



WELCOME

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in cause and prevention of disease." —Thomas Edison

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ SS/HIC/Patient ID# _____
First Middle Initial Last

Address _____ City _____ State _____ Zip _____

Sex: Female Male Birthdate _____ E-mail _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Do you prefer to receive calls at: Home Work Cell No Preference

Married Widowed Single Minor Separated Divorced Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work Phone (____) _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone (____) _____

Responsible Party

Name of person responsible for this account _____

Relationship to patient _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work Phone (____) _____

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone (____) _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Phone (____) _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

DO YOU HAVE ADDITIONAL INSURANCE? No Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone (____) _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

CONFIDENTIAL

Symptoms

Reason for visit _____ When did you first notice the symptoms? _____

Is this condition getting progressively worse? _____

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? Sitting Standing Walking Bending Lying down Other

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling Other

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition?

Medication Surgery Physical Therapy Other _____

Name and address of other doctor(s) who have treated you for your condition: _____

Health History

Check only those conditions which are applicable:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke | _____ |

Dates of last exams _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

List any types of surgeries which you have had and the dates which they occurred: _____

Please list all medications you are currently taking: _____

Allergies: _____

Daily Habits

What type of exercise do you perform on a daily basis? None Moderate Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work) _____

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

Do you smoke? No Yes How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____

Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Patient Summary Form

PSF-750 (Rev.2/18/2009)

Instructions

Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

<input type="checkbox"/> Female			<input type="checkbox"/> Male		
Patient name Last		First		MI	
Patient address				City	
				State	
				Zip code	
Patient insurance ID#		Health plan		Group number	
Referring physician (if applicable)		Date referral issued (if applicable)		Referral number (if applicable)	

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)					2. Federal tax ID(TIN) of entity in box #1														
3. Name and credentials of the individual performing the service(s)																			
<input type="checkbox"/> 1 MD/DO <input type="checkbox"/> 2 DC <input type="checkbox"/> 3 PT <input type="checkbox"/> 4 OT <input type="checkbox"/> 5 Both PT and OT <input type="checkbox"/> 6 Home Care <input type="checkbox"/> 7 ATC <input type="checkbox"/> 8 MT <input type="checkbox"/> 9 Other																			
4. Alternate name (if any) of entity in box #1					5. NPI of entity in box #1					6. Phone number									
7. Address of the billing provider or facility indicated in box #1					8. City					9. State					10. Zip code				

Provider Completes This Section:

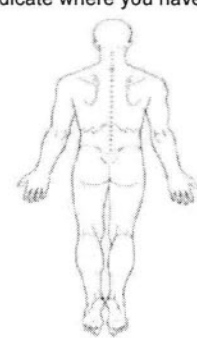
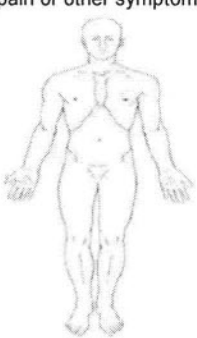
Date you want THIS submission to begin: <input type="text"/>	Cause of Current Episode <input type="checkbox"/> 1 Traumatic <input type="checkbox"/> 4 Post-surgical <input type="checkbox"/> 2 Unspecified <input type="checkbox"/> 5 Work related <input type="checkbox"/> 3 Repetitive <input type="checkbox"/> 6 Motor vehicle	Date of Surgery <input type="text"/>	Diagnosis (ICD code) Please ensure all digits are entered accurately 1° <input type="text"/>
Patient Type <input type="checkbox"/> 1 New to your office <input type="checkbox"/> 2 Est'd, new injury <input type="checkbox"/> 3 Est'd, new episode <input type="checkbox"/> 4 Est'd, continuing care	Type of Surgery <input type="checkbox"/> 1 ACL Reconstruction <input type="checkbox"/> 2 Rotator Cuff/Labral Repair <input type="checkbox"/> 3 Tendon Repair <input type="checkbox"/> 4 Spinal Fusion <input type="checkbox"/> 5 Joint Replacement <input type="checkbox"/> 6 Other	2° <input type="text"/> 3° <input type="text"/> 4° <input type="text"/>	Current Functional Measure Score Neck Index <input type="text"/> DASH <input type="text"/> Back Index <input type="text"/> LEFS <input type="text"/> (other) <input type="text"/>
Nature of Condition <input type="checkbox"/> 1 Initial onset (within last 3 months) <input type="checkbox"/> 2 Recurrent (multiple episodes of < 3 months) <input type="checkbox"/> 3 Chronic (continuous duration > 3 months)	DC ONLY Anticipated CMT Level <input type="checkbox"/> 98940 <input type="checkbox"/> 98942 <input type="checkbox"/> 98941 <input type="checkbox"/> 98943		

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:

1. Briefly describe your symptoms: _____
2. How did your symptoms start? _____
3. Average pain intensity:
 Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
 Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
4. How often do you experience your symptoms?
 1 Constantly (76%-100% of the time)
 2 Frequently (51%-75% of the time)
 3 Occasionally (26% - 50% of the time)
 4 Intermittently (0%-25% of the time)
5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)
 1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely
6. How is your condition changing, since care began at this facility?
 0 N/A — This is the initial visit
 1 Much worse 2 Worse 3 A little worse 4 No change
 5 A little better 6 Better 7 Much better
7. In general, would you say your overall health right now is...
 1 Excellent 2 Very good 3 Good 4 Fair 5 Poor

Patient Signature: X Date: _____

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

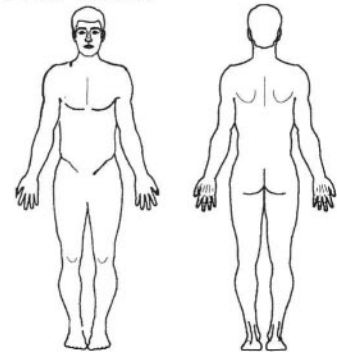
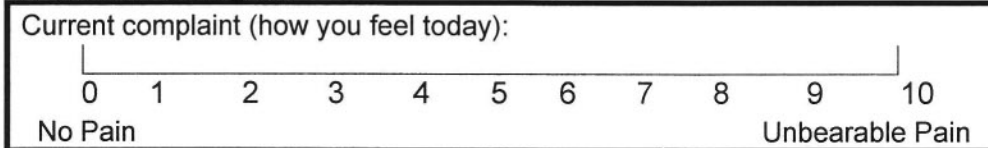
MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

- Headache Neck pain Mid-back pain Low back pain
 Other _____
Is this? Work Related Auto Related N/A

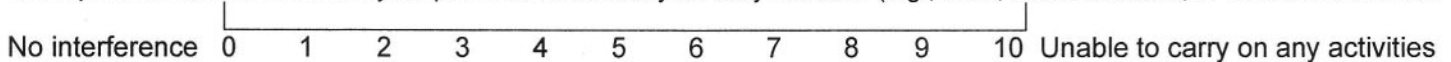
Date Problem Began: _____

How Problem Began:



How often are your symptoms present?
(Intermittent) 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 chores)?



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"/> Recent Fever | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Stroke (date) _____ | <input type="checkbox"/> Currently Pregnant, # weeks _____ |
| <input type="checkbox"/> Corticosteroid Use (cortisone, prednisone, etc.) | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Taking Birth Control Pills | <input type="checkbox"/> Marked Morning Pain/Stiffness |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Pain Unrelieved by Position or Rest |
| <input type="checkbox"/> Numbness in Groin/Buttocks | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Cancer/Tumor (explain) _____ | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Surgeries _____ |
| <input type="checkbox"/> Epilepsy/Seizures | _____ |
| <input type="checkbox"/> Other Health Problems (explain) _____ | <input type="checkbox"/> Medications: _____ |
| _____ | _____ |
| _____ | _____ |

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

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Networks to contact my physician, if necessary.

Patient Signature: _____ **Date:** _____