Chellis Chiropractic

Date: _____

Personal Information

Title: (Check one) ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other _____

First Name _____ Middle Initial ____ Last Name _____

Street _____

City _____ State _____ Zip Code _____

Email _____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Date of Birth _____/_____/_____ Sex: ☐ Male ☐ Female

Social Security Number: ____-____-_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ FT Student ☐ PT Student ☐ Other_____

Employer Data

Employer Name _____

Your Occupation _____ Address _____

City _____ State _____ Zip Code _____

Payment/Insurance Information

Who is responsible for your bill?

☐ Self ☐ Spouse ☐ Parent ☐ Worker's Comp ☐ Auto Insurance

Personal Health Insurance Carrier _____ Ins. Card ID # _____

Policy Holder's Name _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Policy Holder's SSN: _____

Policy Holder's Employer _____

Worker's Compensation Injury / Auto / Personal Injury

Have you filed an injury report with employer? ☐ Yes ☐ No Date: ____/____/____

Have you filed an injury report with an insurance company? ☐ Yes ☐ No Date: ____/____/____

Insurance Company Name _____ Adjustor Name _____

Adjustor Phone Number _____ Claim # _____

Have you filed a claim with a lawyer? ☐ Yes ☐ No Date ____/____/____

Law Firm Name _____ Lawyer Name _____

Lawyer Phone Number _____ Claim # _____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Contact Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

How did you hear about Chellis Chiropractic? Keyword used on Internet_____

 Bing Google MSN Phonebook Super Pages

 Yahoo Yellow Pages □ Insurance Referral If so, by _____

 Other _____

Are you pregnant? Yes No Due Date ____/____/____

Patient History

List any **Allergies**

z Animals z Aspirin z Bees z Chocolate/Sweets z Dairy Productsz Dust z Eggs

z Latex z Molds z Penicillin z Ragweed/Pollen z Rubber z Seasonal Allergies

z Shellfish z Soaps z Wheat z X-Ray Dye z Other: _____

List any **Surgeries**

z Appendix z Back z Brain z Carpal Tunnel z C-Section z Elbow z Foot

z Gallbladder z Gastrointestinal z Heart z Hip/Replacement z Knee z Lumbar Disc z Neck

z Neurological z Obstetrical z Podiatric z Shoulder z Sinus z Thoracic Disc

z Wrist/Hand z Other: _____

List **ALL Past Medical History** conditions

z Ankle Pain z Arm Pain z Arthritis z Asthma z Back Pain z Broken Bones_____

z Cancer z Chest Pain z Depression z Diabetes z Dizziness z Elbow Pain

z Epilepsy z Eye/Vision Problems z Fainting z Fatigue z Foot Pain z Genetic Spinal Condition

z Hand Pain z Headaches/Migraines z Hearing Problems z Hepatitis z High Blood Pressure

z High Cholesterol z Hip Pain z HIV z Jaw Pain z Joint Stiffness

z Knee Pain z Leg Pain z Low Back Pain z Menstrual Problems

z Mid-Back Pain z Minor Heart Problem z Multiple Sclerosis z Neck Pain z Neurological Disorder

z Pacemaker z Parkinson's z Polio z Prostate Problems z Shoulder Pain

z Significant Weight Change z Spinal Cord Injury z Sprain/Strain z Stroke/Heart Attack

z Stomach Problems z Tumor z Ulcer(s) z Wrist Pain

z Other: _____

List Type of **Medications** you are taking

z Allergy z Anxiety z Birth control z Cardiovascular z Insulin z Muscle Relaxers

z Pain Killers z Seizure z Other: _____

List your **Family History**

z Arthritis z Asthma z Back Pain z Cancer z Depression z Diabetes z Epilepsy

z Genetic Spinal Condition z High Blood Pressure z Heart Problems z Multiple Sclerosis

z Neurological Problems z Parkinson's z Polio z Prostate Problems

z Stroke/Heart Attack z Other: _____

Have you had any auto or other accidents? z No zYes

Describe _____

Date of last physical examination _____

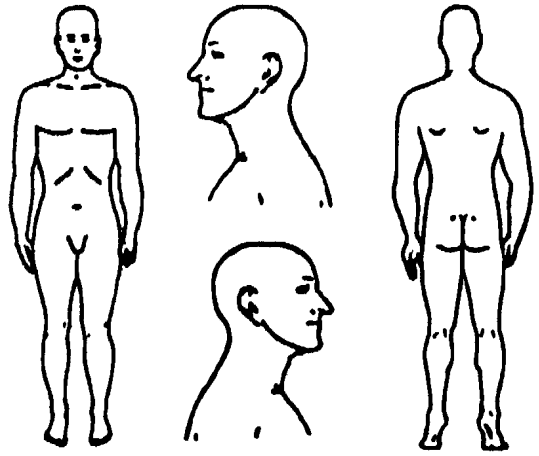
Do you smoke? z No zYes How many packs per day? _____

Do you drink alcohol? z No zYes How many drinks per day? _____

Do you drink caffeine? z No zYes How many drinks per day? _____

Do you exercise? z No zYes Describe _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- z Become pain free
- z Explanation of my condition
- z Learn how to care for my condition
- z Reduce symptoms
- z Resume normal activity level

Have you ever had chiropractic care? z No z Yes
When? _____ Why? _____
Where? _____
Were X-rays taken? z No z Yes
When was your last adjustment? _____

Major Complaint:

What is your major complaint? _____Date problem began? _____

How did this problem begin? _____

Have you had this condition in the past? z YES z NO

How is your condition changing? z GETTING BETTER z GETTING WORSE z NOT CHANGING

Rate your PAIN on a scale of 1 to 10. (0 = no pain and 10 = excruciating pain) z 1 z 2 z 3 z 4 z 5 z 6 z 7 z 8 z 9 z 10

How do your symptoms AFFECT YOUR ABILITY to perform daily activities such as working or driving?

(0 = no effect and 10 = no possible activities) z 1 z 2 z 3 z 4 z 5 z 6 z 7 z 8 z 9 z 10

How INTENSE is your pain? z Minimum z Mild z Moderate z Severe z Unbearable z None

Describe the NATURE of your symptoms z Burning z Dull z Numb z Radiating Pain z Sharp z Shooting

z Stabbing Pain z Tightness z Tingling z Throbbing z Ache z Other: _____

Does your pain interfere with *Activities of Daily Life*? z YES z NO

What makes your pain better? z Acupuncture z Chiropractic z Heat z Ice z Massage z Nothing Works

z Pain Medicines zPhysical Therapy z Sleep/Rest z Stretching z Other

How often do you experience your symptoms? z Constantly z Frequently z Occasionally z Intermittently

Second Complaint:

What is your SECOND complaint? _____Date problem began? _____

How did this problem begin? _____

Have you had this condition in the past? z YES z NO

How is your condition changing? z GETTING BETTER z GETTING WORSE z NOT CHANGING

Rate your PAIN on a scale of 1 to 10. (0 = no pain and 10 = excruciating pain) z 1 z 2 z 3 z 4 z 5 z 6 z 7 z 8 z 9 z 10

How do your symptoms AFFECT YOUR ABILITY to perform daily activities such as working or driving?

(0 = no effect and 10 = no possible activities) z 1 z 2 z 3 z 4 z 5 z 6 z 7 z 8 z 9 z 10

How INTENSE is your pain? z Minimum z Mild z Moderate z Severe z Unbearable z None

Describe the NATURE of your symptoms z Burning z Dull z Numb z Radiating Pain z Sharp z Shooting

z Stabbing Pain z Tightness z Tingling z Throbbing z Ache z Other: _____

Does your pain interfere with *Activities of Daily Life*? z YES z NO

What makes your pain better? z Acupuncture z Chiropractic z Heat z Ice z Massage z Nothing Works

z Pain Medicines zPhysical Therapy z Sleep/Rest z Stretching z Other

How often do you experience your symptoms? z Constantly z Frequently z Occasionally z Intermittently

Third Complaint:

What is your next complaint? _____Date problem began? _____

How did this problem begin? _____

Have you had this condition in the past? z YES z NO

How is your condition changing? z GETTING BETTER z GETTING WORSE z NOT CHANGING

Rate your PAIN on a scale of 1 to 10. (0 = no pain and 10 = excruciating pain) z 1 z 2 z 3 z 4 z 5 z 6 z 7 z 8 z 9 z 10

How do your symptoms AFFECT YOUR ABILITY to perform daily activities such as working or driving?

(0 = no effect and 10 = no possible activities) z 1 z 2 z 3 z 4 z 5 z 6 z 7 z 8 z 9 z 10

How INTENSE is your pain? z Minimum z Mild z Moderate z Severe z Unbearable z None

Describe the NATURE of your symptoms z Burning z Dull z Numb z Radiating Pain z Sharp z Shooting

z Stabbing Pain z Tightness z Tingling z Throbbing z Ache z Other: _____

Does your pain interfere with *Activities of Daily Life*? z YES z NO

What makes your pain better? z Acupuncture z Chiropractic z Heat z Ice z Massage z Nothing Works

z Pain Medicines zPhysical Therapy z Sleep/Rest z Stretching z Other

How often do you experience your symptoms? z Constantly z Frequently z Occasionally z Intermittently

Neurological and Vascular History

Do You Suffer From Neck Pain With Pain In Your Shoulder, Arms, Or Hands?	**Yes**	**No**
Do You Have Weakness, Numbness, Or Burning In Your Shoulder, Arms, Or Hands?	**Yes**	**No**
Do Your Hands Or Arms Fall Asleep Regularly?	**Yes**	**No**
Do You Have Reduced Feeling (Sensation) Or Swelling In Your Hands Or Arms?	**Yes**	**No**
Do You Suffer From A Loss Of Hand Grip Strength?	**Yes**	**No**
Do You Suffer From Back Pain With Pain In Your Buttocks, Legs, Or Feet?	**Yes**	**No**
Do You Have Weakness, Numbness, Or Burning In Your Buttock, Legs, Or Feet?	**Yes**	**No**
Do Your Legs Or Feet Fall Asleep Regularly?	**Yes**	**No**
Do You Have Reduced Feeling (Sensation) Or Swelling In Your Legs Or Feet?	**Yes**	**No**
Do You Suffer From Cold Hands Or Feet?	**Yes**	**No**
Do You Suffer From Headaches, Dizziness, Or Memory Loss?	**Yes**	**No**
Do You Have Difficulty Maintaining Your Balance?	**Yes**	**No**
Do You Suffer From Vertigo Or Blurred Vision?	**Yes**	**No**
Do You Suffer From Reduced Hearing Capacity?	**Yes**	**No**
Do You Suffer From Ringing In Your Ears?	**Yes**	**No**
Do You Have Bladder Or Bowel Control Problems On A Regular Basis?	**Yes**	**No**

Chellis Chiropractic

Patient Name _____ SSN _____ DOB _____

Billing Address _____

Home Phone _____ Cell Phone _____

This is to certify that the above named patient authorizes the request of any records pertinent to the health care of same individual from but not inclusive of any insurance carrier, adjustor, attorney or other health care provider.

This also authorizes this facility to release records, upon receipt of the above named patient's signature, or on an emergency basis, to, but not inclusive of any insurance carrier, attorney, health care provider, hospital or immediate family member.

Privacy: The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") establishes, for the first time, as set of a national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the **Health Insurance Portability and Accountability Act** of 1996 ("HIPAA"). A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and wellbeing.

You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPAA guidelines.

Financial Responsibility and Records Request

This also certifies that the above named guarantor agrees to pay in full for all professional services rendered at the time they are performed, unless other arrangements are made in advance of the set appointment. The below named guarantor understands a $25.00 returned check fee will be charged along with any appropriate collection or attorney's fee which may accrue upon collection of any outstanding balance. **The below named guarantor understands that if 24 hours notice is not provided a $15.00 fee will be charged for a missed chiropractic appointment and $25.00 fee will be charged for a missed massage therapy appointment, except in an emergency situation.**

A photocopy of this assignment shall be considered as effective and valid as the original. This document is considered a living document and does not expire.

Financial Agreement

I acknowledge that I have read and understand the foregoing "Financial Responsibility and Records Request" Form.

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review Chellis Chiropractic's "Notice Of Privacy Practices" Form for protected health information.

Patient Signature _____ Date_____

Consent to Treat a Minor

As the Legal Guardian of the Above Named Patient, I give my written consent for examination and/or treatment of the above stated patient to Chellis Chiropractic. I accept financial responsibility for the Above Named Patient.

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian's Signature Authorizing Care: _____

Relationship: _____ Date_____

Please bring your Insurance Card (if applicable) and ID to your first visit.
If you have X-Rays or a MRI you would like to share with the doctor, please bring them.