Patient Information

Date ___/___/___

Patient Name (last, first) ____ Sex: Male / Female

Home Phone # (_______)_______________________ Cell Phone # (_______)____________________

E-Mail Address ____

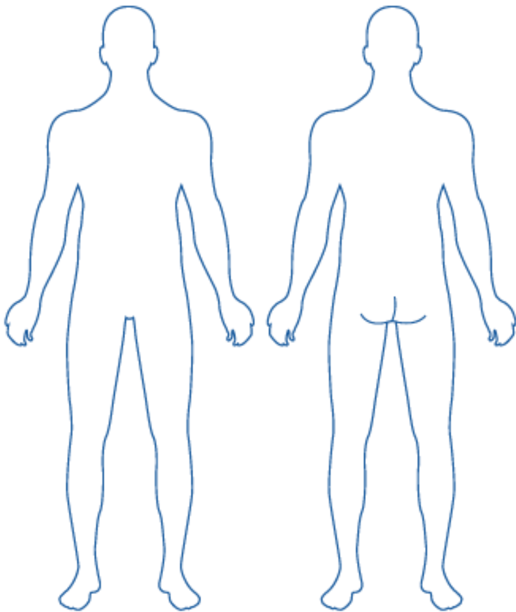
Address ________________________________ City ____________________ State _______ Zip Code ________

Date of Birth ____/____/____ Age ________ Occupation ____

Who Referred You To Our Clinic? ____

Using the symbols below, mark on the body the areas where you feel that particular sensation.

Numbness	Pins & Needles	Burning	Aching	Sharp/Stabbing
//////	+++++	00000	XXXXX	*******



PLEASE CIRCLE YOUR LEVEL OF PAIN: (1 = Minimal Pain; 10= Worst Pain Imaginable)
PAIN CURRENTLY 1 2 3 4 5 6 7 8 9 10
PAIN AT ITS WORST 1 2 3 4 5 6 7 8 9 10
PAIN TYPICALLY 1 2 3 4 5 6 7 8 9 10

Reason for Appointment:____

____

When did this begin?_________________________ Has it happened before? When? ____________________

How did this occur?____

Since it began, has it: Improved Worsened Unchanged

What have you done for this condition? ____

Name ____________________

Date ________

Who have you seen for this condition? ____

Can you perform your daily home activities? Yes Yes, only with help Not at all

Can you perform your daily work activities? All activities Only some Not at all

Describe your stress level: None Mild Moderate High

Do you exercise? Daily Occasionally Not at all

Please list any previous surgeries, hospitalizations, injuries (motor vehicle accidents):______________________

____

Have you had any fractures or dislocations? ____

Have you had previous chiropractic care? Yes No Doctor:_________________ Date:_________

What do you hope to achieve from this visit? Circle all that apply.

Pain relief Nutritional consultation Performance enhancement

Does you pain increase at night? Yes No

Have you had any unexplained weight loss? Yes No

Have you or a family member ever been diagnosed with the following:

	Arthritis or osteoporosis	Cancer (where?)	Diabetes	Heart Disease or Stroke	Kidney Disease	Neurologic Disease	Thyroid Disease
Father							
Mother							
Brother/Sister							
Grandparents							

Have you ever experienced the following conditions?

Whiplash injury (cervical sprain) Yes No Date__________

Were you ever a smoker? Yes No From________To________

Visual disturbances? (blur, loss, double) Yes No

Hearing disturbances? (loss, ringing) Yes No

Slurred speech or other speech problems Yes No

Difficulty swallowing Yes No

Name ____________________

Date ________

Dizziness	Yes	No
Loss of consciousness/blackouts	Yes	No
Numbness, loss of sensation, strength/weakness	Yes	No
Sudden collapse without loss of consciousness	Yes	No

Review of Systems:

Please write in a number: 1. PRESENTLY HAVE 2. PREVIOUSLY HAD 3. RELATED TO CONDITION

General
___Allergy
___Chills
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Sleep loss
___Weight loss/gain
___Nervousness/depression
___Neuralgia (nerve pain)
___Numbness
___Sweats
___Tremors
___Anxiety/Depression

Eyes, Ears, Nose, Throat
___Asthma
___Colds
___Sore throat
___Deafness
___Dental decay
___Earache/ringing
___Ear discharge
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose bleeds
___Failing vision
___Far sighted
___Near sighted
___Gum trouble
___Hoarseness
___Nasal obstruction

Musculoskeletal
___Arthritis
___Bursitis
___Hernia
___Low back pain
___Mid back pain
___Neck pain/stiffness
___Numbness/pain down
the arms or butt/legs
___Arm pain
___Shoulder pain
___Leg pain
___Knee pain
___Foot pain
___Sciatica
___Spinal curvature
___Fractures

Genito-urinary
___Bedwetting
___Blood in urine
___Frequent urination
___Inability to control
bladder
___Kidney infection/stones
___Painful urination
___Prostate issues
___Pus in urine

Women Only
___Painful menstruation
___Hot flashes
___Irregular cycle
___Lumps in breast
___Vaginal/nipple discharge
___Birth control pills
___Pregnancy complications

Cardiovascular
___High blood pressure
___Low blood pressure
___Heart disease
___Pain over heart
___Rapid heart rate
___Slow heart rate
___Poor circulation
___Swelling of ankles

Respiratory
___Chest pain
___Chronic cough
___Difficulty breathing
___Spitting up blood
___Spitting up phlegm
___Wheezing

Gastrointestinal
___Belching or gas
___Abdominal pain
___Constipation
___Diarrhea
___Difficult digestion
___Poor appetite
___Ulcers
___Vomiting
___Vomiting blood
___Abdominal bloating
___Excessive hunger
___Heartburn/reflux
___Hemorrhoids
___Jaundice/liver issues
___Nausea
___Gallbladder issues
___Colitis
___Irritable bowel syndrome

Name ____________________

Date ________

Current Medication: Please list the name and dosage, if possible.

(**Include all vitamins/supplements and over-the-counter medications.)**

1. ______________________________ 4. ______________________________

2. ______________________________ 5. ______________________________

3. ______________________________ 6. ______________________________

7. ______________________________ 8. ______________________________

9. ______________________________ 10. ______________________________

Allergies (medication, food, other substances): ______________________________

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WRITTEN CONSENT TO NOTIFY FAMILY PHYSICIAN OF CHIROPRACTIC CARE

At Banning Family Chiropractic, we strive to maintain open communication and professional relationships with other health care providers. In order to provide updates to your family doctor regarding your care, we need to obtain written consent from you as our patient

Family Physician's Name: ______________________________ **Phone: (______)**________________`__

Patient Signature: ______________________ **Patient Name:** ______________________

(Please Print)

Date: ___/___/___

Name ____________________ Date ________

Insurance Verification (please bring insurance card to your appointment so it can be scanned)

Insurance Company: ______________ Insurance ID: ______________________ Group #: _______________
Patient's DOB: ____________________ Card Holder's Name: ______________ Relationship: ___________
Deductible Per Year: __$___________ Amount Met: __$_________________ Co-payment: _$__________
Co-insurance: ______________%_____

Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully. If you have any questions, do not hesitate to ask.

Appointments

1. We value the time we have set aside to see and treat you. If you are not able to keep an appointment, we would appreciate 24-hour notice prior to your scheduled appointment. A late fee of $20 may be charged at doctor's discretion.
2. If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.

Financial Responsibility

1. According to your treatment/membership plan, you are responsible for all balances accrued. Your co-payment, co-insurance and unmet deductible may be collected at the time of service.
2. Patient has three months to make a payment on accrued/accruing balance. If no payment has been made on balance after 3 months, physician has the right to file patient with a collection agency. Patient is responsible for all costs and expenses of collection including, but not limited to our reasonable attorneys' fees.
3. We accept cash, checks, Visa, MasterCard, and Discover credit and debit cards.
4. A $20 fee will be charged for any checks returned for insufficient funds.

Assignment of Benefits

I hereby instruct and direct myself, to pay by credit card, cash, or check made out to Banning Family Chiropractic for the professional or medical services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner any balance of said professional service charges.

1: A photocopy of this assignment shall be considered as effective and valid as the original;

2: I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case;

3: I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I have read and understand Banning Family Chiropractic's financial policy, cancellation/ late policy, as well as the assignment of benefits. I agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name: ____

Patient Signature: __________________________ Today's Date:__________________________

Name ____________________ Date ________

Patient Name: ______________________ **Date:** ________________

T e r m s o f A c c e p t a n c e

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you. Please read the below and if you have any questions please feel free to ask.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **Banning Family Chiropractic**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, __________________________ being the parent or legal guardian of ________________________, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: ____

Children: ____

Others: ____

No one: ___

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: ____

Signature: ____________________________________ Date: _______________________