INTRODUCTION PATIENT CASE HISTORY

Patient No: ____________ Date: ________________

Name (Mr. Mrs. Miss Ms.)____
(Last, First, MI)

Address: ______________________________City ________________State ______Zip ________

Home Phone: ( )____________Mobile: ( )____________Work Phone: ( )______________

Email Address: ______________________________ Married _____Single _____ Other __________

Social Security No.: ______-______-______ Date of Birth: ___/___/___

Occupation: ______________________________ Empl oyer: ______________________________

Name of your Insurance Company: ____

Primary Insurance Holder:____________________________ Primary Hol ders Dat e of Birth:__________

Previous Chiropractic Care? Yes No Doctor's Name: ______________________________

Major Complaint: __________________________Began When and How____________________

Any Recent Surgeries_________________________ Any Recent Accident's____________________

Medications__________________________ Allergies RX ____________________________

Physi cians Contact____

Who (or what source) referred you? ____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Form 32/C

Terms of Acceptance

Revised 10.06.2016

Patient Name: ______________________________ D.O.B.:_____________ Date: ___________

Consent for Chiropractic Services

By reading below I have been made aware:

1. The process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually, with a table mechanism, or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of vibration, traction, motion, bracing, nutritional advice, heat, or cold;
3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
4. That the chiropractor has made no guarantee of a positive outcome from treatment.

Additionally:

1. I have been afforded ample opportunity for questions and answers.

Therefore by signing below:

I **consent** to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I **consent** to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature: ______________________________

Witness Signature: ______________________________

Terms of Acceptance

Revised 10.06.2016

Patient Name: ________________________________ D.O.B.:______________ Date:____________

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below items. If you refuse to sign this form the doctor reserves the right to refuse care.

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation and examination on the above.

AUTHORIZATION FOR X-RAY WITH RELEASE: By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arrangement between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to be paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail/text, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2014, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGEMENT: By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

Signature of Patient: ____

Signature of Parent or Guardian: ____________________________________

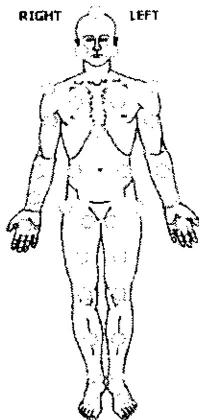
RAPID Doc Documentation

COMPLAINT
(Initial Exam, Daily Note, Follow Up/Final Exam)

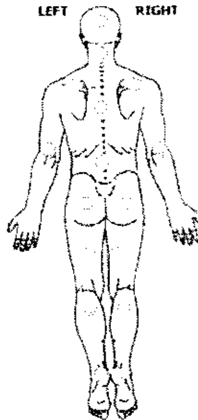
Complaint #__ -

Please place an X on one part of the body where you are experiencing pain or discomfort and list your complaints in the order of severity. (If you do not see your complaint on the picture, please list the complaint on the Other line.

Please grade pain 0-10 (10 is the highest) ⓿ ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿



Other: ___________



This complaint came on:	□ Gradually	□ Immediately	
It is getting:	□ Improving	□ Staying the same	□ Getting Worse
The intensity of this complaint is:	□ Minimal □ Slight	□ Moderate	□ Severe
The frequency of this complaint is: □Intermittent	□ Occasional	□ Frequent	□ Constant
The pain is:	□ Dull	□ Sharp	□ Aching
	□ Shooting	□ Spasm	□ Throbbing
	□ Burning	□ Spasm	□ Tingling
The pain is located on:	□ Left side	□ Right side	□ Both sides
Actions effecting this complaint:			
Morning	□ Brings On	□ Aggravates	□ Relieves
Afternoon	□ Brings On	□ Aggravates	□ Relieves
Cold	□ Brings On	□ Aggravates	□ Relieves
Heat	□ Brings On	□ Aggravates	□ Relieves
Medication	□ Brings On	□ Aggravates	□ Relieves
Resting	□ Brings On	□ Aggravates	□ Relieves
Straining	□ Brings On	□ Aggravates	□ Relieves
Standing	□ Brings On	□ Aggravates	□ Relieves
Sitting	□ Brings On	□ Aggravates	□ Relieves
Lying down	□ Brings On	□ Aggravates	□ Relieves
Bending forward	□ Brings On	□ Aggravates	□ Relieves
Bending back	□ Brings On	□ Aggravates	□ Relieves
Bending left	□ Brings On	□ Aggravates	□ Relieves
Twisting left	□ Brings On	□ Aggravates	□ Relieves
Twisting right	□ Brings On	□ Aggravates	□ Relieves
Lifting	□ Brings On	□ Aggravates	□ Relieves
Coughing	□ Brings On	□ Aggravates	□ Relieves
Sneezing	□ Brings On	□ Aggravates	□ Relieves

RAPID Doc Documentation

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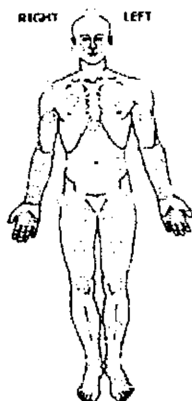
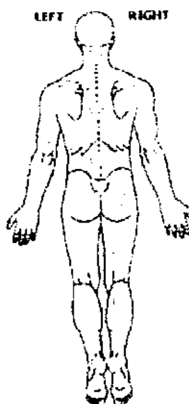


Other: ____________



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