RoyalHealthCare

Name: _____ Sex: Female Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone number: (_____) _____ Date of Birth: _____ Age : _____

Email address: _____ I would like text or email reminders for future appointments: ☐

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Referred by: _____ Social Security #: _____

Occupation: _____ Employer: _____

Emergency contact: _____ Phone: (_____) _____

Primary Insurance

Person Responsible for Account: _____ Relationship to Patient: _____ Birth Date: _____

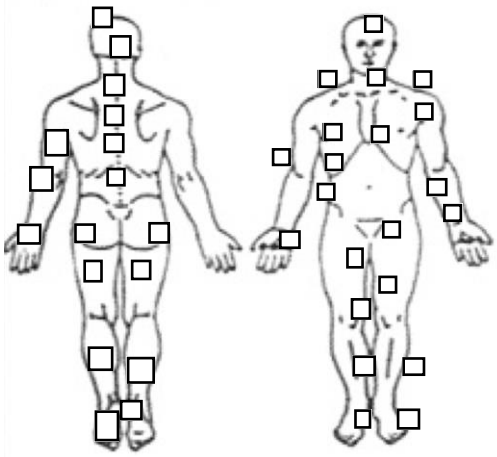
Address (if different from above): _____ City: _____ State: _____ Zip: _____

Employer: _____ Business Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Insurance ID: _____ Group #: _____

Patient is covered by additional insurance ☐

Insurance Company: _____ Insurance ID: _____ Group #: _____



Show where you have pain on the drawing at the left.

How would you describe your pain?

☐ Dull	☐ Burning
☐ Aching	☐ Sharp
☐ Throbbing	☐ Stiff
☐ Tingling	☐ Shooting with motion
☐ Numb	☐ Stabbing with motion
☐ Diffuse	☐ Other _____

2. How long have you had this problem? _____

3. Was your problem caused by an accident, or was it insidious (developed over time)? _____

4. Using a scale from 0-10 (10 being the worst) how would you rate your problem? (*Please Circle*)

◯ ◯ ◯ ◯ 4 5 6 7 8 9 10

5. What is your: Height: _____ Weight: _____ Age: _____

6. How often do you experience your symptoms/pain?

- ☐ Constantly (76-100% of the time)
- ☐ Frequently (51-75% of the time)
- ☐ Occasionally (26-50% of the time)
- ☐ Intermittently (1-25% of the time)

Name_____ **Date**_____

7. How much has this problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. How much has the problem interfered with your social life?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. How are the symptoms changing with time?

☐ Getting worse ☐ Staying the same ☐ Getting better

10. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

_____

11. Please rate your overall health: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

12. What activities do you do at work:

☐ Sit	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Stand	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Computer work	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ On the phone	☐ Most of the day	☐ Half of the day	☐ A little of the day

13. Put an "x" in the past column if you have had the condition in the past. If you presently have a condition listed below, put an "x" in the "present" column. Leave blank if you have never experienced the condition.

	Past	Present		Past	Present		Past	Present
Headaches			**Asthma**			**Excessive Thirst**		
Neck Pain			**High Blood Pressure**			**Frequent Urination**		
Upper Back Pain			**Heart Attack**			**Smoking/Tobacco Use**		
Mid Back Pain			**Chest Pains**			**Drug/Alcohol Dependence**		
Lower Back Pain			**Stroke**			**Allergies**		
Shoulder Pain			**Kidney Disorders/Stones**			**Depression**		
Elbow/Upper Arm Pain			**Bladder Infection**			**Systemic Lupus**		
Wrist Pain			**Painful Urination**			**Epilepsy**		
Hand Pain			**Loss of Bladder Control**			**Dermatitis/Eczema/Rash**		
Hip Pain			**Abnormal Weight Gain/Loss**			**HIV/AIDS**		
Upper Leg Pain			**Loss of Appetite**			**Diabetes**		
Knee Pain			**Abdominal Pain**			**Tumor**		
Ankle/Foot Pain			**Ulcer**			**Dizziness**		
Jaw Pain			**Hepatitis**			**Hormonal Replacement**		
Joint Pain/Stiffness			**Liver/Gall Bladder Disorder**			**Birth Control Pills**		
Arthritis			**General Fatigue**			**Pregnancy**		
Rheumatoid Arthritis			**Muscular Incoordination**			**Cancer**		

14. List all prescription medication you currently take: _____

15. List all over the counter medications you are taking: _____

16. List all surgical procedures you have had: _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic and/or therapeutic care, in accordance with this state's statutes.

Patient Signature _____ **Date** _____

Assignment of Benefits

I hereby assign all medical, chiropractic and physical therapy benefits to Mahmoud Lotfi, DC/Royal Health Care S.C. I authorize and direct my insurance carrier(s) such as private insurances, Medicare, and any other applicable health/medical plans to issue payment directly to Mahmoud Lotfi, DC/Royal Health Care S.C. for all medical, chiropractic, and physical therapy services rendered to myself and any dependent. By signing, I understand that I am responsible for any amount that remains from deductibles and co pays uncovered by my insurance(s) and assign directly to my provider all insurance benefits otherwise payable to me for services rendered.

I hereby authorize Mahmoud Lotfi, DC/Royal Health Care S.C. to:

- Release any pertinent information to insurance carriers regarding my illness and treatments
- Process insurance claims generated in the course of examination and treatment
- Allow a photocopy of my signature to be utilized required by insurances to process claims for the period of lifetime. This will remain in effect until revoked by me in writing.

I have requested medical services from Mahmoud Lotfi, DC/Royal Health Care S.C. On behalf of myself and/or my dependents, I understand by signing that I accept full financial responsibility for any charges incurred in the course of treatment authorized. Furthermore, I understand that fees are due and payable on the date on which services are rendered and also agree to pay all incurred charges in full, immediately, upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless alternative financial arrangements have been made in advance with the provider in writing.

Print Name: _____

Patient Signature: _____ **Date:** _____

Privacy Practices and Consent

I have received or reviewed the privacy practice notice for Royal Health Care, and understand the situations in which this practice may need to utilize or release my medical records. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by the clinic and my respective rights contained therein. I also understand that the Notice furnished to me is subject to change, and that I may obtain a current copy of this notice at any time by contacting Royal Health Care at 708-400-5574.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.
I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other therapists who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____