one

WELCOME

ABOUT YOU

Today's Date: ____/____/____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age:_____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-Mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

two

INSURANCE INFO

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Please inform front desk of 2nd. Insurance source.

REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): _____

_____

Please describe the pain & its location: _____

_____

When did condition begin? ____/____/____

Is this condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? ❑ Yes ❑ No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? ❑ Yes ❑ No

If so, where? _____

Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No

If so, whom? _____ Phone#: _____

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PLEASE CONTINUE ON BACK

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IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____ Work Phone #: _____

Who is your Medical Doctor? _____ Phone #: _____

HEALTH HISTORY

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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) _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Murmur
Y N Congenital Heart Defect	**Y N** Mitral Valve Prolapse	**Y N** Artificial Valves
Y N Alcohol / Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis
Y N HIV+ / Aids	**Y N** Shingles	**Y N** Cancer
Y N Frequent Neck Pain	**Y N** Emphysema / Glaucoma	**Y N** Anemia
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever
Y N Severe/Frequent Headaches	**Y N** Kidney Problems	**Y N** Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Asthma
Y N Diabetes / Tuberculosis	**Y N** Difficulty Breathing	**Y N** Chemotherapy
Y N Lower Back Problems	**Y N** Artificial Bones / Joints	**Y N** Arthritis

Please list any other serious medical condition(s) you have or ever had:

_____

Please list anything that you may be allergic to: _____

_____

List previous surgeries/treatments with dates: _____

_____

List any **past** serious accidents with dates: _____

_____

Family Health History: _____

_____

Do you: Take Supplements or Vitamins? ❑Yes ❑ No / Exercise? ❑Yes ❑ No

Are you on a special diet: ❑ Yes ❑ No / Since: ____/____/____

Do you smoke? ❑ No ❑ Yes / How Much? _____ How Long? _____

Are you wearing: ❑ Heel Lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

What is the age of your mattress? ____ Is it comfortable? ❑ Yes ❑ No

For women: Are you taking Birth Control? ❑ Yes ❑ No

Are you Pregnant? ❑ No ❑ Yes/How long? ____ Nursing? ❑ Yes ❑ No

six

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____

CITY STATE ZIP

SSN: _____

D.L.#: _____

Work Phone#: _____

Payment method: ❑ CASH ❑ Check

_____ /____

❑ Credit Card - Enter card # above (if accepted)

_____ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

PAIN CHART

ABOUT YOU

Name: _____ File #: _____

What is your current weight: _____ lbs., and height, _____ Ft. _____ In..
Please describe your condition:

_____

_____

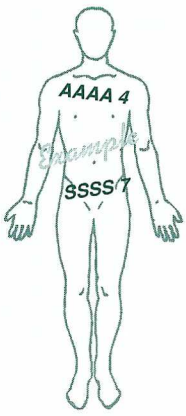
Signature: _____ Date: ____/____/____

SHOW US WHERE IT HURTS

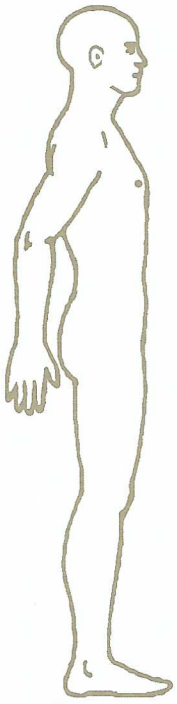
Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

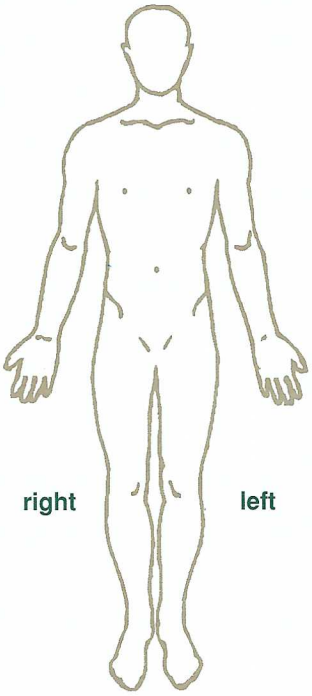
◯ Circle any area of pain not represented by a symbol.



Example

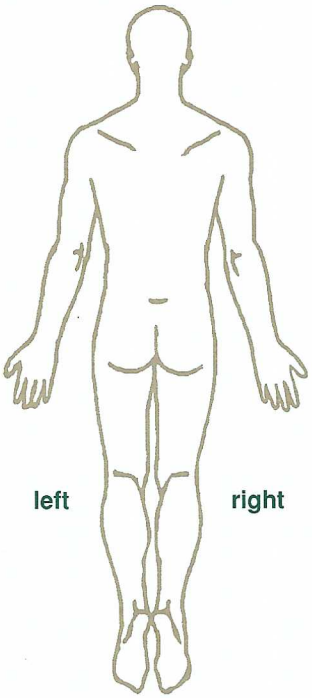


Right



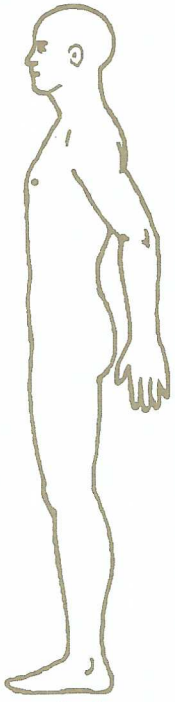
right left

Front



left right

Back



Left

DOCTOR'S NOTES

_____

_____

_____

_____

_____

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

FOUDY CHIROPRACTIC

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 for the same objective.

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

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

Health: The 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 alteration 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.

I, _____, have read and fully understand the above statements.
(Patient's Name)

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

I, therefore accept chiropractic care on this basis.

_____ _____
(Patient's Signature) **(Date)**

Consent to evaluate and adjust a minor:

I, _____, being the parent or legal guardian of _____,
(Parent's/Legal Guardian's Name) **(Patient's Name)**
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy release:

This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____
(Date)

_____ _____
(Patient's Signature) **(Date)**

FOUDY
CHIROPRACTIC

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performances of chiropractic adjustments and other chiropractic procedures, including various modes of therapy and diagnostic x-rays, on me or the patient named below, for whom I am legally responsible, by Dr. Michael Foudy, D.C., including those working at or associated with or serving as back-up for Dr. Michael Foudy, D.C., including those working at Foudy Chiropractic or any other office or clinic.

I have had an opportunity to discuss with Dr. Michael Foudy, D.C. and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

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 Dr. Michael Foudy, D.C. to anticipate and explain all risks and complications during the course of treatment, and I wish to rely on Dr. Michael Foudy, D.C. to exercise judgment during the course of the procedure which he feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its consent, 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 future conditions for which I seek treatment.

_____	_____
(Patient's Name)	**(Representative's Name)**
_____	_____
(Patient's Signature)	**(Representative's Signature)**
_____	_____
(Date)	**(Date)**

FOUD CHIROPRACTIC

MASSAGE POLICY

1. Cancellations/Reschedules requested by the patient must be made **at least 12 business hours** in advance. If the time cannot be filled when a cancellation/reschedule is made with less than 12 hours notice, the patient will be charged $25 for a ½ hour scheduled massage or $45 for a 1 hour scheduled massage.

_____
(Initial)

2. "No Shows" (appointments missed by the patient) will be paid for **at the full rate** for the time missed.

_____
(Initial)

3. When the patient is late, he/she will receive the time remaining.

_____
(Initial)

I have read, initialed and agree to all of the above.

_____
(Patient's Name)

_____
(Patient's Signature)

_____
(Date)

FOUD CHIROPRACTIC

PATIENT AUTHORIZATION REGARDING OUR OPEN-DOOR ADJUSTING ENVIRONMENT, SIGN IN SHEETS, TRAVEL CARD USE AND PATIENT RECORD OF DISCLOSURES

Our office uses sign-in sheets, travel cards, and provides care in an open-door adjusting environment. As a result, patients are in sight of each other, and some ongoing/routine details of care may be in ear shot of other patients and staff. This environment is used for ongoing care and is not the environment for taking patient's histories, performing examinations, or presenting report of findings. Those procedures are done in a private, confidential setting. If you choose not to be adjusted in an open-door adjusting environment, other arrangements will be made for you. Your signature below authorizes us to contact you at all phone numbers/addresses you list on this intake form. If you do not wish to be contacted at any listed numbers/addresses, please let us know.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____

(Patient's Signature) **(Date)**

FOUDY CHIROPRACTIC

PRIVACY RIGHTS NOTIFICATION ACKNOWLEDGMENT

By signing this form, you are granting consent to Foudy Chiropractic to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting a staff member at (949) 365 – 0403.

I hereby acknowledge receipt of the Notice of Privacy Practices.

_____ _____

(Patient's Signature) **(Date)**

---------- FOR OFFICE USE ONLY ----------

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign.

_____ An emergency prevented us from obtaining acknowledgment.

_____ Communication barriers prohibited obtaining the acknowledgment.