WELCOME

Patient Information

Date _____

First _____ MI _____ Last _____ Age _____ Sex: M ◯ F ◯

Address _____ Apt. _____ Birth date _____

Patient SS# _____

City _____ State _____ Zip _____ Cell # _____

Home # _____ Work # _____ Ext. _____ E-Mail _____

◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed Best time & place to reach you _____

IN CASE OF EMERGENCY, CONTACT: Name _____ Relationship _____

Home Phone _____ Work Phone _____ Ext _____

Whom may we thank for referring you? _____

Work Information

Occupation _____ Phone _____ Ext. _____

Company _____ Address _____

Parent/ Spouse Information

Name _____ SS# _____ Birth date _____

Occupation _____ Employer _____

Insurance

Who is responsible for this account? _____ Relationship to patient _____

Insurance Co. _____ Group # _____ Injury related to:

Is patient covered by additional insurance? ◯ Yes ◯ No ◯ Motor vehicle accident ◯ Work comp.

Claim #: _____

Subscriber's name _____ Birth date _____ SS# _____

Relationship to patient _____ Insurance Co. _____ Group # _____

AUTHORIZATION

I certify that I have read and I understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize ChiroSport, PC to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the ChiroSport, PC insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents.

X _____ Date _____

Patient's Signature (or parent if a minor)

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ChiroSport, P.C. Financial Policy

Dear Patient:

Thank you for choosing us as your health care provider. The following is our financial policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our office manager.

We ask that you read and sign our Financial Policy prior to seeing the doctor.

In special circumstances, we may accept an 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 to that contract. Our relationship is with you, not your insurance company.

2. **All charges are your responsibility whether your insurance company pays or not. Some insurance companies select certain services they will not cover. Fees 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. We accept cash, checks, Visa, MasterCard, and Discover. We will be happy to process your claim for reimbursement as long as you provide us with the proper insurance information.**

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 may require you to pay the balance due.**

6. **A charge of 1.5% monthly interest rate may be assessed on all balances over 90 days old.**

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

Thank you for choosing us as your health care provider. We know there are many providers to choose from. We appreciate your trust in us and the opportunity to serve you.

Patient's Signature _____ Date: _____

Consent for Treatment

I, the undersigned, a patient in this office hereby authorize the doctors at ChiroSport P.C. (and whomever he may designate as his assistant(s) to administer treatment as necessary.

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

I understand and agree that 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.

Patient's Signature: _____ Date: _____

Acknowledgement or Receipt of Privacy Practices

I, _____ have received a copy of ChiroSport P.C.'s Notice of Privacy Practices with an effective date of January 1, 2004.

Patient Name: _____ Date: _____

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Current Patient Condition

Reason for visit 1. _____ **When did your symptoms appear?** _____

2. _____ _____

3. _____ _____

Progression of pain? ◯ Getting Better ◯ Getting worse ◯ Unchanging ◯ Unknown

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) [circle one] 1 2 3 4 5 6 7 8 9 10

Type of pain: ○ **Sharp** ○ **Dull** ○ **Throbbing** ○ **Numbness** ○ **Aching** ○ **Shooting**
○ **Burning** ○ **Tingling** ○ **Cramps** ○ **Stiffness** ○ **Swelling** ○ **Other** _____

How often do you have this pain? _____ **Is it often or does it come and go?** _____

Does it interfere with your: ○ Work ○ Sleep ○ Daily routine ○ Recreation

Activities or movements that are painful to perform: ○ Sitting ○ Standing ○ Walking ○ Bending ○ Lying down

Health History

Height _____ **Weight** _____ **Number of Children** _____

Are you recovering from a cold or flu? _____ **Are you pregnant?** _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis, saliva, bone density):

_____

Outcome _____

What types of therapy have you tried for this problem(s)?

Diet modification ◯ Podiatrist ◯ Vitamins/minerals ◯ Herbs ◯ Homeopathy ◯ Chiropractic ◯

Acupuncture ◯ Conventional drugs ◯ Physical therapy ◯ Other ◯

Medical: PCP/Internist ◯ Orthopedist ◯ Neurologist ◯ Neurosurgeon ◯ Physiatrist ◯

Date of exam _____ **Practitioner name & contact** _____

_____ _____

_____ _____

List current health problems for which you are being treated: _____

_____

Current medications (prescription and/or over-the-counter): _____

_____

Major hospitalizations, surgeries, injuries. Please list all procedures, complications (if any) and dates: Year

Surgery, illness, injury **Outcome**

_____

_____

_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., job change, family status change, work related, finances, etc...) _____

Do you consider yourself: ◯ Underweight ◯ Overweight ◯ Just right **Your weight now:** _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last 3 months? ◯ Yes ◯ No

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)?

_____

Do you experience any of these general symptoms EVERYDAY?

◯ Shortness of breath ◯ Nausea ◯ Fecal incontinence ◯ Bleeding ◯ Insomnia

◯ Headaches ◯ Vomiting ◯ Urinary incontinence ◯ Discharge ◯ Constipation

◯ Dizziness ◯ Diarrhea ◯ Low grade fever ◯ Itching/rash ◯ Chronic pain/inflammation

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Medical History

- ○ Arthritis
- ○ Allergies/hay fever
- ○ Asthma
- ○ Alcoholism
- ○ Alzheimer's disease
- ○ Autoimmune disease
- ○ Blood pressure problems
- ○ Bronchitis
- ○ Cancer
- ○ Chronic fatigue syndrome
- ○ Carpal tunnel syndrome
- ○ Cholesterol - elevated
- ○ Circulatory problems
- ○ Colitis
- ○ Dental problems
- ○ Depression
- ○ Diabetes
- ○ Diverticular Disease
- ○ Drug addiction
- ○ Eating disorder
- ○ Epilepsy
- ○ Emphysema
- ○ Eyes, ears, nose, throat problems
- ○ Environment sensitivities
- ○ Fibromyalgia
- ○ Food intolerance
- ○ Gastroesophageal reflux disease
- ○ Genetic disorder
- ○ Glaucoma
- ○ Gout
- ○ Heart disease
- ○ Inflammatory bowel disease
- ○ Irritable bowel syndrome
- ○ Kidney or bladder disease
- ○ Learning disability
- ○ Liver or gall bladder disease (stones)
- ○ Mental illness
- ○ Migraine headaches
- ○ Neurological problems
- ○ Sinus problems
- ○ Thyroid trouble
- ○ Obesity
- ○ Osteoporosis
- ○ Pneumonia
- ○ Sexually transmitted disease
- ○ Seasonal affective disorder
- ○ Skin problems
- ○ Tuberculosis
- ○ Ulcer
- ○ Urinary tract infection
- ○ Varicose veins
- ○ Other _____

Medical (Men)

- ○ Benign prostatic hyperplasia (BPH)
- ○ Prostate cancer
- ○ Decreased sex drive
- ○ Infertility
- ○ Sexually transmitted disease
- ○ Other _____

Medical (Women)

- ○ Menstrual irregularities
- ○ Endometriosis
- ○ Infertility
- ○ Fibrocystic breasts
- ○ Fibroids/ovarian cysts
- ○ Premenstrual syndrome (PMS)
- ○ Breast cancer
- ○ Pelvic inflammatory disease
- ○ Vaginal infections
- ○ Decreased sex drive
- ○ Sexually transmitted disease

Other _____

Age of first period _____

Last genealogical exam _____

Mammogram: + -

PAP: + -

Birth control (form) _____

# of children _____

# of pregnancies _____

- ○ C-section
- ○ Surgical menopause
- ○ Menopause

Date of last menstrual period ____

Length of cycle _____

Interval between cycles ____

Changes in normal flow

_____

Family Health History

- ○ Arthritis
- ○ Asthma
- ○ Alcoholism
- ○ Alzheimer's disease
- ○ Cancer
- ○ Depression
- ○ Diabetes
- ○ Drug addiction
- ○ Glaucoma
- ○ Heart disease
- ○ Infertility
- ○ Learning disabilities
- ○ Mental illness
- ○ Mental retardation
- ○ Migraine headaches
- ○ Neurological disorders
- ○ Obesity
- ○ Stroke
- ○ Suicide

Health Habits

- ○ Tobacco: # per day ___
- ○ Alcohol:
- ○ Wine: # glasses/d or wk _
- ○ Liquor: #oz./d or wk ___
- ○ Beer: # glasses/d or wk _
- ○ Caffeine:
- ○ Coffee: # 6oz. Cup/day _
- ○ Tea: # 6oz. Cup/day ___
- ○ Soda: # cans/day _____
- ○ Other _____
- ○ Water: # glasses/day ___

Exercise

- ○ 5 - 7 days per week
- ○ 3 - 4 days per week
- ○ 1-2 days per week
- ○ 45 min or more workout
- ○ 30- 45 min workout
- ○ Less than 30 min workout
- ○ Walk
- ○ Run, Jog, Jump rope
- ○ Weight lift
- ○ Swim
- ○ Box
- ○ Yoga
- ○ Other_____

Nutrition & Diet

- ○ Mixed food diet (animal & veg)
- ○ Vegetarian
- ○ Vegan
- ○ Salt restriction
- ○ Fat restriction
- ○ Starch/ carbohydrate restriction
- ○ Other food restrictions:

_____

Food Frequency

Servings per day:

Fruits _____

Dark green or deep yellow veggies

_____

Grains (unprocessed) ____

Beans, peas, legumes ____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

- ○ Skip breakfast
- ○ Two meals/ day
- ○ One meal/ day
- ○ Graze (small frequent meals)
- ○ Eat on the run
- ○ Add salt to food

Current Supplements

- ○ Multivitamin/mineral
- ○ Vitamin C
- ○ Vitamin E
- ○ EPA/DHA
- ○ Evening primrose/GLA
- ○ Calcium, source _____
- ○ Magnesium
- ○ Zinc
- ○ Minerals, describe _____
- ○ Friendly flora (acidophilus)
- ○ Digestive enzymes
- ○ Amino acids
- ○ CoQ10
- ○ Antioxidants (lutein, resveratrol, etc.)
- ○ Herbs – teas
- ○ Herbs - Extracts
- ○ Chinese herbs
- ○ Ayurvedic herbs
- ○ Bach flowers
- ○ Protein shakes
- ○ Super foods
- ○ Liquid meals
- ○ Other _____

Would you like to:

- ○ Have more energy
- ○ Be stronger
- ○ Have more endurance
- ○ Increase your sex drive
- ○ Be thinner
- ○ Be more muscular
- ○ Improve your complexion
- ○ Have stronger nails
- ○ Have healthier hair
- ○ Be less moody
- ○ Feel more motivated
- ○ Be more organized
- ○ Think more clearly, be more focused
- ○ Improve memory
- ○ Do better on tests
- ○ No dependents on over-the-counter drugs
- ○ Stop using laxatives or stool softeners
- ○ Be free of pain
- ○ Sleep better
- ○ Have agreeable breath
- ○ Have agreeable body odor
- ○ Have stronger teeth
- ○ Have less colds and flus
- ○ Get rid of allergies
- ○ Reduce your risk of inherited disease tendencies

Patient Name: _____ Date: _____

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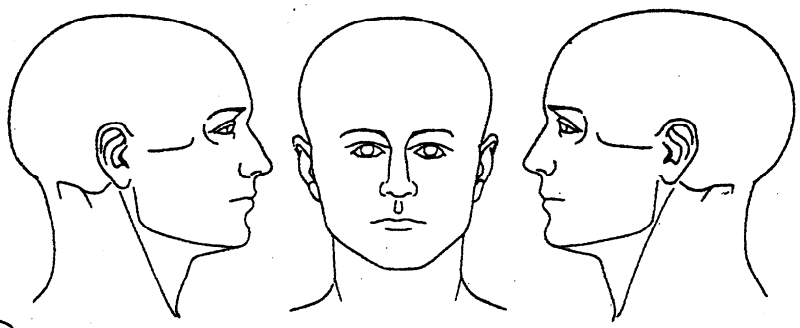
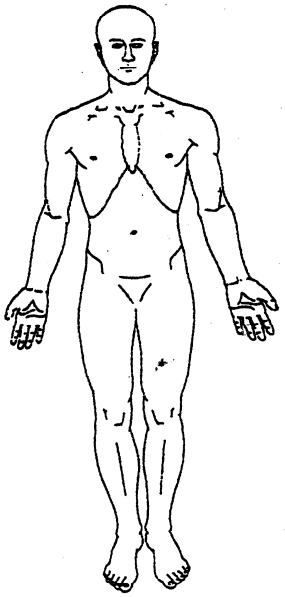
CONFIDENTIAL PATIENT HISTORY



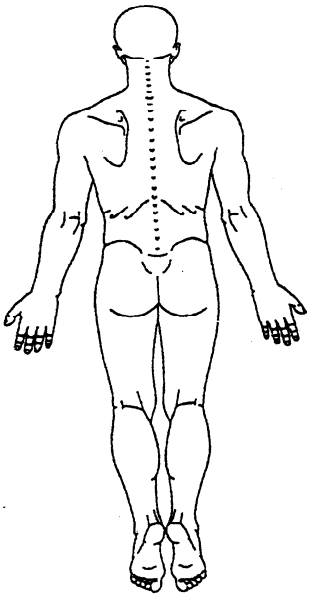


DRAW YOUR PATTERN OF PAIN

Draw the area of most intense pain darkest.

Draw the area of mildest pain lightest.

S-Sharp
B- Burning
D- Dull
T- Tingling
N- Numbness
A- aching



I verify that all information contained within these pages is true and accurate.

_____ _____

Patient's Signature Date

Patient Name: _____ Date: _____

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