HERE FOR GOOD.... NATURALLY!

Name:	Age:	Cell Phone:
Date of Birth:		Work Phone:
E-mail:	Occupation:	
Please circle the best way to contact you.		

1 **Check any of the following symptoms you have experienced in the past six months:**

- ❑ Headaches/Migraines
- ❑ Fatigue
- ❑ Pain/Tension/Numbness:
  - ❑ Neck ❑ Legs
  - ❑ Low Back ❑ Arms
  - ❑ Cold Hands or Feet
- ❑ Insomnia/Sleep Problems
- ❑ Irritability
- ❑ Sinus Problems/Allergies
- ❑ Digestive Trouble:
  - ❑ Constipation ❑ Diarrhea
  - ❑ Gas ❑ Bloating
- ❑ Menstrual Problems
- ❑ Asthma
- ❑ Bladder Problems
- ❑ Ring in Ears
- ❑ Nervousness
- ❑ Dizziness
- ❑ Weight Trouble
- ❑ Stress
- ❑ Anxiety/ Racing Mind
- ❑ Depression

_____

What problem bothers you the most? _____

How long have you been bothered by this condition? _____

Describe how it feels when it's at its worst: _____

2 Does this cause you to be:	**3** Does this affect your work:	**4** Does this affect your life:
❑ Moody	❑ Decision making/productivity	❑ Lose patience with spouse/children or Friends
❑ Irritable	❑ Poor attitude	❑ Restricted household duties
❑ Interrupts sleep	❑ Exhausted at end of day	❑ Hard to Exercise/play sports
❑ Restricts daily Activities	❑ Unable to work long hours	❑ Interferes with hobbies/Other Activities

❑ I would like to make an appointment in the office for a complete evaluation

❑ I would like the doctor to call me to discuss my health problems before making an appointment.

❑ I would like the doctor's office to call me to schedule an appointment.

❑ I have the following health insurance: _____

❑ The best day for me to come in is: **M T W Th F** Best time is: _____

First Name: _____ Last Name: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Age: _____ Birthday: _____ Gender (M) (F) Marital Status: (M) (S) (W) (D)

Spouse's Name (if applicable): _____ Spouse's Phone Number: _____

Emergency Contact Person: _____ Emergency #: _____

Occupation: _____ Employer: _____

Referred By: _____

Insurance Information

Is your condition due to an auto accident or job related injury? (Yes) (No)

Do you have health insurance? (Yes) (No)

If yes... Name of Company: _____ Policy #: _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office, will be credited to my account upon receipt. 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. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I will be paying today by: Cash ( ) Check ( ) Credit Card ( )

Patient's Signature: _____ Date: _____

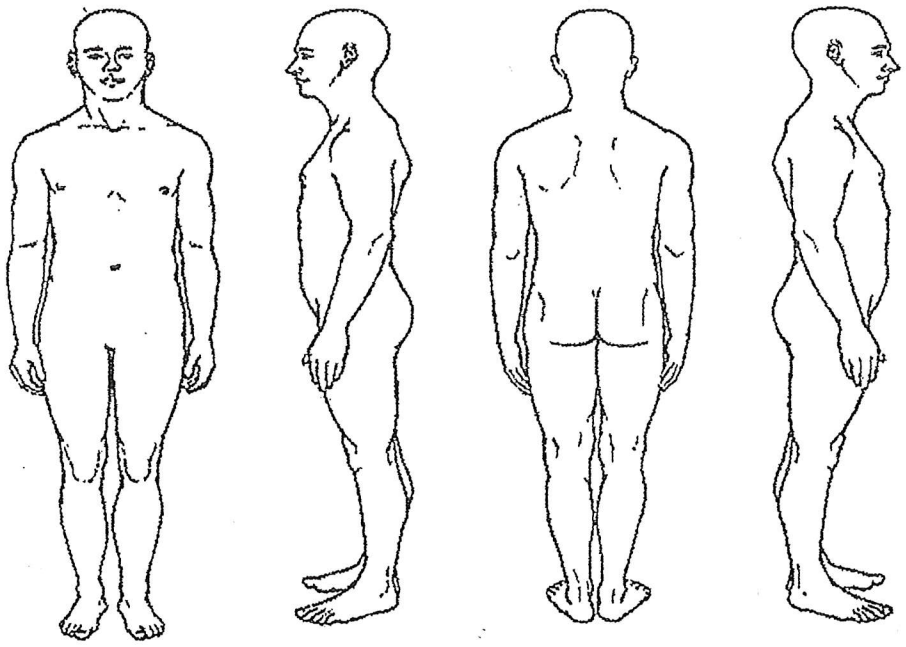
Guardian or Spouse's Signature (if applicable): _____

Doctor's Signature: _____ Date: _____

PAIN DRAWING

Using the descriptive symbols, draw the location of your pain on the body outlines below.
In addition, mark the level of pain you experience on the scale below.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^^	======	oooooo	.....	///////	xxxx



No Pain — Please make a slash through this line as to the level of your pain — Worst Possible Pain

Medical Illness H story: *(Check if you have or have had any of the following)*

	Y	N		Y	N		Y	N		Y	N
Asthma			Emphysema			Gyn. Disorders			Muscular Disease		
Diabetes			Seizures			Prostate Disease			Skin Disease		
Ulcer			Tuberculosis			Cancer			Eye Disease		
Rheumatic Disease			Syphilis			Arthritis			Hearing Defect		
Heart Disease			Abdominal Disorders			Thyroid Disease			Gall Bladder Disease		
High Blood Pressure			Kidney Disorder or Stones			Nervous Disorder			Other		

Review of Symptoms: *(Check if you have or have had any of the following in the past year)*

	Y	N		Y	N		Y	N		Y	N
Headache			Dizziness			Weight Gain/Loss			Stress		
Blurred Vision			Fainting			Palpitations			Muscle Cramps		
Hearing Loss			Vomiting			Loss of Appetite			Numb/Tingling		
Nosebleeds			Constipation			Urine Infection			Neck Pain		
Chest Pain			Diarrhea			Blood in Urine			Back Pain		
Shortness of Breath			Indigestion			Other Urine Issue			Joint Pain (list)		
Frequent Cough			Blood in Stool			Swollen Glands					
Wheezing			Abdomen Pain			Swollen Joints					
Coughing up Blood			Fatigue			Rash					

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Chiroworx Chiropractic & Wellness Studio (CCWS) to use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Chiroworx Chiropractic & Wellness Studio Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Chiroworx Chiropractic & Wellness Studio reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

With this consent form, Chiroworx Chiropractic & Wellness Studio may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminders, insurance items and any calls pertaining to my clinical care including laboratory results, among others.

With this consent form, Chiroworx Chiropractic & Wellness Studio may mail to my home or other alternative location any items that assist in carrying out treatment, payment or healthcare operations such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With this consent form, Chiroworx Chiropractic & Wellness Studio may email to my home or other alternative location any times that assist the practice in carrying out treatment, payments or healthcare operations such as appointment reminders. I have the right to request that restrict how it uses or discloses my PHI to carry out treatments, payments and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting Chiroworx Chiropractic & Wellness Studio use and disclosure of PHI to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Chiroworx Chiropractic & Wellness Studio may decline to provide treatment to me.

_____ _____

Patient Name Date

_____

Signature of the Patient or Legal Guardian

_____

Print Name of Legal Guardian (if applicable)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the **Health Insurance Privacy & Accountability Act of 1996** (HIPPA) I have certain rights to privacy regarding my protected health insurance. I understand that this information can and wil be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that I have reviewed your **Notice of Privacy Practice** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may obtain a current copy of the **Notice of Privacy Practices.**

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do not agree that you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICIAL USE ONLY:

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

ASSIGNMENT AND DIRECT PAYMENT TO DOCTOR OR PRIVATE GROUP

ACCIDENT AND HEALTH INSURANCE

Patient _____

Insurance: _____

Group #: _____

Social Security/State ID #: _____

I hereby instruct and direct my insurance company, Legal representation on Lien agreement, or accident insurance to pay the following provider direct payment for services rendered:

If policy provisions prohibit direct payment to healthcare providers, I hereby request payment for services rendered per current policy provisions. Payment is for the profession or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for profession and services rendered.

Patient's Signature: _____ Date: _____

Attorney's Signature: _____ Date: _____

OFFICIAL USE ONLY

Insurance Carr er: _____ Plan: (POS) (HMO) (EPO) (PPO) (INDEMNITY)

ID #:_____ Policy/Group #:_____ Phone: _____

Effective Date: _____ Deductable: $_____ (Met) (Not Met) Due: _____ Co-Pay: $ _____

Referral Needed: (Yes) (No) % R&C: _____ (w/ Med. Nec.) or (w/o Med. Nec.) Visits per Condition: _____

Physical Therapy: _____ Chiropractic: _____ Max out of Pocket: _____

Benefits: Calendar Year / Lifetime / Maintenance Coverage

Financial Agreement

I, _____, understand that my insurance carrier _____

will cover _____ % of my treatments with the following stipulations: _____

_____

and I am respc nsible for a $_____ deductible. Also, I am responsible for $_____ co-pay/co-insurance per visit which will be collected at each visit, weekly or monthly. I realize that I am ultimately responsible for any unpaid bil s and will contact the office with any changes in coverage.

Patient's Signature: _____ Date: _____