PERSONAL INFORMATION

Date_____ Case#_____
Name (Last)_____ (First)_____
Street Address_____Apt # _____
City_____ State_____
Zip_____
Email_____ Phone (Home/Cell)_____
Sex: M F Date of Birth_____/_____/_____ Social Security #_____-_____-_____
Status: Married Single Widowed Divorced Spouses Name_____# of children_____
Employed: Full Time Part Time Retired Not Employed Student
Occupation_____Employer'sName_____
Address_____
City_____State_____ Zip_____Phone_____
How did you hear about our office?_____ Referred by_____
Emergency Contact:_____ Phone:_____ Relationship_____

HISTORY OF COMPLAINT

What is the primary reason for contacting our office? _____
When did this condition begin? _____
Have you ever had this condition before? YES NO When:_____
Describe the onset of your condition: SUDDEN GRADUAL
Is your condition the result of ANY type of accident? YES NO Type_____
Since it began, has this condition gotten: BETTER WORSE SAME
What is your current pain level? 0 1 2 3 4 5 6 7 8 9 10
What is your pain level at its worst? 0 1 2 3 4 5 6 7 8 9 10
What is your pain level at its best? 0 1 2 3 4 5 6 7 8 9 10
How often do you experience this pain? CONSTANT INTERMITTENT OCCASSIONAL
When does the pain bother you most? MORNING DAY NIGHT
Describe the type of pain: ACHING BURNING DULL NUMB SHARP SHOCK-LIKE SORE THROBBING TINGLING OTHER: _____
Is your pain LOCAL or RADIATING? Where: _____
What aggravates your condition? _____
What relieves your condition? _____
What activities has this condition interfered with: WORK HOME PERSONAL OTHER
Please describe_____
Is there anything else you would like us to know?_____
What other healthcare providers have you seen for this condition?_____
Are you taking any medication for this condition?_____
Have you been under Chiropractic care before? YES NO
Doctor's Name:_____ When was your last visit? _____
Did you follow the Doctors recommendations? YES NO If No, why?_____
Why did you not return to that office?_____
What type of care do you desire?

- □ RELIEF - Symptomatic relief of pain or discomfort.
- □ CORRECTION - Correcting and relieving the cause of the problem as well as the problem
- □ WELLNESS – Achieving and maintaining optimal nerve system function

How committed are you to obtaining such results? 10 9 8 7 6 5 4 3 2 1 0

PAST HEALTH HISTORY

Please list all medications you currently take: _____

Please list all surgeries (with dates): _____

Please list all major accidents or injuries (with dates): _____

PLEASE CIRCLE ALL THAT APPLY:

NEUROLOGICAL
ADD/ADHD
Allergies
Anxiety
Depression
Dizziness/Vertigo
Fainting
Fatigue
Headaches
Irritability
Migraines
Nervousness
Numbness/Tingling
Sleeping Problems
Seizures
Tremors

RESPIRATORY
Asthma
Bronchitis
Chronic Cough
Pneumonia

GENITO-URINARY
Bedwetting
Bladder Infections/Stones
Frequent Urination
Kidney Infections/Stones
Prostate Trouble
Urinary Incontinence

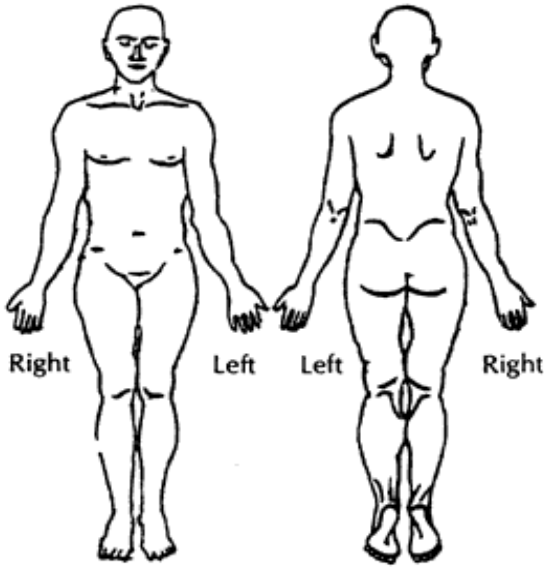
CARDIOVASCULAR
Chest Pain
Heart Attack
High Blood Pressure
Irregular Heartbeat
Low Blood Pressure
Swollen Ankles
Stroke

GASTROINTESTINAL
Acid Reflux
Constipation
Diarrhea
Irritable Bowel
Nausea/Vomiting

EYES, EARS, NOSE, THROAT
Ear Aches/Infections
Hearing Loss
Ringing in Ears
Sinus Infections
Thyroid Dysfunction
Visual Disturbances

FEMALES:
Are you pregnant? Yes No
Date of last period: _____

Please mark the areas of your discomfort



YOU NEED TO KNOW

Chiropractic is NOT a treatment of any condition. It is our ONLY practice obective to detect and correct Vertebral Subluxations and to allow your body to express a higher level of healing.

HEALING TAKES TIME

Consent to care:

I, _____ give my consent to the doctors and staff of TEAM Chiropractic to perform any examinations, x-rays and or adjustments that are deemed necessary for my care.

I, _____ being the parent or legal guardian of: _____ give my consent to the doctors and staff of TEAM Chiropractic to perform any examinations, x-rays and or adjustments that are deemed necessary to care for my child.

Signature: _____ Date: _____

Office Fee Schedule

Service	Insurance	Non-Insurance
Consultation	N/C	N/C
Initial Examination	$125	$100
Re-Examination	$75	$60
X-Rays (2 views)	$80-$150	$64-$120
Spinal Adjustment	$45-$65	$40
Extremity Adjustment	$40	$20

Financial Policy

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered. In effort to serve you best, we offer several different payment options to help reduce any financial burdens your condition may have caused. Please select from the following options that best describes how you intend to pay for your care:

θ **3rd Party Insurance:** Our office is happy to file your claim and accept payment from your insurance carrier as an Out of Network provider. We will verify your benefits and coverage limits and report back to you on your second visit. With the variety of insurance plans please understand that having Chiropractic coverage is not a guarantee of payment by any insurance carrier. You will ultimately be responsible for the cost of your care.

θ **Non-Insurance:** This option fits the majority of our practice members. We have found with the rapid increase of 3rd party deductibles, co-pays, etc. that is more economical and less stressful to offer an administrative discount for all self-pay practice members. Ask about our Budget Billing program to **SAVE AN ADDITIONAL 10%.**

HIPPA Privacy

I give TEAM Chiropractic permission to use or disclose protected health information. This information may be used to contact me with appointment reminders, holiday CARDS, TREATMENT OR OTHER HEALTH RELATED INFORMATION. Team Chiropractic contact me and leave phone messages on my voicemail.
I understand that I will be receiving treatment in an open room where other patients are being treated. I am aware tht it is possible for personal conversations to be overheard by other patients. I understand I may request to speak to the doctor in a private room if needed.
This document does not expire, but I understand that I have the right to revoke it at any time. This request must be placed in writing and submitted to our privacy officer and must include my name, social security number, date of birth and intent to revoke.

Informed Consent for Chiropractic Care

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases complications such as sprain/strain injuries, irritation of a disc condition and minor fractures can occur. One of the rarest complications associated with chiropractic care, occurring at a rate between one instances per one million to one per two million, have been associated with chiropractic adjustments. Prior to receiving chiropractic care from this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition and your overall health. These procedures will assist us in determining if chiropractic care is needed or if any other examinations, studies or referrals to other healthcare providers are needed. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and agree to the *Fee Schedule, Financial Policy, HIPPA Privacy and Informed Consent* of TEAM Chiropractic. I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

_____
(Print name)

_____ _____/_____/_____
Signature Date