



"Treating Active Lifestyles"

Patient Information Sheet

Patient:

Last Name: _____ First Name: _____ Middle: _____
 Gender: M / F Date of Birth: ___/___/___ Age: _____ SS# _____ - _____ - _____
 Home Address: _____ Apt#: _____
 City: _____ State: _____ Zip: _____
 Home Phone#:(_____) _____ - _____ Work Phone#:(_____) _____ - _____
 Cell Phone#:(_____) _____ - _____ e-mail: _____
 Occupation: _____ Employer Name _____
 Employer Address: _____ City: _____ State: _____ Zip: _____

Spouse or Guardian:

Last Name: _____ First Name: _____ Middle: _____
 Employer Name: _____ Primary Phone#:(_____) _____ - _____
 Date of Birth: ___/___/___ SS# _____ - _____ - _____

Emergency: Name and address of the nearest relative or friend not living with you:

Last Name: _____ First Name: _____ Middle: _____
 Employer Name: _____ Primary Phone#:(_____) _____ - _____
 Relationship to Patient: _____

Responsible Party: Complete the section if you are not the patient but are responsible for the bill

Responsible Party: _____ Relationship to Patient: _____
 Home Address: _____ Apt#: _____
 City: _____ State: _____ Zip: _____
 Home Phone#:(_____) _____ - _____ Work Phone#:(_____) _____ - _____
 Cell Phone#:(_____) _____ - _____
 Employer Name: _____ Occupation: _____

Signature: (Patient, Parent, Legal Guardian, or Responsible Party)

I Request Services _____ Date: ___/___/___

Acknowledgement of Receipt of Privacy Practices

I, _____ have received a copy of Center for Chiropractic & Athletic Medicine P.C.'s Notice of Privacy Practices with an effective date of January 1, 2004.

Signature of Patient: _____ Date: ___/___/___



Consent for Treatment

I, the undersigned, a patient in this office hereby authorize Dr. Ross McDaniel and Dr. Jason Henry (and whoever may be designated as their assistant(s) to administer treatments necessary.

I also certify that no guarantee of assurance has been made to the results that may be obtained.

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I will permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Signature of Patient: _____ Date: ___/___/___

Center for Chiropractic & Athletic Medicine, P.C. Financial Policy

Dear Patient:

Thank you for choosing us as your health care provider. The following is our financial policy. The complexity of today's medical billing and insurance reimbursement can often make receiving health care very confusing. It is important to us that you understand the process from the beginning of care. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our office manager.

We do, in most instances, accept assignment of insurance benefits. However you must understand that.

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party of that contract.
2. All charges are your responsibility whether your insurance company pays or not. Some insurance companies select certain services they will not cover. Fee for these services are your responsibility, however we will attempt to make you aware of these situations as soon as possible.
3. Co-payments and co-insurance are due at the time of service.
4. If the insurance company does not pay your balance in full within 30 days we ask that you contact the carrier to help speed things up.
5. If the insurance company does not pay in full within 45 days, we ask that you pay the balance due with cash or check.
6. A charge of 1.5% may be assessed on all balances of 30 days old.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we assist you in the management of your account.

Thank you again for choosing us. We appreciate your trust and the opportunity to serve you.

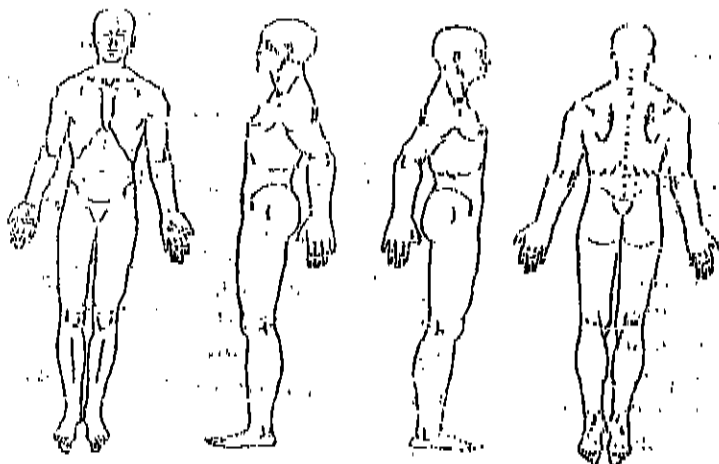
Signature of Patient: _____ Date: ___/___/___

CENTER FOR CHIROPRACTIC & ATHLETIC MEDICINE PC.

Patient Health Questionnaire

Patient Name _____ Date _____
When did your symptoms start? _____ Describe your symptoms and how they began: _____

Indicate on the picture below where you have pain or other symptoms. How often do you experience your symptoms?



- 1 Constantly (76-100% of day)
- 2 Frequently (51-75% of day)
- 3 Occasionally (26-50% of day)
- 4 Intermittently (0-25% of day)

What describes the nature of your symptoms?

- Sharp Shooting
- Dull Ache Burning
- Numb Tingling

How are your symptoms changing?

- Getting better
- Not changing
- Getting worse

What is the intensity of your symptoms at their _____
 Worst
 None Unbearable
 0 1 2 3 4 5 6 7 8 9
 Best

Who have you seen for this episode of your symptoms?
 No one Medical Doctor Other Chiropractor
 Physical Therapist Other

When and what treatment? _____

Have you had the same or similar symptoms in the past? Yes No

If you have received treatments in the past for This office Medical Doctor Other Chiropractor

the same or similar symptoms who did you see? Physical Therapist Other

What tests have you had for your symptoms? X-rays CT Scan MRI Scan Other

What is your occupation? 1-Professional/Executive 4-Laborer 7-Retired
 2-White Collar/Secretarial 5-Homemaker 8-other
 3-Tradesperson 6-FT Student

If you are not retired, a homemaker, or a student, what is your current work status?
 1-Full time 4-unemployed
 2-Part time 5-Employed, off work due to restrictions
 3-Self-employed 6-other

As a result of your symptoms are you restricted in your ability to perform work and/or daily activities? Yes No
Describe your restrictions _____

What type of regular exercise do you perform? 1-None 2-Light 3-Moderate 4-strenuous

What is your height and weight? Height _____ feet _____ inches Weight _____ lbs.

Patient Signature _____ Date: _____

Patient Health Questionnaire-cont. page 2

Patient Name: _____

Date: _____

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

| Past | Present | Past | Present | Past | Present |
|--------------------------|---|--------------------------|--|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Headaches | <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> | <input type="checkbox"/> Stroke | <input type="checkbox"/> | <input type="checkbox"/> Chronic Sinusitis |
| <input type="checkbox"/> | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> | <input type="checkbox"/> Rapid Heart Beat | <input type="checkbox"/> | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> | <input type="checkbox"/> Angina | <input type="checkbox"/> | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> | <input type="checkbox"/> Depression |
| <input type="checkbox"/> | <input type="checkbox"/> Elbow/Upper Arm Pain | <input type="checkbox"/> | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> | <input type="checkbox"/> Drug/Alcohol Dependency |
| <input type="checkbox"/> | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> | <input type="checkbox"/> Kidney Stones | | |
| <input type="checkbox"/> | <input type="checkbox"/> Hand Pain | <input type="checkbox"/> | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> | <input type="checkbox"/> Systemic Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> Hip/Upper Leg Pain | <input type="checkbox"/> | <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> Knee/Lower Leg Pain | <input type="checkbox"/> | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> | <input type="checkbox"/> Dermatitis/Eczema/Rashes |
| <input type="checkbox"/> | <input type="checkbox"/> Ankle/Foot Pain | <input type="checkbox"/> | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> | <input type="checkbox"/> Prostate Problems | | |
| <input type="checkbox"/> | <input type="checkbox"/> Joint Swelling/Stiffness | <input type="checkbox"/> | <input type="checkbox"/> Abnormal Weight Gain/Loss | | |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Anorexia | | |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Loss of Appetite | | |
| <input type="checkbox"/> | <input type="checkbox"/> General Fatigue | <input type="checkbox"/> | <input type="checkbox"/> Abdominal Pain | <i>Females Only</i> | |
| <input type="checkbox"/> | <input type="checkbox"/> Muscular Incoordination | <input type="checkbox"/> | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> | <input type="checkbox"/> Irregular Menstrual Flow |
| <input type="checkbox"/> | <input type="checkbox"/> Fainting | <input type="checkbox"/> | <input type="checkbox"/> Constipation | <input type="checkbox"/> | <input type="checkbox"/> Profuse Menstrual Flow |
| <input type="checkbox"/> | <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> | <input type="checkbox"/> Heartburn Indigestion | <input type="checkbox"/> | <input type="checkbox"/> Breast Soreness/Lumps |
| <input type="checkbox"/> | <input type="checkbox"/> Convulsions | <input type="checkbox"/> | <input type="checkbox"/> Ulcer | <input type="checkbox"/> | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> | <input type="checkbox"/> Dizziness | <input type="checkbox"/> | <input type="checkbox"/> Colitis | <input type="checkbox"/> | <input type="checkbox"/> PMS |
| <input type="checkbox"/> | <input type="checkbox"/> Tinnitus (ear noises) | <input type="checkbox"/> | <input type="checkbox"/> Irritable Colon | <input type="checkbox"/> | <input type="checkbox"/> Birth Control Pills |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> Hormonal Replacement |
| <input type="checkbox"/> | <input type="checkbox"/> Tumor | <input type="checkbox"/> | <input type="checkbox"/> Liver/Gall Bladder Disorder | <input type="checkbox"/> | <input type="checkbox"/> Pregnancy |

Indicate if an immediate family member has had any of the following:

Chronic Back Problems
 Rheumatoid Arthritis
 High Blood Pressure
 Cancer
 Lupus
 Chronic Headaches
 Lung Problems
 Heart Problems
 Diabetes
 Other

Do you have a permanent disability rating? Yes No Rating? _____ Date Rating Received _____

Describe your disability _____

List all Prescription and over-the-counter medications you are taking _____

List all the surgical procedures you have had and times you have been hospitalized. _____

Patient Signature _____ Date: _____

Doctor's Additional Comments: _____

Doctor's Signature _____ Date: _____