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CONFIDENTIAL CLIENT INFORMATION

Personal Information

Full name (Preferred Name):		Date:	
Address:		City	State
		Zip	
Home phone:	Work phone:		
Cell phone:	Please circle best number to call: Home Cell Work		
Email address:	Last 4 of Social Security Number:		
Date of birth:	Age:		
No. of children:	Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Names of children: Ages of children:			
Marital status: M S W D	Spouse/guardian name:		
Occupation:			
Employer's name & address:			
Spouse's Occupation/Employer:			
Name of person responsible for account:			
Do you have Medicare coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, please allow us to make a copy of your Medicare card.	
Have you ever seen a chiropractor, physical therapist, or massage therapist before? Yes <input type="checkbox"/> No <input type="checkbox"/>		Approximate date of last visit ___/___/___	
Previous Provider's Name/City/State:		Did you see the results you hoped to? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Please check if you are here for any of the following: Motor Vehicle Injury <input type="checkbox"/> Work Injury <input type="checkbox"/> Other Injury <input type="checkbox"/>			

Who may we thank for referring you? _____

Addressing What Brought You Into This Office:

What is the reason for your visit today? How long has it been going on?

Are there any other specific concerns?

Please use the table below to detail ALL of the issues you are having.

Rate your pain on a scale from 0-10, indicate frequency by choosing constant, comes and goes, or rare (how many times per month) and checkmark the type of pain you are having.

	Pain	Frequency			Type of Pain							Changes
	0=none 10=severe	Constant	Comes & goes	Rare (# per month)	Radiating	Numbness/ Tingle/Burn	Stabbing/ Sharp	Spasms	Achy	Tight/Stiff	Swollen	What helps or worsens the issue?
Headache												
Migraine												
Neck												
Upper back												
Mid back												
Low back												
Pelvis												
Hip joint												
Knee												
Ankle												
Foot												
Shoulder												
Elbow												
Wrist												
Hand												
Other:												

Do any of the symptoms above keep you from doing any of the following: Working, Sitting, Sleeping, Standing, Exercising, Driving, Family time, Hobbies, Other? If yes, please provide details.

For Office Use Only - Adjuster Notes:

1) When you were a child, (birth to 12 years), did any of the following occur?

- | | | |
|---|--|--|
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Frequent crying spells | <input type="checkbox"/> Sports Accident |
| <input type="checkbox"/> Tumble down stairs | <input type="checkbox"/> Frequent fevers | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Fall out of crib | <input type="checkbox"/> Frequent bouts of diarrhea | <input type="checkbox"/> Bed-wetting |
| <input type="checkbox"/> Fall from tree or playground | <input type="checkbox"/> Constipation or stomach pains | <input type="checkbox"/> Hyperactivity/Autism |
| <input type="checkbox"/> Involved in car accident | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Learning difficulties |
| <input type="checkbox"/> Fall off bicycle | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Leg/knee pain |
| <input type="checkbox"/> Play in a "Jolly Jumper" | <input type="checkbox"/> Allergies or asthma | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Colic | |
| <input type="checkbox"/> Reaction to vaccination | <input type="checkbox"/> Did not gain weight | |

Please explain the above _____

2) From adolescence through adulthood, (12-present time), have any of the following occurred?

- | | | |
|--|---|--|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Tingling in arms/legs | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness in arms/hands | <input type="checkbox"/> Calcification of arteries |
| <input type="checkbox"/> Allergies/Asthma/Sinus Issues | <input type="checkbox"/> Arm/wrist pains | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Hyperactivity/Autism | <input type="checkbox"/> Neck/Shoulder pains | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Mid/Lower back pains | <input type="checkbox"/> High/Low blood pressure |
| <input type="checkbox"/> Attention/focus issues | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Low blood sugar |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Played sports | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Foot/ankle pains | <input type="checkbox"/> Sports accidents or injuries | |
| <input type="checkbox"/> Leg/knee pains | <input type="checkbox"/> Car accident | |

Please explain the above _____

Current Medicines and Supplements

Please list any medications, supplements, or vitamins that you are currently taking and why:

Date	Name of Medication, Vitamin, or Supplement	Dosage	Dose Schedule	Reason for Taking

Have you had any surgeries or hospitalizations? Please explain.

Our Fee Structure

Consultation	Complimentary
Examination	\$ 100.00
Infant Exam	\$ 40.00
Adjustment	\$ 60.00

Please Note: If you and the provider decide this is the place for you to be, then you will receive an adjustment on your first visit which will be an additional fee. Your clinical Report of Findings, the time that the provider will spend with you to go over your results, will be included with your examination. You will receive an adjustment after your Report of Findings that will be a separate fee.

Insurance and Payment Policy

We are committed to providing you with the best possible care. If you have Chiropractic coverage in your insurance policy, we are willing to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our payment policy.

Payment Policy:

1. Full payment is due at time of service. We accept cash, checks, Visa, MasterCard and Discover.
2. We must emphasize that our relationship is with you and not your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract and therefore do not file your insurance for you. As a courtesy that we extend to our patients, we will provide you with a completed insurance form that you are responsible for filing, which simply means placing it in an envelope and mailing it.
3. Not all services are a covered benefit in all contracts. It will depend on your individual policy.
4. In some cases, once you have met your deductible your insurance company will begin to reimburse you up to an allowed amount. If you have a question about your specific policy and coverage, please call the toll free number on the back of your insurance card and they should be able to answer your questions regarding your policy.
5. Medicare patients are responsible for payment at the time of service because Medicare does not cover services in this office. We will not file claims to Medicare. Medicare patients will sign an Advanced Beneficiary Notice of Noncoverage stating that they understand this and they would still like to receive services.
6. In the case of a Personal Injury accident (car accident or accident at work), our policy stays the same. Payment will still be required upon time of service. All services received will be at our full price for the duration of the Personal Injury case. You must inform us BEFORE you are seen by an adjuster if you have been involved in an accident after you have started care.

There is no fee for consulting with the providers. Fees begin when a problem related to structural misalignment is found and you decide to begin receiving care.

_____ I fully understand the above fees and give my consent to consult with the provider and to any BioStructural examination that the provider deems necessary. I understand that any fee for service is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Patient Signature: _____
(Or signature of Parent/Guardian if patient under age 18)

We sincerely thank you for choosing our office and for taking the time to honestly reflect upon and share your current level of health and well-being, as well as your goals.

We look forward to helping you maximize your experience and expression of health and life!