

ABOUT THE PATIENT

Name _____
 Address _____
 City _____ State _____ Zip _____
 Home Phone () _____ Birthdate _____
 Age _____ Gender M F Number of Children _____
 Employer _____
 Work Address _____
 Type of Work _____
 Marital Status Married Single Divorced
 Separated Widowed
 Social Security # _____
 Driver's License # _____
 E-mail Address _____

WHO REFERRED YOU?

Name _____
 Relationship _____
 Ad Red Book Yellow Pages AT&T Yellow Pages
 Internet Other _____

PHONE NUMBERS

Cell Phone () _____
 Home Phone () _____
 Work Phone () _____
 In case of emergency, contact:
 Name _____
 Relationship _____
 Home Phone () _____
 Cell Phone () _____

PATIENT CONDITION/ REASON FOR THIS VISIT

Is your condition due to an auto accident work injury Date _____

Primary Complaint _____

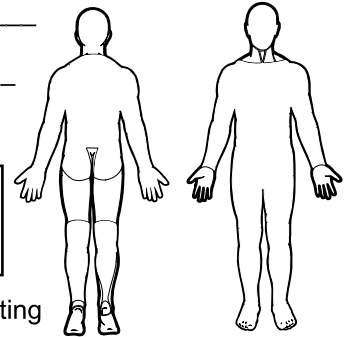
Secondary Complaint _____

How long have you had your symptoms? _____

How did your symptoms begin? _____

Has the condition been getting better no change progressively worse

Mark an X on the body diagram where you continue to have pain, numbness or tingling.



On a scale from 1 (least pain) to 10 (severe pain), rate the severity of your pain today.
 1 2 3 4 5 6 7 8 9 10
 On the scale from 1 to 10, rate the severity of your pain at its best _____ and at its worst _____.

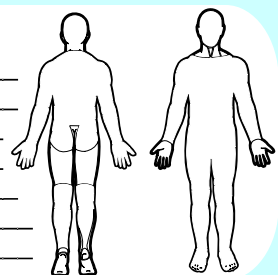
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling
 How often do you have this pain? Constant Comes and goes
 Does it interfere with your Work Sleep Daily Routine Recreation

What makes your pain worse? _____

What makes your pain better? _____

Have you seen anyone for this condition? Yes No Whom? _____

OFFICE USE



PATIENT CONDITION / REASON FOR VISIT CONTINUED

Check the following conditions as they apply to you:

Past What Year?	Now	Condition
		Headaches
		Neck Mid Back Pain
		Low Back Pain
		Sinus / Allergies
		Shoulder / Elbow Pain
		Knee / Ankle / Foot
		Numbness in: arm hand leg foot
		Broken Bones
		Arthritis

Past What Year?	Now	Condition
		Cancer
		Balance Problem
		Thyroid problem
		Heart Attack / Stroke
		Gout
		Serious Depression
		Asthma
		Diabetes
		HIV
		Shingles
		Heart Murmur

MEDICATIONS

Past What Year?	Now	Type of Medication
		Insulin
		Cortisone
		Thyroid Medication
		Blood Pressure Medication
		Blood Thinner
		Muscle Relaxer
		Pain Killers
		Antidepressant
		Antianxiety
		Stimulants

Number of medications / prescriptions I am currently taking _____

FOR WOMEN

Check all that apply:

- Pregnant Nursing
 Taking Birth Control Painful periods
 Breast Implants Irregular periods

SURGERY

Surgery	Yes	No	Year
Tonsils			
Colon			
Hernia			
Appendix			
Gall Bladder			
Stomach			
Heart			
Kidney			
Other			

HEALTH HABITS

- | | | |
|----------------------------|-----------------------------|--|
| Do you smoke? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ packs/day |
| Do you drink alcohol? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ drinks/day |
| Do you drink coffee? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ cups/day |
| Do you exercise regularly? | <input type="checkbox"/> No | <input type="checkbox"/> Moderate <input type="checkbox"/> Daily |

FAMILY HISTORY

- Diabetes Heart Problems / Stroke
 High Blood Pressure Rheumatoid Arthritis
 Cancer _____

EXPERIENCE WITH CHIROPRACTIC

Have you been adjusted by a chiropractor before? Yes No

Reason for those visits? _____

Doctor's Name _____ Approximate date of last visit _____

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that...

- ...Doctors of Chiropractic work with the nervous system? Yes No
 ...the nervous system controls all bodily functions and systems? Yes No
 ...Chiropractic is the largest natural healing profession in the world? Yes No
 ...if Chiropractic care starts at birth, you can achieve a higher level of health throughout life? Yes No

INSURANCE INFORMATION

Do you have insurance that covers chiropractic care? Yes No Not Sure

Primary Insurance Blue Cross United Aetna Cigna Medicare Other _____

Do you have any onther insurance? Yes No What? _____

Please provide the following information if you are not the primary insured.

Insured Name _____ Relationship _____

Insured SS# _____ Policy # _____

Insured Place of Employment _____

Insured Date of Birth _____

Financial Responsibility and Acknowledgement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, HealthSource shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby authorize assignment of my insurance rights and benefits directly to HealthSource Chiropractic & Progressive Rehab for services Rendered.

GOALS FOR MY CARE / AUTHORIZATION TO TREAT

Which form of care do you prefer?

- Relief Care** - Symptomatic relief of pain or discomfort only
- Corrective Care** - Corrective care is what 90% of our patients choose and includes two stages: Relief from your symptoms as soon as possible and stabilization of your condition and correcting the underlying cause so you may reach your full potential for health and wellness.

I, _____, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatments(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff. I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including but not limited to, fractures, disc injuries, strokes, sprains, and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgement during the coarse of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantee or assurances have been made to me concerning the results intended from treatment.

By my signature below, I hereby agree to the above terms and conditions of my care, including the financial responsibility acknowledgment and office policies and authorize HealthSource Chiropractic and Progressive Rehab to treat my condition as deemed appropriate.

Patient / Guardian Signature

Date