

**PATIENT INFORMATION**

**WELCOME TO OUR OFFICE!**

DATE: \_\_\_\_\_ PATIENT NAME: \_\_\_\_\_

SS#: \_\_\_\_\_ PHONE (BEST # TO REACH YOU): \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ OK TO SEND CLASS / OTHER INFO TO EMAIL: YES / NO

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SEX: \_\_\_\_M \_\_\_\_F BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_

PATIENT EMPLOYED BY: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_

BUSINESS PHONE: \_\_\_\_\_

TYPE OF CASE:  
\_\_\_\_CHRONIC/NEW ONSET OF CONDITION \_\_\_\_WELLNESS \_\_\_\_WORKMAN'S COMP. \_\_\_\_AUTO ACCIDENT

REFERRED TO THIS OFFICE BY:  
\_\_\_\_INSURANCE CARRIER \_\_\_\_OUR WEBSITE  
\_\_\_\_REFERRAL (PLEASE LIST REFERRAL NAME SO WE CAN THANK THEM) \_\_\_\_\_  
\_\_\_\_OTHER ADVERTISING \_\_\_\_\_  
\_\_\_\_DRIVE BY

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?  
\_\_\_\_\_ PHONE: \_\_\_\_\_

OKAY TO CALL THE ABOVE PHONE NUMBER TO LEAVE MESSAGES ABOUT YOUR APPOINTMENTS? \_\_\_\_YES \_\_\_\_NO

**PRIMARY INSURANCE**

RESPONSIBLE PARTY NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ PHONE: \_\_\_\_\_

GROUP/POLICY#: \_\_\_\_\_ SUBSCRIBER ID#: \_\_\_\_\_



## ABOUT YOUR CONDITION

WHAT IS YOUR CURRENT WEIGHT: \_\_\_\_\_ LBS. HEIGHT: \_\_\_\_\_ FT. \_\_\_\_\_ IN.

PLEASE DESCRIBE YOUR CONDITION: Date Condition Began \_\_\_\_/\_\_\_\_/\_\_\_\_

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WHAT IS YOUR LEVEL OF PAIN TODAY? (Scale of 1-10; 10 being severe): \_\_\_\_\_

IS THIS CONDITION GETTING WORSE? \_\_\_\_ YES \_\_\_\_ NO \_\_\_\_ CONSTANT \_\_\_\_ COMES & GOES

IS THIS CONDITION INTERFERING WITH YOUR (Please circle): \_\_\_\_ WORK \_\_\_\_ SLEEP \_\_\_\_ DAILY ROUTINE

IF SO, PLEASE EXPLAIN:

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HAVE YOU HAD THIS OR SIMILAR CONDITIONS IN THE PAST? \_\_\_\_ YES \_\_\_\_ NO

IF SO, PLEASE EXPLAIN:

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ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

\_\_\_\_ NERVE PILLS \_\_\_\_ PAIN KILLERS (including aspirin) \_\_\_\_ MUSCLE RELAXERS \_\_\_\_ STIMULANTS

\_\_\_\_ BLOOD THINNERS \_\_\_\_ TRANQUILIZERS \_\_\_\_ INSULIN

\_\_\_\_ OTHER(S) \_\_\_\_\_

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PLEASE LIST ANY OTHER SERIOUS MEDICAL CONDITION(S) YOU HAVE OR EVER HAD:

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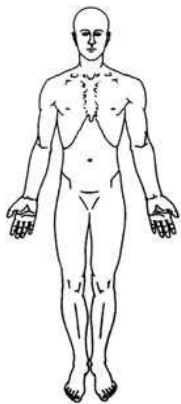
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LIST ANY PAST SERIOUS ACCIDENTS (with dates):

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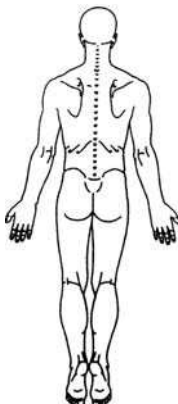
### PLEASE MARK AREA(S) OF INJURY OR DISCOMFORT AS SHOWN BELOW IN THE KEY



FRONT



RIGHT



BACK



LEFT

<b>Pain</b> X X X X
<b>Numbness</b> * * * *
<b>Pins &amp; Needles</b> o o o o
<b>Burning</b> ^ ^ ^ ^
<b>Aching</b> A A A A
<b>Stabbing</b> • • • •

## GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much pain presently prevents you from doing what you would normally do. Please indicate the overall impact your present pain has on your life, not just when pain is at its worst.

Please circle the number which best describes how your typical level of pain affects these six categories of activities.

1. Family / At-home responsibilities such as yard work, chores, driving the kids to school, etc.

    0    1    2    3    4    5    6    7    8    9    10  
Completely Able to function Totally Unable to function

2. Recreation including hobbies, sports or other leisure activities.

    0    1    2    3    4    5    6    7    8    9    10  
Completely Able to function Totally Unable to function  
function

3. Employment including volunteer work and homemaking tasks.

    0    1    2    3    4    5    6    7    8    9    10  
Completely Able to function Totally Unable to function

4. Self care such as taking a shower, driving or getting dressed.

    0    1    2    3    4    5    6    7    8    9    10  
Completely Able to function Totally Unable to function

5. Life support activities such as eating and sleeping

    0    1    2    3    4    5    6    7    8    9    10  
Completely Able to function Totally Unable to function

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Score: \_\_\_\_\_

Benchmark: . = 5 \_\_\_\_\_

**MEDICAL FAMILY HISTORY**

Circle S = Self, M = Mother, F = Father

- |                             |                          |
|-----------------------------|--------------------------|
| Aids S M F                  | HIV/ARC S M F            |
| Anemia S M F                | Kidney disorder S M F    |
| Arthritis S M F             | Bowel control loss S M F |
| Asthma S M F                | Menstrual cramps S M F   |
| Back pain S M F             | Multiple sclerosis S M F |
| Bladder trouble S M F       | Muscular dystrophy S M F |
| Bone fracture S M F         | neck pain S M F          |
| Cancer S M F                | Nervousness S M F        |
| Chest pain S M F            | Numbness S M F           |
| Concussion S M F            | Polio S M F              |
| Convulsions S M F           | Poor circulation S M F   |
| Diabetes S M F              | Hepatitis S M F          |
| Indigestion S M F           | Rheumatic fever S M F    |
| Dislocated joints S M F     | Scarlet fever S M F      |
| Epilepsy S M F              | Serious injury S M F     |
| German measles S M F        | Sinus trouble S M F      |
| Headaches S M F             | Stroke S M F             |
| Heart Trouble S M F         | Tuberculosis S M F       |
| Reproductive Disorder S M F | Venereal disease S M F   |
| High blood pressure S M F   |                          |

Have you been treated by a physician for any health condition in the last year?    Yes    No

Describe condition \_\_\_\_\_

Date of Last Physical Exam \_\_\_\_\_

**SURGICAL HISTORY**

- |          |             |
|----------|-------------|
| 1. _____ | Date: _____ |
| 2. _____ | Date: _____ |
| 3. _____ | Date: _____ |

Have you ever had a metal implant?    Yes    No

**ACCIDENT HISTORY**

- |          |      |      |       |             |
|----------|------|------|-------|-------------|
| 1. _____ | Work | Auto | Other | Date: _____ |
| 2. _____ | Work | Auto | Other | Date: _____ |
| 3. _____ | Work | Auto | Other | Date: _____ |

# FINANCIAL POLICY

## EXPLANATION OF INSURANCE COVERAGE

Many insurance policies do cover chiropractic care but **this office makes no representation that yours does**. Insurance policies may vary greatly in terms of deductible and percentage of coverage for chiropractic care. Because of the variance from one insurance policy to another, **we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office**. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner as a courtesy to you.

\*We do not guarantee that insurance quotes obtained directly from your insurance carrier are accurate and will pay as stated to us either via phone or via their website. Please call your carrier in order to receive a quote in regards to Chiropractic Coverage. **(Deductibles, Coinsurance, Maximum Dollar Amounts, Co Pays and Visit Limits often apply)**. Most common codes used are: 98941, 97140, G0283.

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I understand that I am financially responsible to Back to Health for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

### Payment Policy:

- All co pays, are due at time of service.
- Your portion of any services is due at time of service – re: 10, 20% co insurance.
- All point of service fees (cash only patients) are due at time of service.
- Statements will be sent one time a month. Services not paid by insurance are due at the time of the statement; otherwise, there will be a 9% service charge on accounts 60 days past due.

### Voluntary Termination of Care:

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office.

### Collections:

If your account is sent to collections, you will be responsible for all service charges, collections fees added by the collections agency, and/or legal fees and court costs.

### I have read and agree to the above:

**X** \_\_\_\_\_  
Patient (or responsible party) Signature

\_\_\_\_\_  
Date