Patient's Full Name: _____ **Age:**_____ **Sex:** _____ **Date:** _____
Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
E-Mail Address:_____ **Date of Birth:** ____/____/_____ ☐ Male ☐ Female
Patient Social Security #: _____-____-_____ **Social Security # of Primary Insured:** _____-____-_____

Occupation: _____ Employer: _____
Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Unemployed

Who may we thank for referring you? ☐ Friend ☐ Relative ☐ Physician ☐ Website ☐ Race ☐ Other_____
_____

☐ *Married* (Spouse's Name: _____) ☐ *Single* ☐ *Widowed* ☐ *Divorced* ☐ *Separated*
Race (check only 1) ☐ *American Indian* ☐ *Asian* ☐ *Alaska Native* ☐ *White* ☐ *Black or African American*
☐ *Native Hawaiian* ☐ *Other Pacific Islander* ☐ *Decline to State*
Ethnicity (check only 1) ☐ *Decline to State* ☐ *Hispanic or Latino* ☐ *Not Hispanic or Latino*
Smoking Status (check only 1) ☐ *Current Everyday Smoker* ☐ *Current Some Day Smoker* ☐ *Former Smoker* ☐ *Never Smoker*
Smoking Start Date: _____ End Date: _____ In effort to quit smoking, I am currently taking: _____
Preferred Language: _____ **HEIGHT:** ____ft ____ in **WEIGHT:** _____ pounds

What medications are you currently taking? _____
_____
Do you have any allergies to medication? ☐ Yes ☐ No
Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____
Start/End Date: _____/_____ Start/End Date: _____/_____
Are you currently taking any anti-coagulant or blood thinning medication? ☐ Yes ☐ No
Please describe any family history of:
Cancer: _____Diabetes (I or II):_____Stroke:_____
High Blood Pressure: _____Back Pain/Disc Problem:_____Headache_____
Migraines:_____Allergies:_____Arthritis::_____
Scoliosis:_____

Family Physician/Internist: _____ City/State:_____ Phone: _____
May we share your information in our patient records with your above listed physician for integrated care? ☐ YES ☐ NO

Have you had previous Chiropractic Care: ☐ Yes ☐ No *If yes, for what problem?*_____
Doctor's Name: _____ City/State: _____

We offer many types of care in our office. What type of care are you interested in?
☐ Spinal Pain Relief ☐ Non-Spinal Pain Relief (i.e. knee, shoulder) ☐ Graston ☐ Massage Therapy

Is today's visit due to a work related injury? ☐ Yes ☐ No Date of Injury: _____
Is today's visit due to an auto accident? ☐ Yes ☐ No Date of Injury: _____
(If yes to either question above, please check with receptionist, additional information may be needed)

INSURANCE INFORMATION: ***(If we have a copy of your insurance card(s), you may skip this section)***
Primary Insurance Company: _____ ID #: _____
Group #: _____ Insured Name: _____ DOB: ____/____/_____
Employer: _____ Relation to Insured: _____

Secondary Insurance Company: _____ ID #: _____
Group #: _____ Insured Name: _____ DOB: ____/____/_____
Employer: _____ Relation to Insured: _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

West County Spine & Joint
Chiropractic Clinic

Dear Patient: ***Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you, and where to focus your examination. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU!***

In general, would you say your health is (check one): ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

PAST HEALTH HISTORY:

1. Have you ever experienced your present problem you are consulting us for previously? ☐ Yes ☐ No
   If yes, when? _____
   Was treatment provided? ☐ Yes ☐ No If yes, by whom: _____ Outcome:_____
2. Have you ever had a **stroke** or issues with **blood clotting**? ☐ Yes ☐ No If yes, when? _____
3. Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? ☐ Yes ☐ No
   If yes, when? _____
4. Have you ever had any major illnesses, injuries, broken bones, hospitalizations, car accidents, or surgeries?

Date	Injury/Fracture/Illness/Accident/Surgery	Treatment	Results

SYSTEMS REVIEW QUESTIONS:

Do you, or have you ever, had any problems with the following areas? (Please mark Y for yes or N for no:)

1. _____ Eyes
2. _____ Ears, Nose, Mouth, Throat
3. _____ Heart
4. _____ Lungs/Breathing
5. _____ Intestines/Bowels
6. _____ Urinary
7. _____ Muscles
8. _____ Nerves
9. _____ Joints/Bones
10. _____ Skin
11. _____ Internal Organs
12. _____ Blood
13. _____ Allergies
14. _____ Psychological/Emotional
15. _____ Eating Disorder

For Females Only:

16. _____ Gynecological/Menstrual
17. _____ Breast

For Males Only:

18. _____ Prostate/Testicular/Penile

Please explain any of the above YES answers:

_____

_____

Social History:

Recreational Activities/Hobbies: _____

Have these activities been limited by your pain? If yes, describe: _____

Yes	No	
☐	☐	Do you exercise? _____ times/week
☐	☐	Do you smoke/use tobacco? _____ packs/day (*If you have quit smoking, when did you quit?* _____)
☐	☐	Do you consume alcohol? How many drinks per week? _____
☐	☐	Do you eat a balanced diet? If no, explain: _____
☐	☐	Do you get adequate sleep? How many hours per night:_____
☐	☐	Is work stressful to you? If yes, explain: _____
☐	☐	Is family life stressful to you? If yes, explain: _____
☐	☐	Do you use recreational drugs? If yes, explain: _____
☐	☐	Do you drink enough water daily? How much water do you drink per day? _____oz/day
☐	☐	Do you consume caffeine? How much? _____oz/day

Are you training or working towards for a specific race, event and/or goal? Please describe: _____

_____

_____

West County Spine & Joint
Chiropractic Clinic

PLEASE ANSWER ALL QUESTIONS BELOW:

What problem brings you to us today? _____

When did your symptoms begin? _____

Have you had this problem before? ☐ Yes ☐ No Explain: _____

Have you received treatment from another professional for this condition? Please explain: _____

_____

Was the onset: ☐ Gradual ☐ Sudden Since its onset, pain has gotten: ☐ Better ☐ Worse ☐ No Change

Please describe what caused the pain: _____

What aggravates this condition? _____

What decreases the symptoms/pain? _____

Does this pain interfere with your sleep? ☐ Yes ☐ No

Is your pain worse in the: ☐ AM ☐ PM ☐ Constant ☐ With Activity: _____

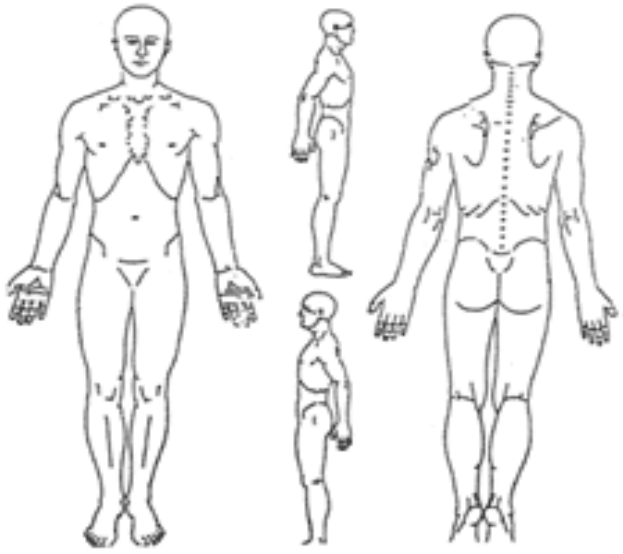
Have you detected any possible relationship of your current complaint with any of the following:
☐ Muscle Weakness ☐ Bowel/Bladder problems ☐ Digestion ☐ Cardiac/Respiratory ☐ Other: _____

Are you currently pregnant? ☐ Yes ☐ No

PAIN CHART:

Please mark areas of pain using these codes:

+++ Burning
Dull/Ache
***** Numbness/Tingling**
=== Throbbing
ooo Sharp/Stabbing



SEVERITY OF PAIN:
Please list area of pain & write a number 1-10 which represents the intensity of your pain (1= minor pain, 10=unbearable):

1. Complaint: _____ At worst: ____/10 At best: ____/10 Typical: ____/10
2. Complaint: _____ At worst: ____/10 At best: ____/10 Typical: ____/10
3. Complaint: _____ At worst: ____/10 At best: ____/10 Typical: ____/10

Do you require special care, or have any concerns that might affect your treatment or recovery? _____

_____

OUR MISSION STATEMENT

Our MISSION is to provide the best care possible to every patient which is accomplished by supporting our staff and providers in every way possible to allow them to practice efficiently and dedicate their time to the individual needs of the patient.

INFORMED CONSENT

I understand this Facility, its doctors & staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctor's care, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change occur.

I further understand that in the practice of medicine, chiropractic, massage therapy, weight loss counseling and physical therapy there are some risks including but not limited to fractures, disc injuries, strokes, dislocations, sprain-strains, drug interactions & reactions and/or other injuries or side effects which cannot be predetermined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or other complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

Patients have the right to refuse treatment, but must be aware of the probably consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Therefore I give my full consent to the doctor/provider to render treatment on me or the minor whom I am legally responsible by a health care provider of this Facility.

ASSIGNMENT OF BENEFITS- AUTHORIZATION AND LEIN

I, the assignee, being the patient or legal guardian for the said minor listed below, do herby irrevocable authorize, direct, assign and give full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any and all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I, the assignee, further authorize any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any and all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any and all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits.

Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse and/or sign my name on any and all checks for payment of any indebtedness owed this office & assignee.

INSURANCE BENEFITS- CREDIT POLICIES- PAYMENT TERMS & CONDTIONS

1. As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers mis-quote benefits, coverage, and liability. Our Facility and staff are not responsible for what third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.
2. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in additional filing medical report charge which you are responsible to pay.
3. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
4. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
5. All account balances, including automobile and work injury claims must be pain in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90 day period, the patient must pay the balance in full. Assignee if fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
6. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchase, vitamins, supplements, ointments, acupuncture treatments, weight loss programs and massage therapy.
7. A service charge is computed by a "periodic rate" of 1 ½% per month- 18% per annum and is added to all balances owed 60+ days. Any balance past due 90 days or more will be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, costs related to but not limited to all collection related expenses, attorney fees, court & filing fee's.
8. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge.

I understand & agree to the above statements. Any questions I have had regarding the above have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

_____ _____

Signature **Date**

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20____

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

I furthermore hereby authorize West County Spine & Joint to release my medical information to the following person(s)/entities:

_____
_____
_____
_____

_____ _____ _____
Patient **ID** **Date**