Patient's Full Name:______________________________________**Date of Birth:**________________**Age:**_____

Address: ____________________________________**City:** __________________ **State:** ____ **Zip:**__________

Patient Social Security #: ____________________**Gender:** ______ **Height:**__________ **Weight:**__________

Cell Phone: __________________**Other Phone:** _________________**E-Mail:**___________________________

Preferred appointment reminder: ( )Text: Cell Phone Provider:_________________ **( )E-Mail ( )Neither**

Occupation:______________________________**Employer:**_____________________________________

Status: ( ) Employed ( ) Full-Time Student ( ) Part-Time Student ( ) Retired ( ) Unemployed

Who may we thank for referring you?____

Smoking Status: ( ) Current Daily Smoker ( ) Current Social Smoker ( ) Former Smoker ( ) Never Smoker
Smoking Start Date: ______ End Date: ______ In effort to quit smoking, I am currently taking: _________________

What medications are you currently taking?____

____

____

Are you currently pregnant? ( ) Yes, due date: ___________ ( ) No ( ) Unsure

Have you had previous Chiropractic or Acupuncture: ( ) Yes ( ) No *If yes, for what problem?*__________________

Doctor's Name: __________________________________ City/State: _____________________________________

What type of care are you interested in?
( ) Chiropractic ( ) Acupuncture ( ) Massage ( ) Home exercises ( ) Other:________________________________

Is today's visit due to a work related injury? ( ) Yes ( ) No Date of Injury: ____________________________

Is today's visit due to an auto accident? ( ) Yes ( ) No Date of Injury: _______________________________

(If yes to either question above, please check with receptionist, additional information may be needed)

Emergency Contact__________________________**Relationship**_______________**Phone**________________

Primary Insured Name, Relationship, Date of Birth:____

Please present your photo ID and insurance card to front desk receptionist

In general, would you say your health is (check one): ( )Excellent ( ) Very Good ( )Good ( )Fair ( ) Poor

PAST HEALTH HISTORY:

1. Have you ever had a **stroke** or issues with **blood clotting**? ( )Yes ( ) No If yes, when? ___________________
2. Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? ( )Yes ( )No

   If yes, when? ____
3. Have you ever had any major illnesses, injuries, hospitalizations, car accidents, surgeries, etc?

Date	Injury/Illness/Accident/Surgery	Treatment	Results

SYSTEMS REVIEW QUESTIONS:

Do you, or have you ever, had any problems with the following areas? (Y for yes, X for no)

1. ______Eyes
2. ______ Ears, Nose, Mouth, Throat
3. ______ Heart
4. ______Lungs/Breathing
5. ______Intestines/Bowels
6. ______Urinary
7. ______ Muscles
8. ______Nerves
9. ______Joints/Bones
10. ______ Skin
11. ______Internal Organs
12. ______ Blood
13. ______ Allergies
14. ______ Psychological
15. ______ Eating Disorder

For Females Only:

16. ________ Gynecological/Menstrual
17. ______ Breast

For Males Only:

18. ______Prostate/Penile

Please explain: ____

____

Social History:

Recreational Activities/Hobbies: ____

Have these activities been limited by your pain? If yes, describe: ________________________________

Yes	No	
☐	☐	Do you exercise? ________________ times/week
☐	☐	Do you consume alcohol? How many drinks per week? _______________________________
☐	☐	Do you eat a balanced diet? If no, explain: _____________________________________
☐	☐	Do you get adequate sleep? How many hours per night:_______________________________
☐	☐	Is work stressful to you? If yes, explain: ______________________________________
☐	☐	Is family life stressful to you? If yes, explain: _________________________________
☐	☐	Do you use recreational drugs? If yes, explain: _________________________________
☐	☐	Do you drink enough water daily? How much water do you drink per day? ____________oz/day
☐	☐	Do you consume caffeine? How much? ______________________________oz/day

Are you training or working towards for a specific race, event and/or goal?_ ____________________________

____

What problem brings you to us today? ____

When did your symptoms begin? ____

Have you had this problem before? ( )Yes ( )No Explain: ___________________________

Previous treatment from another professional for this condition? ( )Yes ( )No; Send Notes ( ) Yes ( )No

If yes, please explain diagnosis and treatment from another professional for this condition

____

____

Was the onset: ( ) Gradual ( )Sudden; Since its onset, pain has gotten: ( ) Better ( ) Worse ( )No Change

Please describe what caused the pain: ____

What aggravates this condition? ____

What decreases the symptoms/pain?____

Does this pain interfere with your sleep? ( ) Yes ( )No Does it interfere with daily activities ( ) Yes ( )No

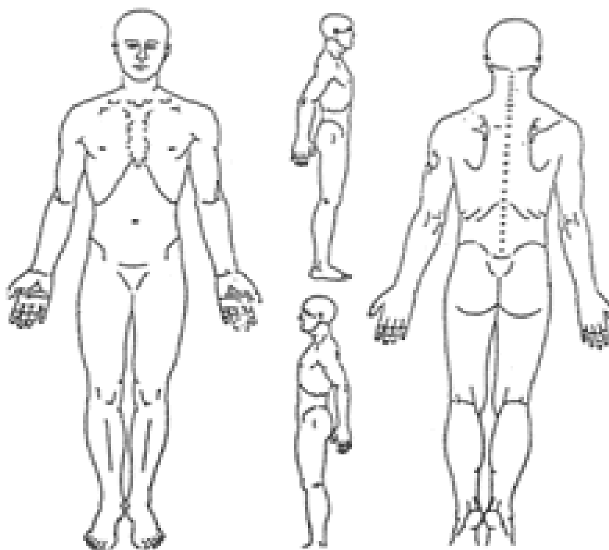
Is your pain worse in the: ( ) AM ( ) PM ( ) Constant ( ) With Activity:____________________

Have you detected any possible relationship of your current complaint with any of the following:
( )Muscle Weakness ( )Bowel/Bladder ( )Digestion ( )Cardiac/Respiratory ( ) Other:__________

PAIN CHART:

Please mark areas of pain using these codes:

+++ Burning
Dull/Ache
***** Numbness/Tingling**
=== Throbbing
000 Sharp/Stabbing



SEVERITY OF PAIN:
Please list area of pain & write a number 1-10 which represents the intensity of your pain (1= minor pain, 10=unbearable):

1. Complaint: ______________________At worst: _____/10 At best: _____/10 Typical: _____/10
2. Complaint: ______________________ At worst: _____/10 At best: _____/10 Typical: _____/10
3. Complaint: ______________________ At worst: _____/10 At best: _____/10 Typical: _____/10

Do you require special care, or have any concerns that might affect your treatment or recovery?

____

OUR MISSION STATEMENT

Our MISSION is to provide the best care possible to every patient which is accomplished by supporting our staff and providers in every way possible to allow them to practice efficiently and dedicate their time to the individual needs of the patient.

INFORMED CONSENT

I understand this Facility, its doctors & staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctor's care, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change occur.
I further understand that in the practice of medicine, chiropractic, massage therapy, acupuncture and physiotherapy there are some risks including but not limited to fractures, disc injuries, strokes, dislocations, sprain-strains, drug interactions & reactions and/or other injuries or side effects which cannot be predetermined.
I do not expect the doctor/provider to be able to anticipate and explain all risks and/or other complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.
In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.
Patients have the right to refuse treatment, but must be aware of the probably consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.
Therefore I give my full consent to the doctor/provider to render treatment on me or the minor whom I am legally responsible by a health care provider of this Facility.

ASSIGNMENT OF BENEFITS- AUTHORIZATION AND LEIN

I, the assignee, being the patient or legal guardian for the said minor listed below, do herby irrevocable authorize, direct, assign and give full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any and all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.
I, the assignee, further authorize any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any and all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any and all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits.
Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse and/or sign my name on any and all checks for payment of any indebtedness owed this office & assignee.

INSURANCE BENEFITS- CREDIT POLICIES- PAYMENT TERMS & CONDTIONS

1. As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers mis-quote benefits, coverage, and liability. Our Facility and staff are not responsible for what third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.
2. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in additional filing medical report charge which you are responsible to pay.
3. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
4. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
5. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90 day period, the patient must pay the balance in full. Assignee if fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
6. There is a $25 "no show" fee applied to all appointments that have not been cancelled within 24 hours. Text message or email reminders are available to avoid missed appointments.
7. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge.
8. Acupuncture along with associated exams and massages are cash services in our office and will not be submitted to insurance. Payment is due at time of service. Acupuncture sessions bought in packages are non-refundable and non-transferable.
9. **Even if we are in network with your insurance company, they may determine they may only cover acute care. If you are coming in for maintenance or wellness care, they may deny coverage, leaving you to pay the cash price of $50 a visit.**

I understand & agree to the above statements. Any questions I have had regarding the above have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely

______________________________ ______________________________

Patient's Signature Date

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name____ Date________________________

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

____ ____

Patient's Signature Date

If patient is a minor or under a guardianship order as defined by

State law: By___________________________________

Signature of Parent/Guardian

I furthermore hereby authorize Clayton Chiropractic Center to release my medical information to the following person(s)/entities including primary care, OB/GYN, orthopedist, physical therapist, other medical doctor to provide integrated care:

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