MAIN STREET CHIROPRACTIC

PATIENT DEMOGRAPHICS

Name _____ Birth Date:_____-_____-_____ Age:_____ □ Male □ Female

Address _____ City: _____ State: _____ Zip:_____

Home Phone: ( )_____ Cell Phone: ( )_____ □ Married □ Single

Work Phone: ( )_____ Email: _____ SS #:_____

Employed by: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Children in Family (Please list names and ages):_____

Name & Number of Emergency Contact:_____ Relationship:_____

Whom may we thank for referring you to our office?_____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____
Secondarily: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number:***

Primary or chief complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Second complaints is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Third complaint: : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Fourth complaint: : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

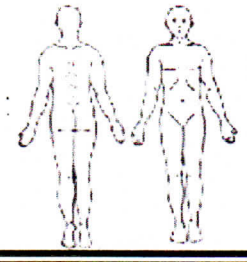
How did the injury happen?_____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ ☐ **N/A**

***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



What relieves your symptoms? _____

What makes them feel worse? _____

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____:	_____	
_____:	_____	
_____:	_____	
_____:	_____	

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

I hereby authorize payment to be made directly to Main Street Chiropractic, PC for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application 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 Main Street Chiropractic, PC for any and all services I receive at this office.

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

_____ _____
Doctor's Signature Date Form Reviewed JDD,DC 5/2011

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? _____ When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____, and who provided it: _____ **How long ago?** _____What were the results. ☐ Favorable ☐ Unfavorable→ please explain. _____

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

_____

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

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions:

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

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

SOCIAL HISTORY

1. **Smoking**: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. **Alcoholic Beverage**: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. **Recreational Drug use**: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect the following, See pg 2- Activities of Life

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)
   Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know
2. **Any** other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

Please mark P for in the **Past, C** for **Currently** have and **N** for **Never**

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

MAIN STREET CHIROPRACTIC

ACTIVITIES OF DAILY LIVING

Daily Activities: Effects of Current Conditions on Performance
Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

	No Effect	Painful (Can Do)	Painful (Limits)	Unable to Perform
Bending				
Concentrating				
Doing Computer Work				
Gardening				
Playing Sports				
Recreation Activities				
Shoveling				
Sleeping				
Watching TV				
Carrying				
Dancing				
Dressing				
Lifting				
Pushing				
Rolling Over				
Sitting				
Standing				
Working				
Climbing				
Doing Chores				
Driving				
Performing Sexual Activity				
Reading				
Running				
Sitting to Standing				
Walking				

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

List Prescription & Non-Prescription drugs you take:

_____

_____

MAIN STREET CHIROPRACTIC

TERMS OF ACCEPTANCE

INFORMED CONSENT

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Main Street Chiropractic, PC have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

OFFICE POLICIES

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

FEMALES ONLY: X-RAYS/IMAGING STUDIES

Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on _____(date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant. By my signature below, I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to o have the diagnostic x-ray examination the doctor has deemed necessary in my case.

FINANCIAL POLICY

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.

PRIVACY PRACTICES

HIPAA

I have received a copy of Main Street Chiropractic's Patient Privacy Notice. 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.

_____

Patient's Signature Date

JDD,DC 5/2011