

Patient Information

Name: _____ Age: _____ Date of Birth: _____

Primary Address: _____

Secondary Address: _____

City, State, Zip Code: _____

Phone: (Home) _____ (Work) _____

(Mobile) _____ Email: _____

Employer's Name: _____

Driver's License #: _____ Social Security #: _____

Marital Status: S M D W Sex: M F

Spouse's Name (if applicable): _____ Referred By: _____

Are your present problems due to an injury? Yes No (if yes) Auto Work
 Personal Injury Other

Insurance Information

Primary Insurance Company: _____

Policy Holder's Name: _____ Policy Holder's Birthdate: _____

Policy Number: _____ Group #: _____

Secondary Insurance Company: _____

Policyholder's Name: _____ Policyholder's Birthdate: _____

Policy Number: _____ Group #: _____

Payment for professional services rendered is the patient's responsibility. **Payment or insurance co-pays and deductibles are due at the time of service** unless special arrangements have been made with our office. A late fee of \$10 will be assessed to any unpaid balance at the next billing cycle.

Health & accident policies are an arrangement between the insurance carrier and the patient. Chiro-Technology will bill your insurance company. I authorize direct payment to Chiro-Technology. This is a direct assignment of my rights and benefits under my policy. The patient will be responsible for charges not covered by insurance.

Signature of patient or guardian: _____ Date: _____

Consent for Purpose of Treatment, Payment and Healthcare Operations

I acknowledge that Chiro-Technology, P.C.'s "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Chiro-Technology, P.C.'s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiro-Technology, P.C. The Notice of Privacy Practices for Chiro-Technology is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Chiro-Technology, P.C.'s duties with respect to my protected health information.

Chiro-Technology, P.C reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Missed or Canceled Appointments

If you need to cancel or change an appointment time you must call 24 hours in advance. Patients canceling or changing an appointment without 24 hours notice will be charged a fee of \$15. We apologize for any inconvenience this may cause. As our clinic continues to grow we are forced to find more efficient ways to help as many patients as possible.

Massage and Exercise Session Policy

Due to the large number of patients receiving Massage and Exercise Therapy, we request that you give 24 hours notice when canceling or changing an appointment. This allows us to fill the appointment time for our waiting list. If you fail to give 24 hours notice, there will be a charge of 50% of the total appointment charge. Emergencies will be taken into consideration. Please also note that your appointment time includes the time needed for dressing and undressing.

Patient Name

Date

Patient Signature

Chiro-Technology

Patient History

Name _____ Date _____

PLEASE CHECK ALL ANSWERS THAT APPLY AND FILL IN BLANKS WHERE APPROPRIATE.

The information you provide concerning your medical history assists your doctor in understanding your state of health. This is important information. Please be thorough.

Please describe the condition that brings you to our clinic: _____

Please describe the character of your current discomfort (*You may check more than one response*):

- Sharp/Stabbing Ache Dull Soreness Weakness Throbbing/Gnawing Numbness
- Shooting Gripping/Constricting Burning Tingling

How often are the complaints present? Constant (more than 75% of the time) Frequent (51-75%)

- Occasional (26-50%) Intermittent (25% or less)

On a scale of 0 to 10 (with 10 being the worst) how bad is the pain?

NONE UNBEARABLE
0 1 2 3 4 5 6 7 8 9 10

How did the problem begin? _____

When did it begin: (Specific Date if Possible) _____

Did your pain start: Immediately after a specific incident Multiple Incidents Gradually over time Unknown

Is the pain Increasing Decreasing Staying the same Comes and goes

What treatment have you received for this condition? None Surgery Injections Physical Therapy

Medications _____ Other _____

Were you previously treated for this problem? Yes No If yes, by Chiropractor MD Therapist

Other _____ Specify dates, type of treatment and results _____

What helps the symptoms feel better? Nothing Lying Down Walking Standing Sitting

Movement/Activity Inactivity Other _____

How would you grade your general stress level? No Stress Minimal Stress Moderate Stress Greatly Stressed

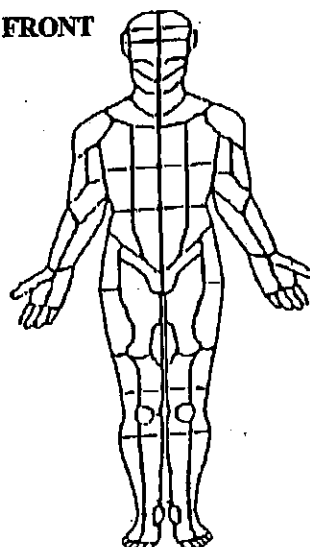
Physical Activity Level at Work: Sit 50% or more of the day Light labor General labor Heavy labor

General Physical Activity: No regular exercise Light routine exercise Strenuous routine exercise

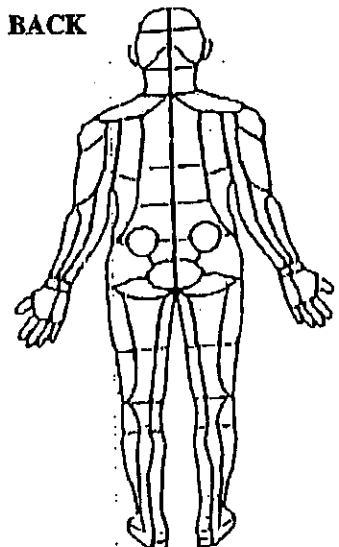
Who is your family doctor? _____ May we have your permission to consult with

your family doctor regarding your current condition? Yes No

FRONT



BACK



Patient History (page 2)

Name _____ Date _____

	Past	Present		Past	Present
Headache/Migraine.....	<input type="radio"/>	<input type="radio"/>	Irregular Menstrual Flow.....	<input type="radio"/>	<input type="radio"/>
Neck Pain.....	<input type="radio"/>	<input type="radio"/>	Profuse Menstrual Flow.....	<input type="radio"/>	<input type="radio"/>
Shoulder Pain.....	<input type="radio"/>	<input type="radio"/>	Breast Soreness/Lumps.....	<input type="radio"/>	<input type="radio"/>
Back Pain.....	<input type="radio"/>	<input type="radio"/>	Vaginal Discharge.....	<input type="radio"/>	<input type="radio"/>
Lower Back Pain.....	<input type="radio"/>	<input type="radio"/>	PMS.....	<input type="radio"/>	<input type="radio"/>
Hand Pain.....	<input type="radio"/>	<input type="radio"/>	Loss of Bladder.....	<input type="radio"/>	<input type="radio"/>
Upper Leg/Hip Pain.....	<input type="radio"/>	<input type="radio"/>	Painful Urination.....	<input type="radio"/>	<input type="radio"/>
Lower Leg/Knee Pain.....	<input type="radio"/>	<input type="radio"/>	Frequent Urination.....	<input type="radio"/>	<input type="radio"/>
Ankle/Foot Pain.....	<input type="radio"/>	<input type="radio"/>	Abdominal Pain.....	<input type="radio"/>	<input type="radio"/>
Jaw Pain.....	<input type="radio"/>	<input type="radio"/>	Constipation/Irregular Bowel.....	<input type="radio"/>	<input type="radio"/>
Joint Swelling/Stiffness.....	<input type="radio"/>	<input type="radio"/>	Difficulty Swallowing.....	<input type="radio"/>	<input type="radio"/>
Fainting/Nausea.....	<input type="radio"/>	<input type="radio"/>	Heartburn/Indigestion.....	<input type="radio"/>	<input type="radio"/>
Convulsions.....	<input type="radio"/>	<input type="radio"/>	Dermatitis/Rash/Eczema.....	<input type="radio"/>	<input type="radio"/>
Dizziness.....	<input type="radio"/>	<input type="radio"/>			

	Past	Present		Past	Present
Fatigue.....	<input type="radio"/>	<input type="radio"/>	Tobacco Use.....	<input type="radio"/>	<input type="radio"/>
Muscular Incoordination.....	<input type="radio"/>	<input type="radio"/>	Alcohol Use.....	<input type="radio"/>	<input type="radio"/>
Tinnitus (Ear Ringing).....	<input type="radio"/>	<input type="radio"/>	Birth Control Pills.....	<input type="radio"/>	<input type="radio"/>
Rapid Heart Beat.....	<input type="radio"/>	<input type="radio"/>	Loss of Appetite.....	<input type="radio"/>	<input type="radio"/>
Chest Pain.....	<input type="radio"/>	<input type="radio"/>	Drug and Alcohol Dependence.....	<input type="radio"/>	<input type="radio"/>
Excessive Thirst.....	<input type="radio"/>	<input type="radio"/>	Constipation/Irregular Bowel.....	<input type="radio"/>	<input type="radio"/>
Chronic Cough.....	<input type="radio"/>	<input type="radio"/>	Pregnancy.....	<input type="radio"/>	<input type="radio"/>
Chronic Sinusitis.....	<input type="radio"/>	<input type="radio"/>	Coffee/Tea/Caffeinated drinks (Cups per day) _____		

Surgical Procedures (Please List)

Current Medications (Please List)

Do you have a permanent disability rating? Yes No Body Part _____
 Date you received disability rating: ____/____/____ Disability Percentage ____%
 Present Body Weight _____ Pounds Present Height ____ Feet ____ Inches
 Is there a family history of any type of disease (i.e. heart disease, cancer, diabetes)? _____

	Past	Present		Past	Present
Depression.....	<input type="radio"/>	<input type="radio"/>	Arthritis.....	<input type="radio"/>	<input type="radio"/>
Aneurysm.....	<input type="radio"/>	<input type="radio"/>	Emphysema.....	<input type="radio"/>	<input type="radio"/>
High Blood Pressure.....	<input type="radio"/>	<input type="radio"/>	Diabetes.....	<input type="radio"/>	<input type="radio"/>
Angina.....	<input type="radio"/>	<input type="radio"/>	Ulcer.....	<input type="radio"/>	<input type="radio"/>
Heart Attack.....	<input type="radio"/>	<input type="radio"/>	Kidney Stones.....	<input type="radio"/>	<input type="radio"/>
Stroke.....	<input type="radio"/>	<input type="radio"/>	Bladder Infection.....	<input type="radio"/>	<input type="radio"/>
Asthma.....	<input type="radio"/>	<input type="radio"/>	Allergies.....	<input type="radio"/>	<input type="radio"/>
Cancer.....	<input type="radio"/>	<input type="radio"/>	Irritable Bowel/Colitis.....	<input type="radio"/>	<input type="radio"/>
Prostate Problems.....	<input type="radio"/>	<input type="radio"/>	HIV/AIDS.....	<input type="radio"/>	<input type="radio"/>
Blood Disorders.....	<input type="radio"/>	<input type="radio"/>	Other _____		