑ Widowed ❑ Single ❑ Minor
❑ Separated ❑ Divorced ❑ Partnered

Employer / School _____
Occupation _____
Spouse's Name _____
Spouse's Employer _____
Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT
Name _____
Relationship _____
Contact Number _____
Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

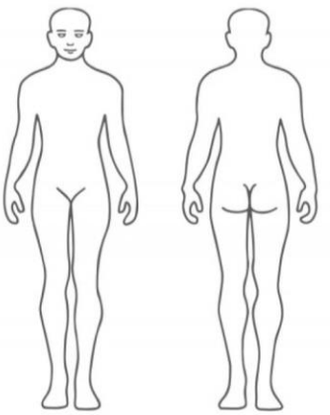
_____

If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle)

0 (NO SYMPTOMS) 1 2 3 4 5 6 7 8 9 10 (INTENSE SYMPTOMS)

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

❑ Numbness ❑ Sharp
❑ Tingling ❑ Shooting
❑ Stiffness ❑ Burning
❑ Dull ❑ Throbbing
❑ Aching ❑ Stabbing
❑ Cramping ❑ Swelling
❑ Nagging ❑ Other _____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	❑	❑	❑	❑	Energy	❑	❑	❑	❑
Exercise	❑	❑	❑	❑	Attitude	❑	❑	❑	❑
Recreation	❑	❑	❑	❑	Patience	❑	❑	❑	❑
Relationships	❑	❑	❑	❑	Productivity	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	Creativity	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑	Other _____	❑	❑	❑	❑

How committed are you to correcting this issue?

0 (NOT COMMITTED) 1 2 3 4 5 6 7 8 9 10 (VERY COMMITTED)

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM

DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications Poor quality of life Potential becomes limited Body has limited function	Symptoms Drug therapy Surgery Losing normal function	No symptoms Nutrition inconsistent Exercise sporadic Health not a high priority	Regular exercise Good nutrition Wellness education Minimal nerve interference	100% function Continuous development Active participation Wellness lifestyle

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ❑ No ❑ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- ❑ Allergies
- ❑ Angina
- ❑ Cancer_____
- ❑ Asthma/Difficulty Breathing
- ❑ Heart Palpitation
- ❑ Heat Intolerance
- ❑ Sinus Congestion
- ❑ Heart Murmur
- ❑ Cold Intolerance
- ❑ Ear Ringing
- ❑ Anemia
- ❑ Depression
- ❑ Earache
- ❑ Dizziness
- ❑ Sinus Congestion/Infections
- ❑ Hypertension
- ❑ Tonsillitis/Strep Throat
- ❑ Diabetes
- ❑ Swallowing Difficulty
- ❑ Stroke
- ❑ Facial Paralysis
- ❑ Difficulty with Speech
- ❑ ADHD/ADD
- ❑ Focus/Memory Issues
- ❑ Uncoordinated
- ❑ Anxiety
- ❑ Seizures
- ❑ Neck Soreness
- ❑ Tension Headache
- ❑ Migraine
- ❑ Stiff Neck
- ❑ Pain/Numbness Arms/Hands
- ❑ Shoulder Pain
- ❑ Arm/Hand Pain
- ❑ Hand Trembling
- ❑ Loss of Sensation
- ❑ Pain/Numbness Legs/Feet
- ❑ Muscle Pain
- ❑ Muscle Weakness
- ❑ Muscle Cramps
- ❑ Muscle Twitching
- ❑ Thyroid Condition
- ❑ Hair Changes
- ❑ Breast Changes
- ❑ Constipation
- ❑ Weak Grip
- ❑ Abdominal Pain
- ❑ Joint Stiffness
- ❑ Heartburn/Indigestion/GERD
- ❑ Diarrhea/IBS/Diverticulitis/Crohn's Dx
- ❑ Autoimmune Dx
- ❑ Menstrual Cramps
- ❑ Joint Pain
- ❑ Reproductive Issues
- ❑ Endometriosis
- ❑ Bladder Trouble
- ❑ Ankle/Foot/Knee Pain
- ❑ Urinary Trouble
- ❑ Other _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)

Please READ AND INITIAL the following:

Acknowledgement of Receipt of Notice of Privacy Practices: I have read/acknowledged the Notice of Privacy Practices for Protected Health Information. Notice of Privacy Practices is available at the front desk upon request.

Initials ____

Payment Policy: I acknowledge I am financially responsible for all charges incurred at Sturgis Chiropractic, P.C. It is the policy of this office that payment be made at the time of service for all services rendered. If the incorrect insurance is provided at the time of service, these visits will be considered self-pay. If care is ceased, any remaining balance must be paid in full. The credit/debit card on file will be ran for the remaining balance.
If the chiropractic services received are deemed maintenance/wellness/corrective care, the visits will not be submitted to insurance and the patient is responsible for the associated fees.

Initials _____

Insurance Assignment: I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. If the incorrect insurance is provided at the time of service, these visits will be considered self-pay.
If the chiropractic services received are deemed maintenance/wellness/corrective care, the visits will not be submitted to insurance and the patient is responsible for the associated fees.

Initials _____

Signature of Patient or Parent/Guardian _____ Date _____

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of procedures, including chiropractic adjustments, examinations, various modes of physiotherapy, shockwave treatment, diagnostic x-rays, massage therapy, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the Sturgis Chiropractic and /or other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up providers, including those working at the clinic or office.

I will discuss with the Sturgis Chiropractic provider and/or with other office or clinic personnel the nature and purpose of the procedures, if I choose to do so.

I understand, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures, disc injuries, strokes, dislocation and sprains. I do not expect the Sturgis Chiropractic provider to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor/health care provider to exercise judgment during the procedure which the doctor/health care provider feels at the time, based upon the facts then known, is in my best interests.

I further understand that treatment is designed to improve health. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final, and no refunds will be issued.
I further understand that there are treatment options available for my condition, these treatment options include, but not limited to self-administered, over the counter analgesics, bracing, rest or medical care. I understand I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I will ask the doctor/health care provider questions about its consent if I have any, and by signing below I agree to the above-named procedures. I consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient: _____

Name Printed of Guardian/Parental and Relationship to Patient: _____

Guardian/Parental Signature: _____

Date: _____

INSURANCE ABN

Advanced Beneficiary Notice

Deductible needs to be met before services are covered.

To use insurance, you must have a neuromusculoskeletal injury or problem.

Insurance companies will say you have so many visits a year, but unless it is for an injury, our contract with the insurance company states: **"Services to be billed must be medically necessary."**

***Insurance only covers visits that are medically necessary, no maintenance/wellness or corrective care.**

*Insurance pays for one chiropractic visit a day when covered.

***Covered visits must be in a treatment plan with a current diagnosis and visits must be used within a certain time frame.**

*Treatment plan must be reasonable within healthcare guidelines showing progress.

*It is fraudulent to continue billing insurance once treatment plan is finished.

*Progress exams are a required part of treatment plan and not covered by insurance.

***The Gonstead Chiropractor seeks the cause of dis-ease through the use of x-ray analysis to deliver a specific adjustment.**

Non-Covered Charges:

SELF PAY ADJUSTMENT $50
PROGRESS EXAM $40
SELF-PAY REHAB $20
EXTREMITY ADJUSTMENT $15
ELEC STIM $20
SHOCKWAVE $60
CERVICAL X-RAYS $100
THORACIC X-RAYS $120
LUMBAR X-RAYS $120
FULL SPINE X-RAYS $160
MASSAGE THERAPY $45-$115

_____ _____

SIGNATURE **DATE**