Vrzal Chiropractic for your *health* and *vitality*

About You **(confidential)**

Name _____ **Address** _____ **Today's Date** _____
City _____ **State** _____ **Zip** _____
Home# _____ **Work#** _____ **Cell#** _____ **Fax#** _____
Social Security # _____ **Email** _____
Drivers License # _____ **Height** _____ **Weight** _____ **Birth date** _____
Occupation _____ **Employer** _____
Address _____ **City** _____ **State** _____ **Zip** _____
Spouse's Name _____ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated** ☐
or Legal Guardian _____ **Address** _____
Occupation _____ **Cell#** _____ **Home#** _____
Spouses Employer _____ **City** _____ **State** _____
Emergency Contact _____ **Phone #** _____
# of children ____ **At home** _____

Whom may we thank for referring you to our office? _____

Responsible Party **(if other than yourself)**

Name _____ **Social Security #** _____
Home # _____ **Relationship to Patient** _____
Address _____ **City** _____ **State** _____
Method of payment: Cash ☐ **Insurance** ☐ **WorkComp** ☐ **Personal Injury** ☐

Present Chief Complaint

What is your primary reason for your visit today? _____

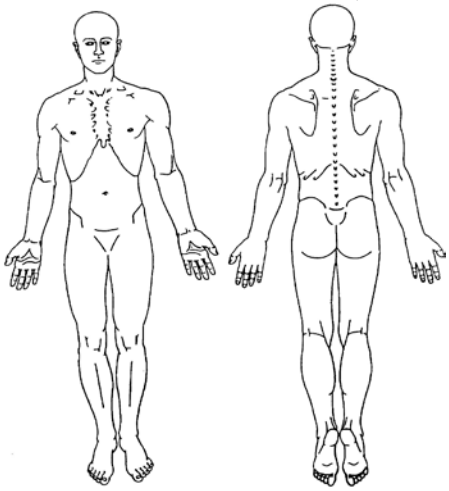
Other health goals 1._____ 2._____ 3._____ 4._____

When did your problem begin? ☐ **Job Injury/Date** _____ ☐ **AutoAcc./Date** _____ ☐ Other/Date_____
Explain how _____
Have you had this problem previously? ☐ **Yes** ☐ **No** **When?** _____
Have you been given a named diagnosis for your condition? Yes ☐ **No** ☐ **Name** _____
Treated by 1. D.C._____ 2. M.D. _____ 3. P.T._____
4. Acupuncture_____ 5. Others_____

(*circle the pain severity level*)

Pain Severity Level 0 1 2 3 4 5 6 7 8 9 10
None Mild Moderate Severe

Please draw your areas of pain



Check P- Prior or C – Currently

P	C	Habits/Exercise
		Smoking
		Alcohol
		Coffee
		Chocolate
		Drugs
		Stretching/Yoga
		Weights
		Cardio Exercise
		Prayer/Meditation

We will review your findings during your second visit, therefore we recommend bringing your spouse to the visit.

Affects on Lifestyle **(check all that apply)**

You
__ Interrupted sleep
__ Moody
__ Uncomfortable/Nervousness
__ Hinders recreational activities
__ Trouble falling asleep
__ Irritable
__ Anxiety

Work
__ Not as productive
__ Hinders decisions
__ Poorer attitude
__ Can't work long hours
__ Other_____
_____
_____

Family
__ Losing patience w/Spouse
__ Losing patience w/Kids
__ Hinders household activities
__ Poorer attitude
__ Other_____
_____
_____

What vitamins, minerals or herbs do you take?_____

_____

List current medications, prescribed or not, used to treat your injury/pain**?**_____

List all other medications_____

_____

Past Medical Injuries

List any significant injuries, surgeries, fractures hospitalizations, major dental work, medical condition	**When**	**Length of treatment?**	**By Whom**	**Treatment**

Family History

Check **Y** **if you have had.** Check **F** **if a family member has had.**

Y	F		Y	F		Y	F		Y	F		Y	F	
		Allergy			Diabetes			Kidney Disease			Polio			Thyroid
		Anemia			Eczema			Lung Disease			Pleurisy			Tonsillitis
		Arthritis			Epilepsy			Mental Illness			Pneumonia			Tuberculosis
		Asthma			Gout			Measles			Rheumatic Fever			Whooping Cough
		Cancer			Heart Disease/Attack			Migraines			Small Pox			Other:_____
		Chicken Pox			Influenza			Mumps			Spinal Disorders			_____

PLEASE READ AND SIGN BELOW

OFFICE POLICIES:

1. **Please be on time for your appointment**. Being late or last minute cancellations will cause severe scheduling disruptions which can interfere with the quality of care and other patients you receive.
2. **Please do not wear strong perfume or colognes**. We see many patients with allergies or respiratory problems. Strong scents can impair their progress.
3. Continued cancellations or missed appointments may result in being released from care. If you need to reschedule, please call at least 24 hours prior to your scheduled appointment.
4. If you need to spend extra time discussing your health concerns with your doctor, please let our staff know, so we may schedule your next appointment accordingly.

FINANCIAL AGREEMENT:

1) We accept the following forms of payment: Cash, personal checks, debit cards, Visa, Discover, Master card, American Express and Amex.
2) Payment is expected at the time of the visit.
3) We will bill primary insurance company for the Initial Intensive Care as courtesy to you.
4) The patient is always responsible for the payment of their care. An insurance contract is between the patient and the insurance company.
5) **Insurance coverage is never guaranteed**. If there are any problems between the insurance company and the patient, the latter may file a grievance directly with their insurance company. The signature below allocates assignment to this office for collection of benefits and also authorizes this office to release daily chart notes when necessary for the processing claims.
6) The office manager may approve account balances. Active monthly payments are required. Accounts with balances 30 days past due may be charged a service fee of 12% per year compounded monthly.
7) Any account where no payment has been received for sixty days may be sent to a third party collection agency. Any additional collection fees will be the responsibility of the patient. NSF checks or rejected credit card payments will be charged a service fee of $25 per occurrence.
8) **We do offer *a time of service discount*** when services are paid in full at the time of the visit.
9) **There is a $35.00 charge for missed massage appointments** (cancellation must be received 24 hours before scheduled appointment)
10) Please feel free to ask us any financial questions you may have. Our intent is to provide you with the highest level of service as well as care.
11) Your insurance company determines benefits when they receive our billings. Any statements made by our staff regarding you coverage in no way or guarantees that your care will be covered by your insurance company and you will be responsible for your account regardless of insurance.

We pray that this begins the best step you've ever taken for your health.

By signing below, I acknowledge that I understand the policies as contained herein.

Patient or guardian: _____ Date: ___/___/_____