INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT.

Today's Date _______________ Name __________________________________

Home Phone ______________ Work Phone______________ Cell Phone _____________________

E-Mail Address ____

Address ________________________________ City ___________________ State ________ Zip__________

Age ______ Birth date ____________________

Marital Status (Circle One): S M W D

Number of Children _____ Name of Spouse or Parent ____________________ Their Phone Number: _______________

Your Employer ______________________________ Occupation ____________________

Years On Job ____ Insurance Company ___________________________________

Do you have Medicare (Circle One)? Y or N Medicaid (Circle One)? Y or N

Who can we thank for referring you to our office?: _______________________________

How payment will be made following today's visit (Circle One): Cash Credit/Debit Card Check

Please place a check in the appropriate box

	Personal history	Family history
Heart disease		
High blood pressure		
High cholesterol		
Diabetes		
Thyroid disease		
Cancer		

List surgical operation(s) and year(s):

____

____

Drugs you now take:

☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers ☐ Birth control pills

Others: ____

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No

When? ___________________________

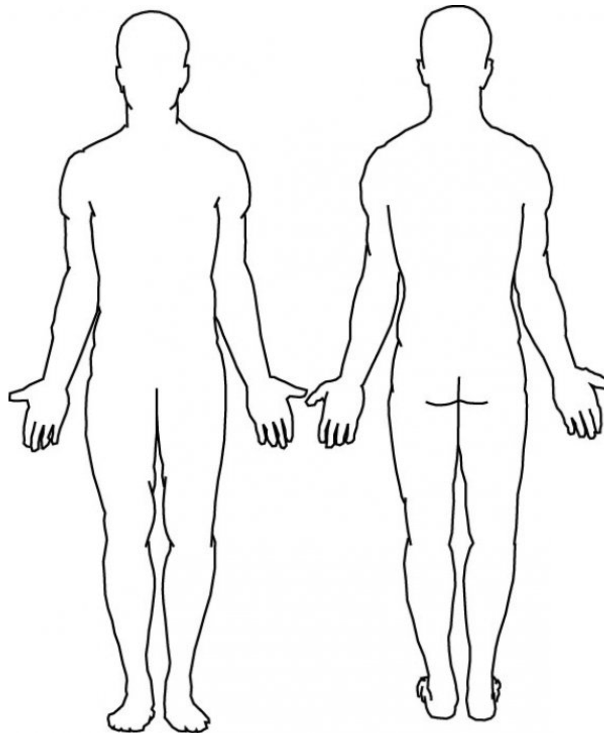
Have others in your family had such disorders? ☐ Yes ☐ No

When? _____________________________

HAVE YOU EVER:	Yes	No
Been knocked unconscious?	☐	☐
Used a cane, crutch, or other support?	☐	☐
Been treated for a spine or nerve disorder?	☐	☐
Had a fractured bone?	☐	☐
Been hospitalized for anything other than surgery?	☐	☐

CHIEF COMPLAINT #1: _____________________________________

Describe your major concerns and mark them on the diagram



➢ Description of pain (Circle One): Sharp Dull Ache Weakness Throbbing Numbness Tingling

➢ Frequency of pain (Circle One): Constant (daily) Frequent (weekly) Occasional (monthly) Intermittent (comes and goes)

➢ How long have you been experiencing these symptoms (Circle One): Days Months Weeks Years

➢ Please indicate the intensity of your pain at its highest level (Circle One): 1 2 3 4 5 6 7 8 9 10

➢ Your symptoms are: decreasing _____ not changing _____ increasing_____

➢ Symptoms are worse in the: Morning _____ Night _____ Increases during the day _____ Same all day_____

➢ Is your condition due to an accident? Yes _____ No _____ Date of accident? ____________________

- ○ Type of accident? Auto _____ Work/On Job _____ At Home _____ Other ______________________

➢ Have you ever been in an auto accident? Past Year ___ Past 5 Years ___ Over 5 Years ___ Never____

➢ What makes your condition(s) better? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting

☐ Movement/Exercise ☐ Inactivity ☐ Other __________

➢ What makes your condition(s) worse? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting

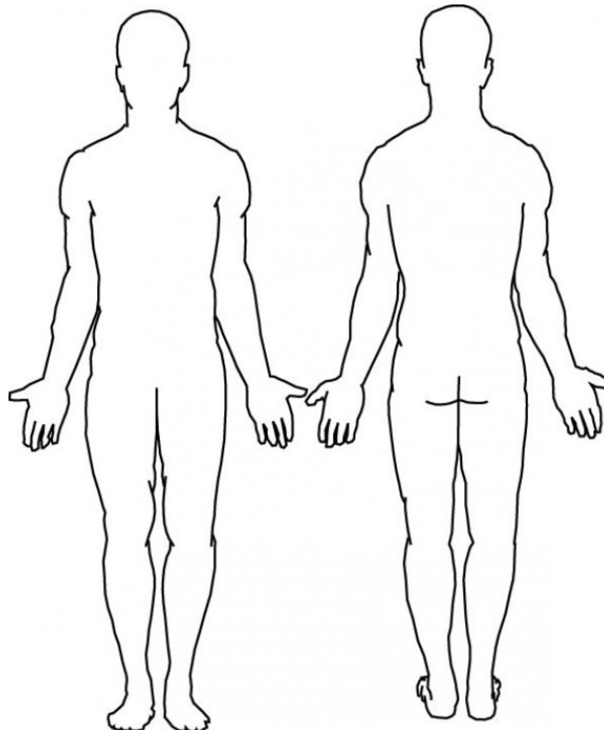
☐ Movement/Exercise ☐ Inactivity ☐ Other __________

➢ Have you seen another health care provider for this condition(s)? ☐ Yes ☐ No

- ○ Type of provider(s) seen ___________________, ____________________, _______________
- ○ Diagnosis and treatment received to date for this condition(s) ____________________________

CHIEF COMPLAINT #2: _____________________________________

Describe your major concerns and mark them on the diagram



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➢ Is your condition due to an accident? Yes _____ No _____ Date of accident? ____________________

○ Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____________________

➢ Have you ever been in an auto accident? Past Year ___ Past 5 Years ___ Over 5 Years ___ Never____

➢ What makes your condition(s) better? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting

☐ Movement/Exercise ☐ Inactivity ☐ Other __________

➢ What makes your condition(s) worse? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting

☐ Movement/Exercise ☐ Inactivity ☐ Other __________

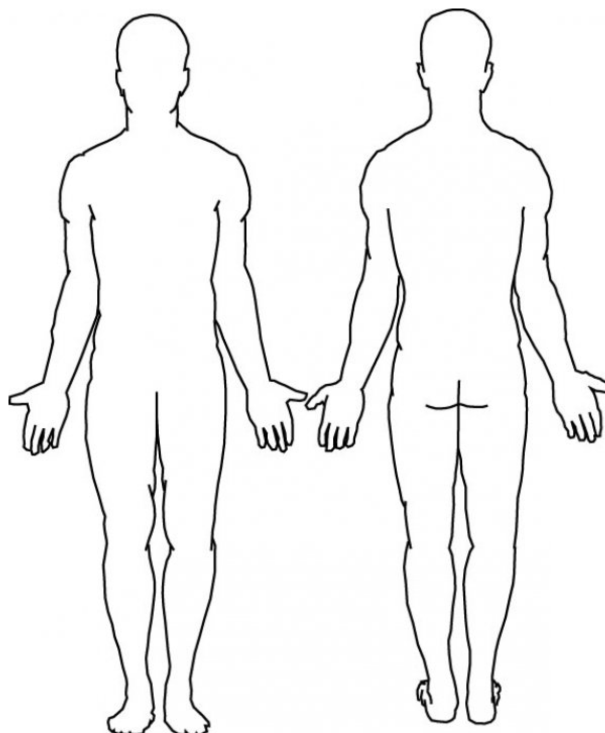
➢ Have you seen another health care provider for this condition(s)? ☐ Yes ☐ No

○ Type of provider(s) seen ___________________, ____________________, _______________

○ Diagnosis and treatment received to date for this condition(s) ____________________________

CHIEF COMPLAINT #3: _____________________________________

Describe your major concerns and mark them on the diagram



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➢ Frequency of pain (Circle One): Constant (daily) Frequent (weekly) Occasional (monthly) Intermittent (comes and goes)

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➢ Please indicate the intensity of your pain at its highest level (Circle One): 1 2 3 4 5 6 7 8 9 10

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➢ Is your condition due to an accident? Yes _____ No _____ Date of accident? ____________________

○ Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____________________

➢ Have you ever been in an auto accident? Past Year ___ Past 5 Years ___ Over 5 Years ___ Never____

➢ What makes your condition(s) better? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting

☐ Movement/Exercise ☐ Inactivity ☐ Other __________

➢ What makes your condition(s) worse? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting

☐ Movement/Exercise ☐ Inactivity ☐ Other __________

➢ Have you seen another health care provider for this condition(s)? ☐ Yes ☐ No

○ Type of provider(s) seen ___________________, ____________________, _______________

○ Diagnosis and treatment received to date for this condition(s) ____________________________

***Notice to our new patients**: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.*

Patient or Guardian Signature ____ Date ____________ IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

NAME ____

ADDRESS: ____

PHONE: ________________________

CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

I hereby request and consent to the performance of an examination, including x-rays to be performed for the use to diagnose the need of chiropractic adjustments and other chiropractic 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 licensed doctors of chiropractic 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, Dr. Drew Adkins, 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.

To the best of my knowledge, I am **NOT** pregnant and the above-named Doctor has my permission to x ray me for diagnostic interpretation.

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 _____________

Privacy Notice and Disclosure:

The Practice's Privacy Notice will be provided to me upon request. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the practice to obtain payment for that treatment to carry out health care operations.

I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me, b) telephoning my home and/ or cellular phone 4 and leaving a message on my answering machine or with the individual answering the phone, c) leaving a message via text message on my cellular phone, d) contacting me via email.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Patient Signature_________________________________ Date _____________

Witness Signature ________________________________ Date______________

OFFICE FINANCIAL POLICY

DEAR PATIENTS:

We welcome you and your family to our office. We take pride in providing quality care for families. Please take time to review our Office Financial Policy, as these guidelines have been designed to better serve your individual needs.

PAYMENT POLICY:

• Please communicate with the receptionist whether you will be filing claims to an insurance company and present your current insurance card to the receptionist for her to make a copy. If at any time you change insurance companies, please notify the receptionist immediately to update your records.

• Our doctor is not in any insurance networks. There may be out-of-network coverage through your policy.

• Payment is due the day service is provided. If you have insurance, we will gladly print you a super bill for you to submit, so that you may receive any reimbursements per your policy.

• We print super bills at the end of every month

• We will not enter any dispute with your insurance company. If coverage problems arise, you will be expected to directly assist your insurance company, adjustor or agent. Any denied or disputed claims will be treated as uncovered services.

• If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, payment in full is due; regardless of any claims submitted.

• In accordance with Medicare Law, our office cannot give any special promotions or offers to patients who receive Medicare benefits.

• By law, a fee of up to, but not to exceed 40% may be added to any account that is turned over to our collection agency.

CANCELLATION POLICY:

If for any reason you cannot make your pre-scheduled appointment time, we do ask for a 24-hour notice. If we do not hear from you to cancel your appointment at all or at least one hour before your pre-scheduled appointment an administrative fee of $15.00 will be charged to your account. No further treatments will be administered until this fee is paid. We are at a point in our clinic where we are extremely busy and need every available time slot for folks who are hurting and NEED care. If you consistently miss your pre-scheduled appointments, we can and will dismiss you from our practice. We will give you the names of other chiropractors within town to better suit your needs. We thank you for your understanding. I have read and understand the Financial Office Policy and agree to abide by these terms.

Patient's Signature: ____ Date _____________