Welcome to Specific Care CHIROPRACTIC

Confidential Patient Information

Patient's Name: _____ Account Number: _____

Today's Date: _____ Date of Injury: _____

Home Address_____

City/State: _____ Zip: _____

Home Phone _____Cell Phone_____

E-mail: _____Social Security: _____

Emergency Contact

Name: _____ Relationship:_____

Phone Number_____ Date of Birth: _____

Date of Birth: _____ Age: _____

Gender: **Male** **Female** Are You Pregnant? **No** **Yes** Due Date: _____

How did you hear about us? Circle one / Fill in:

Word of Mouth Ad/Sign Facebook Google Instagram Friend Family Previous Patient

Doctor: _____ Attorney: _____SCC Employee: _____

Have you ever received Chiropractic Care? _____

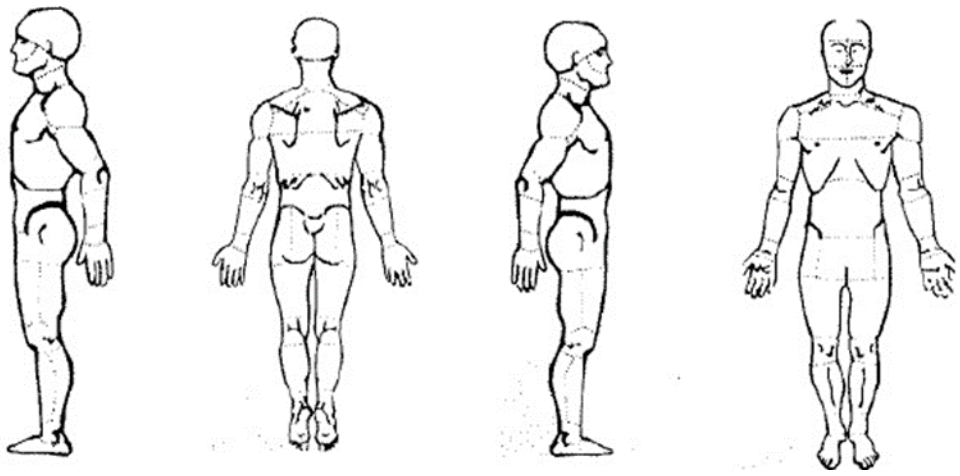
Patient Signature:_____

Spouse or Guardian Signature to Authorize Care:_____

PLEASE TURN OFF CELL PHONES DURING YOUR VISIT HERE IN THIS OFFICE!

History of the Present Illness

Please mark or circle where you are feeling pain and or symptoms:



Please describe any other areas or symptoms: _____

_____

_____

Circle the number describing your pain/symptom severity: 1-minimal 10-extremely severe

Circle pain level at its best and worst: 1 2 3 4 5 6 7 8 9 10

How often do you experience your pain and or symptoms? Circle

All day (76% to 100%) Most of the day (51% to 75%)

Half the day (26% to 50%) Occasionally (1% to 25%)

Circle all that apply to your pain and symptoms:

Sharp Shooting Dull Aching Burning Numbing Tightness Throbbing Tingling Diffuse (All Over)

Other: _____

Patient initials: _____

What makes your symptoms worse: Circle all that apply

Any Movement Bending Carrying Changing positions Climbing Stairs Coughing Laying down Pulling Pushing Reaching Sitting Sleeping Squatting Standing Standing up (from a sitting or lying position) Stretching Turning Twisting Walking

Other: _____

What makes your symptoms Better: Circle all that apply

Changing positions (often) Cold Heat Laying down Medication Movement Resting Sitting Sleeping Standing Stretching Walking

Other:_____

What activities are you having difficulty or pain performing because of your injury? Circle

Bathing Bicycling Boating Carrying objects Child care Computer use Dressing Driving Exercising Gardening Getting out of bed Golfing Household chores Lifting objects Pet care Playing sports Running Sexual activities Sleeping Weightlifting Working Yard Work

Other: _____

Have you had these Symptoms in the past? No Yes

If yes please explain: _____

_____

How and when did these symptoms start? _____

_____

Are Your Symptoms Getting: Better Worse or Staying the same

Patient initials: _____

Past Medical History

If the Questions below do not apply **Circle None**

List all of your past surgeries (**including Month/Year**)

None_____

_____

List all of your past fractures, traumas, injuries and accidents (including **Month/Year**)

None_____

_____

List all of your past Hospitalizations and or Serious Illnesses (**including Month/Year**)

None_____

_____

List any and all Allergies you have:

None_____

_____

List all of your previous motor vehicle accidents (including **Month/Year**)

None_____

_____

If involved in any, did you seek any treatment? No Yes

If so, by whom: _____

Were your symptoms from previous motor vehicle accident/s completely resolved? No Yes

Patient initials: _____

Review of Systems

Past	Present		Past	Present	
____	____	Circulatory Problems	____	____	Loss of bowel / bladder control
____	____	Rheumatoid Arthritis	____	____	Constipation
____	____	Seizures/Convulsions	____	____	Diarrhea
____	____	Excessive Bleeding	____	____	Digestive Problems
____	____	High Blood Pressure	____	____	Nausea
____	____	Low Blood Pressure	____	____	Female Problems
____	____	Diabetes	____	____	Prostate Problems
____	____	Osteoarthritis	____	____	Loss of Memory
____	____	Epilepsy	____	____	Cold Hands/Feet
____	____	Pacemaker	____	____	Hand Tremors
____	____	Strokes	____	____	Depression
____	____	Cancer	____	____	Anxiety
____	____	Asthma	____	____	Speech Difficulty
____	____	Coughing Blood	____	____	Hepatitis
____	____	Eating Disorder	____	____	Liver problems
____	____	Alcoholism	____	____	Swelling
____	____	Drug Addiction	____	____	C.O.P. D
____	____	HIV/ Aids	____	____	Blood Clots
____	____	Gall Bladder	____	____	Bloody/Black Stools
____	____	Headaches	____	____	Loss of Sensation
____	____	Dizziness	____	____	Heart Problems
____	____	Fractures/Broken Bones			
____	____	Fainting	Other health problems: _____		
____	____	Insomnia	_____		
____	____	Fatigue	_____		
____	____	Ulcers	_____		
____	____	Eye/Vision Problems			
____	____	Ear/Hearing Problems			

Circle any illnesses that run in your family: Cancer Diabetes Heart Disease Psychiatric Stroke

Other: **None**_____

_____

List all of your current Medications:

None_____

_____

_____

Primary Care Physician: _____

Phone_____ May we send a report or recommendations to your primary? **YES** **NO**

Patient initials_____

Social History

Marital Status: Circle

Married Single Divorced Widowed

How many Children do you have? _____

Alcohol Use: Never Socially 1-3/week 4-7/week Over 7/week

Tobacco Smoke: Never Socially ½ pack/day Full Pack/day Over 1 pack/day

Cigar Vapor Chew

Exercise: Never Occasionally 1-3 x/week 4-6x/ week Daily

Has the injury/symptoms prevented you from exercising: **Yes** **No**

If you can still exercise has the injury caused you to feel pain while exercising? **Yes** **No**

Employment: Circle

Currently you are: Employed Unemployed Retired Student

If you are currently unemployed is it due to this injury? **Yes** **No**

Has this injury negatively impacted your ability to perform your Job? **Yes** **No**

Type of Labor: Office/Clerical Light labor Moderate Labor Heavy Labor

Patient Signature_____

Print Name_____

Authorized guardian or care taker signature to authorize care_____

Office Financial Policy

If You Do Not Have Insurance: All payments are due at the time of service or at the time arranged for you opted payment plan. Your personal balance may not exceed $100 at any time. At Specific Care Chiropractic, we offer care plans to make it most affordable to your personal budget.

If You Have Insurance: Please fill out your insurance information below. All deductibles and co-payments are due at the time of service or at the time arranged for your opted payment plan. Your co-insurance balance may not exceed $100 at any time. We offer care plans to make it most affordable to your personal budget.

Insurance Company: _____

Insured's Name: _____

Insurance Company Phone Number: _____

Group Number: _____

On File

Policy Number: _____

Attorney's Name: _____

You are considered a cash patient until we qualify and accept your insurance coverage.

*If you currently have secondary insurance, we will bill them for you.

*If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim.

*If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

*If you discontinue care for any reason other than your discharge by the doctor all balances will become immediately due and payable in full by you, regardless of any claims made

Patient Name (printed): _____

Signature: _____ Date: _____

Billing Manager: _____ Date: _____

Contract

Authorization to Release medical Information:
I Authorize release of medical information necessary to process this (these) insurance claim(s) and permit the following to be used in place of this original document for all federal, state, commercial, compensation, or liability insurance claims

1- A photocopy of the other facsimile reproduction of this authorization, or
2- Use of a computer to indicate my signature is on file at clinic, and/or
3- Use of a computer to electronically transmit my claim for processing

Initial_____

Authorization to Assign Medical Benefits to Clinic:
I certify that the information provided relative to injury, illness and insurance coverage is both true and correct. I authorize payment of insurance benefits or proceeds from any liability claim and legal/court settlement to be assigned to the physicians of this clinic to the extent that their charges are paid in full.

Initial_____

Acknowledgment of Insurance Limitations:
Many Insurance carriers require a written referral from a primary care physician (PCP) in advance of service (office visits, surgery, and diagnostic test- MRI). Patients, parents, or the guardians are responsible for 1) obtaining the physician referrals and 2) contacting their insurance carrier to verify benefits in advance of service. Patients are also responsible for non-covered services, deductibles, co-insurance and any penalties imposed by their insurance company on our physician for seeing patients out-of-network. Co-payments are due at the time of service.

Initial_____

Acknowledgment of Payment Responsibility:
Payment for medical services is between the clinic (physician) and the patient. Payment is due in full according to terms of this Clinic's credit policy. I understand that this clinic cannot accept responsibility for collecting or negotiating settlement on any disputed by 1) health insurance claim, 2) worker's compensation claim, 3) accidentally injury/illness liability claim, 4) claim where patient is/will be represented by an attorney, and/or 5) claim to be settled in court of law.

Initial_____

Acknowledgment of Notice of Privacy Practices:
I understand Specific Care Chiropractic will use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining health care bills or to conduct health care operations of Specific Care Chiropractic.

I understand that I have a right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Specific Care Chiropractic is not required to agree to restrictions that I may request. If Specific Care Chiropractic agrees to a restriction, it is binding on them and its providers. I give my permission to Specific Care Chiropractic to use my address, phone number, and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.

Initial_____

Informed Consent for Chiropractic Treatment

TO THE PATIENT: **You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.**

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the licensed Doctors of Chiropractic working at Specific Care Chiropractic.

I have had the opportunity to discuss with Doctor of Chiropractic, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all. I understand that there are some risks to chiropractic treatment including, but not limited to broken bones/sprains/strains, dislocations, strokes, disc injuries, worsening/aggravation of spinal conditions, increased symptoms and pain, no improvement of symptoms or pain.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

.

To be completed by the patient:

Print Name: _____

Signature: _____

Date signed: _____

To be completed by the patient's representative:

Print Name: _____

Signature: _____

Date signed: _____

Medical Information Authorization

I, _____, hereby authorize Specific Care Chiropractic to release
Patient Name

All medical information to the following names below.

Name	Relationship to patient	Phone Numbers
1.		
2.		
3.		

_____ _____

Patient Signature Date

Specific Care CHIROPRACTIC

Name:_____ **ID:** _____ **Date:**_____

Functional Rating Index

In order to properly assess your condition, we must understand how much your neck and back problems have affected your ability to manage everyday activities.

For each item below, CIRCLE the number that closely describes your condition right now.

Pain Intensity	No pain (0)	Mild Pain (1)	Moderate Pain(2)	Severe Pain(3)	Worst Possible Pain (4)
Sleeping	Perfect Sleep (0)	Mildly Disturbed Sleep (1)	Moderate Disturbed Sleep(2)	Greatly Disturbed Sleep (3)	Can't sleep (4)
Personal Care (washing, dressing, etc)	No Pain(0)	Mild Pain (1)	Moderate Pain (2)	Need some assistance (3)	Severe Pain, need 100% assistance (4)
Travel (driving, etc)	No Pain on Long Trips (0)	Mild Pain on Long Trips (1)	Moderate Pain n Long Trips(2)	Moderate Pain on Short Trips (3)	Severe Pain on Short Trips (4)
Work	Can do usual work and unlimited extra work (0)	Can do usual work, no extra work(1)	Can do 50% usual work (2)	Can do 25% usual work (3)	Can't work (4)
Recreation	Can do all activities (0)	Can do most activities (1)	Can do some activities (2)	Can do a few activities (3)	Can't do any activities (4)
Frequency of Pain	No Pain (0)	Occasional Pain, 25% of the day (1)	Intermittent Pain, 50% of the day (2)	Frequent Pain, 75% of the day. (3)	Constant Pain, 100% of the day (4)
Lifting	No Pain with Heavy Weight (0)	Increased Pain with Heavy Weight (1)	Increased Pain with Moderate Weight. (2)	Increased Pain with Light Weight(3)	Increased Pain with Any Weight (4)
Walking	No Pain, Any distance (0)	Increased Pain After 1 Mile (1)	Increased Pain After ½ Mile. (2)	Increased Pain After ¼ Mile. (3)	Increased Pain with All Walking (4)
Standing	No Pain after Several Hours (0)	Increased Pain After Several Hours (1)	Increased Pain After 1 hour. (2)	Increased Pain After ½ hour. (3)	Increased Pain with Any Standing (4)

(For internal use) Total:_____ Percentage:_____

Patient Signature: _____ Date: _____