SCHROEDER FAMILY CHIROPRACTIC

Move well. Live well.

Welcome! We are pleased to welcome you to our office. Please take a few minutes to fill out these forms as completely as you can. If you have any questions we will be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name_____
SSN_____ DL#_____
Address_____ City_____St.____Zip_____
Phone_____ Cell_____ Email Address_____
Height_____ Weight_____ Sex M / F Status M / S / W / D Age_____ Birth Date___/___/_____
Employed By_____ Occupation_____
Business Address_____Phone_____
Spouse's name_____Occupation_____Employer_____
Emergency Contact_____ Home Phone_____Cell_____
Whom may I thank for referring you?_____
Have you ever seen a Chiropractor?_____If yes when and why?_____

Primary Insurance

(Omit if not going through insurance or if providing an insurance card)

Insurance Company_____ Phone_____
ID#_____Group #_____
Person responsible for account_____Relation to patient_____
Birth Date___/___/_____ SS#_____
Address (if different than patients)_____City_____
St._____ Zip _____ Phone _____Cell_____
Person responsible employed by_____Occupation_____
Business Address_____Phone_____

Reason for Visit

What brings you in today?_____
Describe your symptoms & location_____
When did symptoms begin, lately?_____Is this a recurring condition?_____

Is pain getting ☐Worse ☐Better ☐Same How often?_____ ☐Comes & goes
Have seen by a medical physician for this condition?_____ Are you taking any medications? _____
What kind?_____For what condition & Dates_____
List vitamins if taking any_____
List surgical operations & Dates_____ List fractures & Dates_____

I clearly understand and agree that all services rendered to me are changes directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature_____Date_____

HEAD
□ Headache
□ Constant □ Comes & Goes
□ Mild □Moderate □Severe
□ Sinus or allergy
□ Entire head
□ Back of Head
□ Forehead
□ Temples
□ Migraine
□Head feels heavy
□Loss of vision
□Buzzing in ears
□Loss of memory
□Loss of taste
□Ringing in ears
□Light headedness
□Loss of balance
□Dizziness
□Fainting
□Double vision
□Pain in ears

NECK
□Pain in neck
□ Constant □ Comes & Goes
□Mild □Moderate □Severe
□Pain with movement
□Forward
□Backward
□Turn to left
□Turn to right
□Bend to left
□Bend to right
□Grinding sounds in neck
□Popping sounds in neck
□Neck feels out of place
□Arthritis in neck

SHOULDERS
□Pain in shoulder joint (R) (L)
□Pain across shoulders
□Bursitis (R) (L)
□Arthritis (R) (L)
□Can't raise arm (R) (L)
□Above shoulder level
□Over head
□Tension in shoulder (R) (L)
□Pinched nerve in shoulder (R) (L)
□Muscle spasm in shoulder (R) (L)

ABDOMEN
□Nervous stomach
□Constipation
□Diarrhea
□Foods can't eat_____
□Nausea
□Gas
□Hemorrhoids

MIDBACK
□ Mid-back pain
□ Constant □ Comes & Goes
□ Mild □Moderate □Severe
□Dull ache
Location_____
□Pain from front to back
□Pain between shoulder blades

LOW BACK
□Low back pain
□ Constant □ Comes & Goes
Location_____
□ Sacroiliac joint (R) (L)
Low back pain is worse when:
□Working □Standing
□Lifting □Sitting
□Lying down □Stooping
□Bending □Walking
□Pain relieved when_____
□Bulging disk level_____
□Low back feels out of place
□Muscle spasms
□Arthritis

ARMS & HANDS
□Pain in upper arm (R) (L)
□Pain in forearm (R) (L)
□Pins & needles in arm (R) (L)
□Pain in elbow (R) (L)
□Aggravated by_____
□Pain in hands (R) (L)
□Hands cold (R) (L)
□Pain in fingers (R) (L)
□Pins & needles in fingers (R) (L)
□Arthritis in fingers
□Fingers fall asleep
□Numbness in fingers (R) (L)
□Sore joints in fingers
□Swollen joints in fingers (R) (L)
□Numbness in fingers
□Loss of grip strength

HIPS, LEGS & FEET
□ Constant □ Comes & Goes
□Pain in buttocks (R) (L)
□Knee pain (R) (L)
□Inside □Outside
□Pain in hip joint (R) (L)
□Pain down leg (R) (L)
□Leg cramping (R) (L)
□Numbness of leg (R) (L)
□Pins & needles in legs (R) (L)
□Swollen ankles (R) (L)
□Feet feel cold (R) (L)
□Cramps in feet (R) (L)
□Numbness of feet (R) (L)
□Swollen feet (R) (L)
□Numbness of toes

CHEST
□Chest Pain
□Shortness of breath
□Pain around ribs
□Breast pain
□Irregular heartbeat

WOMEN ONLY
□Menstrual pain_____(where)
□Cramping
□Irregularity
□Cycle_____Days
□Birth control_____(Type)
□Hysterectomy
□Genital cancer_____
□Discharge
□Menopause
□Abortions
□Are you or do you think you are pregnant?_____

MEN ONLY
□Urinary frequency
□Night urination
□Prostate pain/swelling

GENERAL
□Nervousness
□Depressed
□Fatigue
□Generally rundown
□Loss of sleep
□Irritable
□Normal sleep_____hrs. /night
□Loss of sleep_____hrs. /night
□Gain/loss of weight_____lbs.
□Coffee_____cups/day
□Tea_____cups/day
□Cigarettes_____pack/day
□Diabetes type_____
□Hypoglycemia
□Heart problems_____
□Stroke_____
□Cancer_____
□Lung disease_____
□Tumors_____
□Cysts_____
□Auto accidents: when_____
□Work injuries: when_____
Describe_____
_____
_____
_____
□Other injuries/health problems_____
_____
_____

Print Name:_____

Signature:_____ Date:_____

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Privacy Practices Acknowledgement

The privacy of your medical information is important to us.

We create a record of the care and services you receive at our office. We need this record to provide you with quality, personalized care and to comply with certain legal requirements.

We understand that your medical information is personal and we are committed to protecting it.

Name_____

Signature_____

Date_____

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Financial Agreement

I _____, agree to pay my bill in full upon receipt of settlement funds. This is regardless of settlement amount. Payment must be received within 3 working days after the claimant/patient received settlement funds. If payment is not received within 3 working days, interest will begin to be added at a rate of 15% per annum, and collection proceedings will begin. The patient will then be liable for interest and collection expenses.

Bear in mind that the patient is responsible for all bills of treatment regardless of settlement. The purpose of this document is to clarify the terms of the doctor awaiting payment till settlement. At anytime, the doctor can ask for payment in full. This is a courtesy of our office that can be revoked at any time.

Any legal costs or dispute arising out of this agreement shall be settled by arbitration, all costs to be awarded to the prevailing party.

Signed: _____ Date: _____

Witness: _____ Date: _____

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Financial Policy

Most insurance policies do cover chiropractic services, but the amount they pay varies from one policy to another. Some pay 100% while others pay only a small amount.

It is important you understand your health or accident insurance.

Your insurance is an agreement between you and your insurance company. As a courtesy to our patients, our office will complete any necessary forms to help you collect from your insurance company. Any amount paid directly to our office by the insurance company will be credited to your account. If there is overpayment, it will be refunded to you. However, you must clearly understand and agree that for all services rendered to you in our office, you are charged directly and you are personally responsible.

Appointment Cancellations:
We ask for a 24 hour notice for appointment cancellations. We have the right to charge if notice is less than 24 hours.

I have read and understand my responsibility concerning the payment of services.

Signature_____Date_____