

# STEWART CHIROPRACTIC

## ALL NATURAL FAMILY CLINIC

Dear Patient,

WELCOME TO OUR OFFICE!! We want you to know that we will do whatever we can to make your visits here as easy as possible.

We will do our best to take you at your appointed time. We know that your time is valuable. There may be days where delays might occur. However, we do promise that you will receive our undivided attention when it is your turn.

Your fees for treatment and therapy depends solely on the extent of your condition. You will be told that fees at the time of your consultation.

For those patients who do not have insurance, payment in full is required at time of service.

For those patients with an insurance plan, we will be happy to complete the necessary forms and submit them to the insurance company. You must bring forms to this office by the second visit. Please keep in mind most insurance plans will cover only a portion of your charges.

### **IN ALL CASES YOU THE PATIENT ARE RESPONSIBLE FOR PAYMENT**

We trust that all of this information is clear. Should you have any questions please feel free to ask for clarification.

Dr. Kevin L. Stewart, D.C.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY

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Patient Signature

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Date

# STEWART CHIROPRACTIC

## ADVANCED BACK & SPORTS INJURY CLINIC

### TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alternation of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we may recommend that you seek the services of another health care provider.

OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our procedures are specific in correcting vertebral subluxations.

I, \_\_\_\_\_ have read and fully understand the above statements.

All my questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore accept chiropractic care on this basis.

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)

Consent to evaluate and adjust a minor child

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.

# STEWART CHIROPRACTIC

DR. KEVIN L. STEWART D.C. ♦ ADVANCED BACK & SPORTS INJURY CLINIC & YOGA CENTER

1420 W. Kettleman Lane Suite K-1 Lodi, Ca 95242 **Phone** (209) 368-0619 **Fax** (209) 334-6779

**Email** drk@bestyoucanfeel.com

Patient Name \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: M / F SSN \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone ( ) \_\_\_\_\_ Primary Language \_\_\_\_\_ Ethnicity \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Health Plan \_\_\_\_\_ Subscriber Name \_\_\_\_\_  
Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_ Spouse Name \_\_\_\_\_  
Primary Care Physician Name \_\_\_\_\_ PCP Phone \_\_\_\_\_

## MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

### DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

- HEADACHES  NECK PAIN  MID BACK PAIN  LOW BACK PAIN  
 OTHER \_\_\_\_\_

Is this:  Work Related  Auto Related  N/A

Date Problem Began \_\_\_\_\_

How Problem Began \_\_\_\_\_

Current Complain (how you feel today):										
0	1	2	3	4	5	6	7	8	9	10

How often are your symptoms present?

(Occasional)  0-25%  26-50%  51-75%  76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities or household)

| \_\_\_\_\_ |  
(No interference) 0 1 2 3 4 5 6 7 8 9 10 (Unable to carry on any activities)

In general would you say your overall health right now is:  Excellent  Very good  Good  Fair  Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT?  NO  YES

Date(s) taken \_\_\_\_\_ What areas were taken? \_\_\_\_\_

### Please check all of the following that apply to you:

- |   |  |
|---|--|
| <input type="checkbox"/> Alcohol/Drug Dependence                          | <input type="checkbox"/> Prostate Problems   |
| <input type="checkbox"/> Recent Fever                                     | <input type="checkbox"/> Menstrual Problems  |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Urinary Problems  |
| <input type="checkbox"/> High Blood Pressure                              | <input type="checkbox"/> Currently Pregnant, # Weeks _____   |
| <input type="checkbox"/> Stroke (Date) _____                              | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Corticosteroid Use (Cortisone, Prednisone, etc.) | <input type="checkbox"/> Marked Morning Pain/Stiffness   |
| <input type="checkbox"/> Birth Control Pills                              | <input type="checkbox"/> Pain Unrelieved by position/rest  |
| <input type="checkbox"/> Dizziness/Fainting                               | <input type="checkbox"/> Pain at night   |
| <input type="checkbox"/> Numbness in Groin/Buttocks                       | <input type="checkbox"/> Visual Disturbances   |
| <input type="checkbox"/> Cancer/Tumor (Explain) _____                     | <input type="checkbox"/> Surgeries _____   |
| <input type="checkbox"/> Osteoporosis                                     | <input type="checkbox"/> Tobacco Use – Type _____  |
| <input type="checkbox"/> Epilepsy/Seizures                                | <input type="checkbox"/> Frequency _____/Day   |
| <input type="checkbox"/> Other Health Problems (Explain) _____            | <input type="checkbox"/> Medications _____   |

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Family History:**  Cancer  Diabetes  High Blood Pressure  Heart Problems/Stroke  Rheumatoid Arthritis

**EXERCISE:**  NONE  MODERATE  DAILY  HEAVY

**WORK ACTIVITY:**  SITTING  STANDING  LIGHT LABOR  HEAVY LABOR

**HABITS:**  COFFEE/CAFFEINE DRINKS or CUPS/DAY \_\_\_\_\_  ALCOHOL DRINKS/WEEK \_\_\_\_\_

HIGH STRESS LEVEL REASON \_\_\_\_\_

ALLERGIES \_\_\_\_\_

VITAMINS/HERBS/MINERALS \_\_\_\_\_

**Email Address** \_\_\_\_\_

**Referred By** \_\_\_\_\_

I agree to pay at the end of each visit, unless other arrangements are approved. This office will gladly prepare medical claim forms, but we cannot render services on the assumption that our charges will be paid by an insurance company. You are responsible for payment whether or not paid by insurance.

**Patient/Parents Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**ASSIGNMENT OF BENEFITS AND POWER OF ATTORNEY TO CASH CHECKS**

I, the undersigned, do hereby authorize payment directly to the office below, the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. If these payments are made out to me I grant unto the office below as attorney the full power and authority in my name and stead to endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid.

**Patient/Parents Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**PATIENT'S AFFIRMATION OF RECEIPT OF PATIENT'S STATEMENT OF PRIVACY RIGHTS**

I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with law and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Affirmed,  
**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_