Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, we will gladly assist you.

Patient Information

Full Name: _____ Date of birth: ____ / ____ / ____
First Middle Int. Last

"_____" SS#____ - ____ - ____
What name do you prefer?

_____ _____
E-mail: How did you hear about us? Whom may we thank?

Address:_____ City_____ State_____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone _____

Parent/Spouse/Contact Person_____ Phone_____ Relation _____

Your employer: _____ Your occupation:_____

Mark all that apply ( ) **Minor** ( ) Female ( ) Male ( ) Student ( ) Retirement date _____
( ) Married ( ) Divorced ( ) Widowed ( ) Single ( ) Separated

Primary Doctor _____ May we contact them? ( ) Yes ( ) No

Address _____ Phone_____

Is treatment related to an accident or work injury? ( ) Yes ( ) No

We need to make a copy of your Insurance Card(s) and Driver's License.
Please have these available when you return these forms to the front desk.

Terms of Acceptance

When a patient seeks Chiropractic care, and we accept a patient for such care, it is essential that all parties be working for the same objective. **Chiropractic has one goal: to reduce interference to the nervous system.**

Vertebral subluxation: A misalignment of one or more bones which causes alteration of nerve function, resulting in a lessening of the body's ability to express its maximum health potential.

Adjustment: The adjustment is the specific application of force to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of subluxation correction is by specific adjustments.

We do not diagnose or treat any disease. However, if during the course of care we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Patient Confidentiality Policy and Patient Information

All patients will receive information (mailings, newsletters, cards, etc.) from our office. These communications are an important part of your care. Patient information is always held confidentially. Except as noted previously, **we will not release ANY information without your written consent.**

Signature:_____ Date:_____

Align Your Health Chiropractic

Dr. Ryan Jones

Assign of Proceeds and Right to Collect

Insurance is a vehicle that assists you, the patient, on covering the cost of chiropractic care. It is a contract between you and the insurance company. We accept your insurance as partial payment. The patient (a.k.a. "me", "I", "my", "you" etc.) **is ultimately responsible for services provided at this office.** I hereby assign, transfer and set over to Dr. Ryan Jones all my rights, title and interest to my medical reimbursement benefits under any insurance policy. I authorize the release of any information needed to determine and/or collect these benefits. This authorization shall remain valid until written notice is given revoking said authorization. I guarantee that all patient information is correct to the best of my knowledge.

Under the event that our office is not under any contract with your current insurance carrier and the bill is not paid within 60 days of billing the obligation of payment of all fees incurred at Dr. Ryan Jones' (Align Your Health Chiropractic PLLC) reverts back to the patient. Our office policy requires that the patient pay their percentage of the total bill, including any co-payment and/or deductible, at the time service is rendered; the percentage depends on your carrier.

In summary, the financial obligation for all treatment received is the patient's responsibility, regardless of insurance coverage, attorney liens, 3rd parties, settlements etc.

Time of Service Discount Options (To assist non-insured patients)

Single Visit $40.00 Bronze **Plan 10 Visits $360.00**

Silver Plan 20 Visits $640.00 **Gold Plan 30 Visits $900.00**

To make Chiropractic care available to everyone, we accept a reduction in our customary treatment fees if certain conditions are met. This fee reduction is considered a Time-of-Service discount and **is only available if payment is made in full prior to, or at, the time service is provided.** This reduced fee reflects a savings in office "overhead" because fees are collected at or before the time of service from the patient without the added labor and expense of having to bill an insurance company. Patients who take advantage of these savings agree that there will **be NO INSURANCE CLAIMS MADE (neither by this office e nor by the individual) for service provided under any time-of-service discount plan.**

Informed consent

Chiropractic has one of the ***safest*** records of all forms of healthcare. Serious complications a very rare but they are possible. Our duty is to inform you of potential side effects or complications that are rarely associated with any form of treatment, including chiropractic care. Soreness or muscle tightness are the most common negative but are usually brief and are only brief reactions to treatment. Possible adverse of adjustments include reactive muscle spasm, injury to disc, pressure on nerve tissue, fractures in weakened bones, and injury to arteries resulting stroke. Some studies suggest the chiropractic adjustments are up to 1,000 times more likely to cause damage than some "routine" neck and back surgeries (information can be found in the June 1999 issue of **New England Journal of Medicine.**

Patient Understanding and Acceptance of All Office Policies

By signing below, I acknowledge that I fully understand and agree to follow all policies and procedures. I accept Chiropractic Care and treatment under the policies listed herein.

Signature: _____ Date_____

Prescription and OTC Medication History

List ALL prescription and over-the counter (OTC) medications you have taken recently:

[ ] High blood pressure _____ [ ] Other_____
[ ] Blood thinners _____ [ ] Other_____
[ ] Birth Control _____ [ ] Vitamins_____

Allergies or adverse reactions to any medications?_____

Family History

Put an **"S"** for your**S**elf, **"M"** for **M**other, **"F"** for **F**ather.

( ) High Blood Pressure ( ) Diabetes ( ) Ulcer or Stomach Problems
( ) Stroke ( ) Osteoporosis ( ) Arthritis-Rheumatism
( ) Seizures-Convulsions ( ) Mental Illness ( ) HIV Positive
( ) Thyroid Disease ( ) Asthma ( ) Circulation Problems
( ) Heart Attack ( ) Cancer ( ) Kidney Disease

Medical History

Yes ____ Do you have chest pain?---------- No ____
Yes ____ Do you have headaches?---------- No ____
Yes ____ Do you have pain in your neck, jaw or face?---------- No ____
Yes ____ Does your pain ever wake you up from a sound sleep?---------- No ____
Yes ____ Has your pain caused you to miss work / school / activities? ---------- No ____
Yes ____ Do you have any change in bowel or bladder habits?---------- No ____
Yes ____ Any blood in your lungs, stool, urine, unusual bleeding or discharge? No ____
Yes ____ Do you have indigestion/heartburn or difficulty swallowing?---------- No ____
Yes ____ Do you have any nausea or vomiting?---------- No ____
Yes ____ Do you have a drooping eyelid or any change in your pupils?--------- No ____
Yes ____ Do you have vertigo, dizziness, faint, or feel light headed easily?----- No ____
Yes ____ Do you have blurred or double vision?---------- No ____
Yes ____ Do you have any slurred speech?---------- No ____
Yes ____ Do you have any ringing in your ears / tinnitus ?---------- No ____
Yes ____ Are you losing weight without trying?---------- No ____
Yes ____ Is there ANY chance of you being pregnant?---------- No ____

Cigarettes? Yes ____ No ____ If Yes, How many packs per day? _____
Alcohol? Yes ____ No ____ If Yes, How much per week? _____

Yes ____ Do you have implants, pacemaker, artificial joint, pins/screws, etc?-- No ____
List _____

Yes ____ Are you seeing any other doctor for any reason?---------- No ____
Reason: _____

List all **Surgeries**_____

Traumas / Fractures _____

Signature:_____ Date:_____

Using the number scale below (Zero - Ten), circle a number to rate your pain:

No Pain	0	1	2	3	4	5	6	7	8	9	10 **Severe Pain**
Current Pain	0	1	2	3	4	5	6	7	8	9	10
Average Pain	0	1	2	3	4	5	6	7	8	9	10
Worst Pain	0	1	2	3	4	5	6	7	8	9	10

Where are your pain(s) / symptom(s)?

_____

_____

_____

When and how did your symptoms start?

_____

_____

_____

Mark all words that describe your symptoms:

❑Sharp	❑Numb	❑Tingling	❑ Tight
❑Dull	❑Shooting	❑Electricity	❑ Throbbing
❑Ache	❑Burning	❑Sore	❑_____

How often do you feel any symptoms?

- ❑ Constantly (76 - 100% of the day)
- ❑ Frequently (51 - 75% of the day)
- ❑ Occasionally (26 - 50% of the day)
- ❑ Sporadically (0- 25% of the day)

Are your symptoms changing?

- ❑ Getting better
- ❑ Not changing
- ❑ Getting worse

What makes you feel worse?

- ❑ Standing for longer than _____
- ❑ Sitting for longer than _____
- ❑ Lifting more than _____
- ❑ Standing up after sitting or lying down
- ❑ Working on a computer

Anything else make you symptoms increase?

_____

What makes you feel better?

- ❑ Rest
- ❑ Stretching
- ❑ Ice or Heat (Circle one or both if it helps)
- ❑ Laying on my back / stomach / left side / right side

What else makes your symptoms decrease?

_____

Signature:_____ Date:_____