ASH
Chiropractic & Wellness

NUTRITIONAL PATIENT REGISTRATION

Patient Name _____ Referred by _____
DOB: _____ Age _____ Sex: □M □F Height _____ Weight _____
Address _____
Home Phone _____Work Phone _____
Cell Phone _____ Cell Phone Provider _____
E-mail address: _____
Occupation _____ Employer _____
Marital Status □ S □ M □ D □ W Name of Spouse _____
Describe health of spouse _____ Number of children if any _____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	___	M/F	_____
_____	___	M/F	_____
_____	___	M/F	_____

Overall health (circle one) □ Excellent □ Good □ Fair □ Poor □ Other _____
Chief complaint (reason you are here) _____
_____
_____
Previous treatments for this complaint _____
_____
Other complaints or problems _____
_____
Do you smoke, drink coffee, alcohol or use recreational drugs? □ Yes □ No
(if yes indicate how much)
Cigarettes _____ Coffee _____ Alcohol _____
Any household pets or other animals you or family members are in close contact with
_____

Diet History

Are you following a special diet presently? □ Yes □ No
If yes, what is it, and for how long? _____
_____
How many meals do you eat per day? _____
What kind of beverages do you drink with or between meals? _____
_____
How often do you eat out? _____
Are you allergic to any foods? □ Yes □ No If yes, which ones? _____
_____

(Continued on the back)

Past Medical History

Circle "C" if the problem is current and "P" if the problem is in the past. Leave blank if it does not apply.

General C P Allergy C P Convulsions C P Fatigue C P Fainting C P Headache C P Sudden Weight Loss C P High Blood Pressure Vascular C P Nausea/Vomiting C P Numbness on one side of the face or body C P Dizziness C P Difficulty Walking C P Difficulty Speaking C P Fainting/Light Headed C P Double Vision C P Rapid Eye Movement C P Neck or Head Pain	Muscle & Joint C P Arthritis C P Bursitis C P Low Back Pain C P Neck Pain/Stiffness C P Shoulder Pain C P Spinal Curvature C P Mid back Pain Pain or Numbness C P Shoulders/Arms C P Elbows/Hands C P Hips/Legs C P Ankles/Knees/Feet Genito-Urinary C P Bedwetting C P Frequent Urination C P Kidney Infection C P Painful Urination C P Prostate Trouble C P Kidney Stones	Eyes, Ears Nose & Throat C P Hearing Loss C P Ear-ache C P Failing Vision C P Nosebleeds C P Sinus Infections C P Strep Throat C P Thyroid Problems Skin Problems C P Bruise Easily C P Hives or Allergic Reaction C P Skin Rash C P Acne For Women Only C P Cramps or Backache w/cycle C P Excessive Menstrual Flow C P Irregular Cycles C P Lumps in Breast C P Pain /intercourse C P Pelvic Inflammatory Disease	Gastrointestinal C P Colon Problems C P Constipation C P Diarrhea C P Gall Bladder C P Hemorrhoids C P Bulimia C P Liver Problems Respiratory C P Asthma C P Chest Pain C P Chronic Cough C P Spitting up blood Other C P Stroke C P Rheum.Fever C P HIV/AIDS C P Alcoholism C P Diabetes C P Cancer

Family History

Some health problems are the result of familial tendencies

Family Member	Illness	Age/or Age at Death	Cause of Death
Father			
Mother			
Brother			
Sister			

Current Medications/Supplements

Month/ Year Prescribed	Name, Strength, and frequency

Ongoing Medical Treatment/Previous Hospitalizations/ Previous Surgeries

Facility/Treating Provider	Condition	Outcome

Patient Signature _____ Date _____

Patient Name _____ Date_____

Financial Policy

SELF PAY PATIENTS

We request that 100% of the visit be paid at the time of the services. We accept your check, Cash, Master Card, Visa, Discover. Unless prior written agreements have been made, any outstanding balance more than 60 days old is considered delinquent. ____ ***INITIAL***

CHIROHEALTH USA

For a $49 annual fee, you and your immediate family can receive a 20% discount on all chiropractic care and 10% discount on massage. Please inquire at the front desk for more information.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

We accept PI insurance cases on a case by case basis. We must have verification from your insurance carrier and a signed assignment of benefits on file prior to treatment. Notify our office immediately if an attorney is representing you. Once the claim is settled or if you suspend or terminate care prior to release, any fees for services are due immediately. ***We also require you to sign a credit card guarantee for any unpaid balances remaining after six months.*** ____ ***INITIAL***

PATIENTS WITH GROUP OR INDIVIDUAL COVERAGE

Ash Chiropractic and Wellness will provide insurance billing services for you with insurance companies that we are contracted with. ***Remember that you are ultimately responsible for any charges incurred in this office***. When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company **are not** a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays. It is your legal responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. ***Your signature on this document indicates that you agree to pay for any outstanding charges incurred in this office.*** ____ ***INITIAL***

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover, which for Chiropractors, is ***ONLY manual manipulation of the spine (adjustments)***. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay deductible and the remaining 20% ***as well as any non-covered services***. Our office completes and files the forms for Medicare at no charge. Please inform us of any secondary insurance that you may have.

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D. (below)** you may have to pay.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Rollerbed	**Medicare states that these are all non-covered services.**	**$20**
Electric Stimulation		**$20**
Physical Therapy Exercises		**$20-$30**
Spinal Decompression		**$55**
Massage		**$35-$65**

Choose an option below about whether to receive the **D. (listed services above)**.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. services listed above.** I may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. services listed above,** but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D. services listed above.** I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

Patient Name _____ Date_____

Signing below means that you have received and understand this notice. You may also receive a copy.

Signature (Medicare Patients only)	Date

Additional Information: This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850. Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

Missed appointments or appointments cancelled without 24 hour notice

I understand that as of July 1, 2014 all existing and new patients may be charged a cancellation fee for missed appointments or appointments that are cancelled with less than 24 hour notice. Patients must be on-time to their appointment. If you are not here at your scheduled time, the doctor may not be able to see you, and you may be charged a cancellation fee. ____ ***INITIAL***

Authorization to treat a minor

I, _____ , the undersigned parent or legal guardian of, _____ (Minor child), hereby give my permission to the staff of Ash Chiropractic and Wellness to treat said minor.

Guardian Signature	Date

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, assign payments to go directly to Ash Chiropractic & Wellness. I hereby authorize the doctor to release all medical information necessary to process all claims. I hereby authorize any plan administer or fiduciary, insurance and my attorney to release to such doctor and clinic and all plan documents, insurance policy and/ or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefits payments. ____ ***INITIAL***

Signature	Date

These signatures will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Patient Name _____ Date_____

SYMPTOMS SURVEY FORM

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Sex: Male ☐ Female ☐

Pulse: Recumbent _____ Standing _____ Vegetarian ☐ Gluten-free ☐

Blood pressure: Recumbent _____/_____ Standing _____/_____ Ragland's Test is Positive ☐

INSTRUCTIONS: Fill in only the circles which apply to you.
- ● ○ ○ MILD symptoms (occurs rarely).
- ○ ● ○ MODERATE symptoms (occurs several times a month).
- ○ ○ ● SEVERE symptoms (occurs almost constantly)
- ○ ○ ○ **Leave circles BLANK if they don't apply to you!**

	1	2	3	
GROUP 1				
1	○	○	○	Acid foods upset
2	○	○	○	Get chilled often
3	○	○	○	"Lump" in throat
4	○	○	○	Dry mouth-eyes-nose
5	○	○	○	Pulse speeds after meal
6	○	○	○	Keyed up - fail to calm
7	○	○	○	Cut heals slowly
8	○	○	○	Gag easily
9	○	○	○	Unable to relax; startles easily
10	○	○	○	Extremities cold, clammy
11	○	○	○	Strong light irritates
12	○	○	○	Urine amount reduced
13	○	○	○	Heart pounds after retiring
14	○	○	○	"Nervous" stomach
15	○	○	○	Appetite reduced
16	○	○	○	Cold sweats often
17	○	○	○	Fever easily raised
18	○	○	○	Neuralgia-like pains
19	○	○	○	Staring, blinks little
20	○	○	○	Sour stomach often
GROUP 2				
21	○	○	○	Joint stiffness on arising
22	○	○	○	Muscle-leg-toe cramps at night
23	○	○	○	"Butterfly" stomach, cramps
24	○	○	○	Eyes or nose watery
25	○	○	○	Eyes blink often
26	○	○	○	Eyelids swollen, puffy
27	○	○	○	Indigestion soon after meals
28	○	○	○	Always seems hungry; feels "lightheaded" often
29	○	○	○	Digestion rapid
30	○	○	○	Vomiting frequent
31	○	○	○	Hoarseness frequent
32	○	○	○	Breathing irregular
33	○	○	○	Pulse slow; feels "irregular"
34	○	○	○	Gagging reflex slow
35	○	○	○	Difficulty swallowing
36	○	○	○	Constipation, diarrhea alternating
37	○	○	○	"Slow starter"
38	○	○	○	Get "chilled" infrequently
39	○	○	○	Perspire easily
40	○	○	○	Circulation poor, sensitive to cold
41	○	○	○	Subject to colds, asthma, bronchitis
GROUP 3				
42	○	○	○	Eat when nervous
43	○	○	○	Excessive appetite
44	○	○	○	Hungry between meals
45	○	○	○	Irritable before meals
46	○	○	○	Get "shaky" if hungry
47	○	○	○	Fatigue, eating relieves
48	○	○	○	"Lightheaded" if meals delayed
49	○	○	○	Heart palpitates if meals missed or delayed
50	○	○	○	Afternoon headaches
51	○	○	○	Overeating sweets upsets
	1	2	3	
52	○	○	○	Awaken after few hours sleep - hard to get back to sleep
53	○	○	○	Crave candy or coffee in afternoons
54	○	○	○	Moods of depression - "blues" or melancholy
55	○	○	○	Abnormal craving for sweets or snacks
GROUP 4				
56	○	○	○	Hands and feet go to sleep easily, numbness
57	○	○	○	Sigh frequently, "air hunger"
58	○	○	○	Aware of "breathing heavily"
59	○	○	○	High altitude discomfort
60	○	○	○	Opens windows in closed rooms
61	○	○	○	Susceptible to colds and fevers
62	○	○	○	Afternoon "yawner"
63	○	○	○	Get "drowsy" often
64	○	○	○	Swollen ankles, worse at night
65	○	○	○	Muscle cramps, worse during exercise; get "charley horses"
66	○	○	○	Shortness of breath on exertion
67	○	○	○	Dull pain in chest or radiating into left arm, worse on exertion
68	○	○	○	Bruise easily, "black and blue" spots
69	○	○	○	Tendency to anemia
70	○	○	○	"Nose bleeds" frequent
71	○	○	○	Noises in head, or "ringing in ears"
72	○	○	○	Tension under the breastbone, or feeling of "tightness", worse on exertion
GROUP 5				
73	○	○	○	Dizziness
74	○	○	○	Dry skin
75	○	○	○	Burning feet
76	○	○	○	Blurred vision
77	○	○	○	Itching skin and feet
78	○	○	○	Excessive falling hair
79	○	○	○	Frequent skin rashes
80	○	○	○	Bitter, metallic taste in mouth in mornings
81	○	○	○	Bowel movements painful or difficult
82	○	○	○	Worrier, feels insecure
83	○	○	○	Feeling queasy; headache over eyes
84	○	○	○	Greasy foods upset
85	○	○	○	Stools light colored
86	○	○	○	Skin peels on foot soles
87	○	○	○	Pain between shoulder blades
88	○	○	○	Use laxatives
89	○	○	○	Stools alternate from soft to watery
90	○	○	○	History of gallbladder attacks or gallstones
91	○	○	○	Sneezing attacks
92	○	○	○	Dreaming, nightmare type bad dreams
93	○	○	○	Bad breath (halitosis)
94	○	○	○	Milk products cause distress
95	○	○	○	Sensitive to hot weather
96	○	○	○	Burning or itching anus
97	○	○	○	Crave sweets
GROUP 6				
98	○	○	○	Loss of taste for meat
99	○	○	○	Lower bowel gas several hours after eating
100	○	○	○	Burning stomach sensations, eating relieves
101	○	○	○	Coated tongue
102	○	○	○	Pass large amounts of foul-smelling gas
103	○	○	○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104	○	○	○	Mucous colitis or "irritable bowel"
105	○	○	○	Gas shortly after eating
106	○	○	○	Stomach "bloating" after eating

GROUP 7A

		1	2	3	
○	107	○	○	○	Insomnia
○	108	○	○	○	Nervousness
○	109	○	○	○	Can't gain weight
○	110	○	○	○	Intolerance to heat
○	111	○	○	○	Highly emotional
○	112	○	○	○	Flush easily
○	113	○	○	○	Night sweats
○	114	○	○	○	Thin, moist skin
○	115	○	○	○	Inward trembling
○	116	○	○	○	Heart palpitates
○	117	○	○	○	Increased appetite without weight gain
○	118	○	○	○	Pulse fast at rest
○	119	○	○	○	Eyelids and face twitch
○	120	○	○	○	Irritable and restless
○	121	○	○	○	Can't work under pressure

GROUP 7B

○	122	○	○	○	Increase in weight
○	123	○	○	○	Decrease in appetite
○	124	○	○	○	Fatigue easily
○	125	○	○	○	Ringing in ears
○	126	○	○	○	Sleepy during day
○	127	○	○	○	Sensitive to cold
○	128	○	○	○	Dry or scaly skin
○	129	○	○	○	Constipation
○	130	○	○	○	Mental sluggishness
○	131	○	○	○	Hair coarse, falls out
○	132	○	○	○	Headaches upon arising, wear off during day
○	133	○	○	○	Slow pulse, below 65
○	134	○	○	○	Frequency of urination
○	135	○	○	○	Impaired hearing
○	136	○	○	○	Reduced initiative

GROUP 7C

○	137	○	○	○	Failing memory
○	138	○	○	○	Low blood pressure
○	139	○	○	○	Increased sex drive
○	140	○	○	○	Headaches, "splitting or rending" type
○	141	○	○	○	Decreased sugar tolerance

GROUP 7D

○	142	○	○	○	Abnormal thirst
○	143	○	○	○	Bloating of abdomen
○	144	○	○	○	Weight gain around hips or waist
○	145	○	○	○	Sex drive reduced or lacking
○	146	○	○	○	Tendency to ulcers, colitis
○	147	○	○	○	Increased sugar tolerance
○	148	○	○	○	Women: menstrual disorders
○	149	○	○	○	Young girls: lack of menstrual function

GROUP 7E

○	150	○	○	○	Dizziness
○	151	○	○	○	Headaches
○	152	○	○	○	Hot flashes
○	153	○	○	○	Increased blood pressure
○	154	○	○	○	Hair growth on face or body (female)
○	155	○	○	○	Sugar in urine (not diabetes)
○	156	○	○	○	Masculine tendencies (female)

GROUP 7F

○	157	○	○	○	Weakness, dizziness
○	158	○	○	○	Chronic fatigue
○	159	○	○	○	Low blood pressure
○	160	○	○	○	Nails weak, ridged
○	161	○	○	○	Tendency to hives
○	162	○	○	○	Arthritic tendencies
○	163	○	○	○	Perspiration increase
○	164	○	○	○	Bowel disorders
○	165	○	○	○	Poor circulation
○	166	○	○	○	Swollen ankles
○	167	○	○	○	Crave salt
○	168	○	○	○	Brown spots or bronzing of skin
○	169	○	○	○	Allergies - tendency to asthma

		1	2	3	
○	170	○	○	○	Weakness after colds, influenza
○	171	○	○	○	Exhaustion - muscular and nervous
○	172	○	○	○	Respiratory disorders

GROUP 8

○	173	○	○	○	Muscle weakness
○	174	○	○	○	Lack of Stamina
○	175	○	○	○	Drowsiness after eating
○	176	○	○	○	Muscular soreness
○	177	○	○	○	Rapid heart beat
○	178	○	○	○	Hyper-irritable
○	179	○	○	○	Feeling of a band around your head
○	180	○	○	○	Melancholia (feeling of sadness)
○	181	○	○	○	Swelling of ankles
○	182	○	○	○	Diminished urination
○	183	○	○	○	Tendency to consume sweets or carbohydrates
○	184	○	○	○	Muscle spasms
○	185	○	○	○	Blurred vision
○	186	○	○	○	Loss of muscular control
○	187	○	○	○	Numbness
○	188	○	○	○	Night sweats
○	189	○	○	○	Rapid digestion
○	190	○	○	○	Sensitivity to noise
○	191	○	○	○	Redness of palms of hands and bottom of feet
○	192	○	○	○	Visible veins on chest and abdomen
○	193	○	○	○	Hemorrhoids
○	194	○	○	○	Apprehension (feeling that something bad will happen)
○	195	○	○	○	Nervousness causing loss of appetite
○	196	○	○	○	Nervousness with indigestion
○	197	○	○	○	Gastritis
○	198	○	○	○	Forgetfulness
○	199	○	○	○	Thinning hair

FEMALE ONLY

○	200	○	○	○	Very easily fatigued
○	201	○	○	○	Premenstrual tension
○	202	○	○	○	Painful menses
○	203	○	○	○	Depressed feelings before menstruation
○	204	○	○	○	Menstruation excessive and prolonged
○	205	○	○	○	Painful breasts
○	206	○	○	○	Menstruate too frequently
○	207	○	○	○	Vaginal discharge
○	208			○	Hysterectomy / ovaries removed
○	209	○	○	○	Menopausal hot flashes
○	210	○	○	○	Menses scanty or missed
○	211	○	○	○	Acne, worse at menses
○	212	○	○	○	Depression of long standing

MALE ONLY

○	213	○	○	○	Prostate trouble
○	214	○	○	○	Urination difficult or dribbling
○	215	○	○	○	Night urination frequent
○	216	○	○	○	Depression
○	217	○	○	○	Pain on inside of legs or heels
○	218	○	○	○	Feeling of incomplete bowel evacuation
○	219	○	○	○	Lack of energy
○	220	○	○	○	Migrating aches and pains
○	221	○	○	○	Tire too easily
○	222	○	○	○	Avoids activity
○	223	○	○	○	Leg nervousness at night
○	224	○	○	○	Diminished sex drive

List the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____