


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 charges 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** _____

<p>HEAD</p> <ul style="list-style-type: none"> <input type="checkbox"/> Headache <ul style="list-style-type: none"> <input type="checkbox"/> Constant <input type="checkbox"/> Comes & Goes <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Sinus or allergy <input type="checkbox"/> Entire head <input type="checkbox"/> Back of Head <input type="checkbox"/> Forehead <input type="checkbox"/> Temples <input type="checkbox"/> Migraine <input type="checkbox"/> Head feels heavy <input type="checkbox"/> Loss of vision <input type="checkbox"/> Buzzing in ears <input type="checkbox"/> Loss of memory <input type="checkbox"/> Loss of taste <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Light headedness <input type="checkbox"/> Loss of balance <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Double vision <input type="checkbox"/> Pain in ears 	<p>MIDBACK</p> <ul style="list-style-type: none"> <input type="checkbox"/> Mid-back pain <input type="checkbox"/> Constant <input type="checkbox"/> Comes & Goes <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Dull ache Location _____ <input type="checkbox"/> Pain from front to back <input type="checkbox"/> Pain between shoulder blades 	<p>CHEST</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Pain around ribs <input type="checkbox"/> Breast pain <input type="checkbox"/> Irregular heartbeat
<p>NECK</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain in neck <ul style="list-style-type: none"> <input type="checkbox"/> Constant <input type="checkbox"/> Comes & Goes <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Pain with movement <input type="checkbox"/> Forward <input type="checkbox"/> Backward <input type="checkbox"/> Turn to left <input type="checkbox"/> Turn to right <input type="checkbox"/> Bend to left <input type="checkbox"/> Bend to right <input type="checkbox"/> Grinding sounds in neck <input type="checkbox"/> Popping sounds in neck <input type="checkbox"/> Neck feels out of place <input type="checkbox"/> Arthritis in neck 	<p>LOW BACK</p> <ul style="list-style-type: none"> <input type="checkbox"/> Low back pain <input type="checkbox"/> Constant <input type="checkbox"/> Comes & Goes Location _____ <input type="checkbox"/> Sacroiliac joint (R) (L) Low back pain is worse when: <ul style="list-style-type: none"> <input type="checkbox"/> Working <input type="checkbox"/> Standing <input type="checkbox"/> Lifting <input type="checkbox"/> Sitting <input type="checkbox"/> Lying down <input type="checkbox"/> Stooping <input type="checkbox"/> Bending <input type="checkbox"/> Walking <input type="checkbox"/> Pain relieved when _____ <input type="checkbox"/> Bulging disk level _____ <input type="checkbox"/> Low back feels out of place <input type="checkbox"/> Muscle spasms <input type="checkbox"/> Arthritis 	<p>WOMEN ONLY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Menstrual pain _____ (where) <input type="checkbox"/> Cramping <input type="checkbox"/> Irregularity <input type="checkbox"/> Cycle _____ Days <input type="checkbox"/> Birth control _____ (Type) <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Genital cancer _____ <input type="checkbox"/> Discharge <input type="checkbox"/> Menopause <input type="checkbox"/> Abortions <input type="checkbox"/> Are you or do you think you are pregnant? _____
<p>SHOULDERS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain in shoulder joint (R) (L) <input type="checkbox"/> Pain across shoulders <input type="checkbox"/> Bursitis (R) (L) <input type="checkbox"/> Arthritis (R) (L) <input type="checkbox"/> Can't raise arm (R) (L) <ul style="list-style-type: none"> <input type="checkbox"/> Above shoulder level <input type="checkbox"/> Over head <input type="checkbox"/> Tension in shoulder (R) (L) <input type="checkbox"/> Pinched nerve in shoulder (R) (L) <input type="checkbox"/> Muscle spasm in shoulder (R) (L) 	<p>ARMS & HANDS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain in upper arm (R) (L) <input type="checkbox"/> Pain in forearm (R) (L) <input type="checkbox"/> Pins & needles in arm (R) (L) <input type="checkbox"/> Pain in elbow (R) (L) <input type="checkbox"/> Aggravated by _____ <input type="checkbox"/> Pain in hands (R) (L) <input type="checkbox"/> Hands cold (R) (L) <input type="checkbox"/> Pain in fingers (R) (L) <input type="checkbox"/> Pins & needles in fingers (R) (L) <input type="checkbox"/> Arthritis in fingers <input type="checkbox"/> Fingers fall asleep <input type="checkbox"/> Numbness in fingers (R) (L) <input type="checkbox"/> Sore joints in fingers <input type="checkbox"/> Swollen joints in fingers (R) (L) <input type="checkbox"/> Numbness in fingers <input type="checkbox"/> Loss of grip strength 	<p>MEN ONLY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Night urination <input type="checkbox"/> Prostate pain/swelling
<p>ABDOMEN</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nervous stomach <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Foods can't eat _____ <input type="checkbox"/> Nausea <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids 	<p>HIPS, LEGS & FEET</p> <ul style="list-style-type: none"> <input type="checkbox"/> Constant <input type="checkbox"/> Comes & Goes <input type="checkbox"/> Pain in buttocks (R) (L) <input type="checkbox"/> Knee pain (R) (L) <ul style="list-style-type: none"> <input type="checkbox"/> Inside <input type="checkbox"/> Outside <input type="checkbox"/> Pain in hip joint (R) (L) <input type="checkbox"/> Pain down leg (R) (L) <input type="checkbox"/> Leg cramping (R) (L) <input type="checkbox"/> Numbness of leg (R) (L) <input type="checkbox"/> Pins & needles in legs (R) (L) <input type="checkbox"/> Swollen ankles (R) (L) <input type="checkbox"/> Feet feel cold (R) (L) <input type="checkbox"/> Cramps in feet (R) (L) <input type="checkbox"/> Numbness of feet (R) (L) <input type="checkbox"/> Swollen feet (R) (L) <input type="checkbox"/> Numbness of toes 	<p>GENERAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nervousness <input type="checkbox"/> Depressed <input type="checkbox"/> Fatigue <input type="checkbox"/> Generally rundown <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Irritable <input type="checkbox"/> Normal sleep _____ hrs. /night <input type="checkbox"/> Loss of sleep _____ hrs. /night <input type="checkbox"/> Gain/loss of weight _____ lbs. <input type="checkbox"/> Coffee _____ cups/day <input type="checkbox"/> Tea _____ cups/day <input type="checkbox"/> Cigarettes _____ pack/day <input type="checkbox"/> Diabetes type _____ <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Heart problems _____ <input type="checkbox"/> Stroke _____ <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Lung disease _____ <input type="checkbox"/> Tumors _____ <input type="checkbox"/> Cysts _____ <input type="checkbox"/> Auto accidents: when _____ <input type="checkbox"/> Work injuries: when _____ Describe _____ _____ _____ _____ <input type="checkbox"/> Other injuries/health problems _____ _____ _____

Print Name: _____

Signature: _____ Date: _____



Privacy Practices Acknowledgement

The privacy of your medical information is important to us.

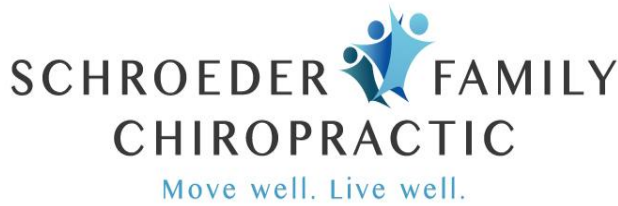
We create a record of the care and services you receive at our office. We need this record to provide you with quality, personalized care and to comply with certain legal requirements.

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

Name_____

Signature_____

Date_____



Financial Agreement

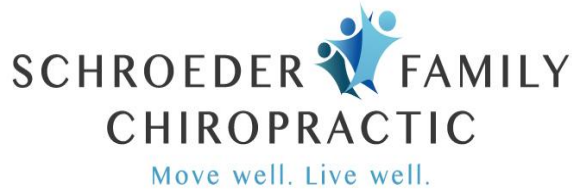
I _____, agree to pay my bill in full upon receipt of settlement funds. This is regardless of settlement amount. Payment must be received within 3 working days after the claimant/patient received settlement funds. If payment is not received within 3 working days, interest will begin to be added at a 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: _____



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 _____