Integrative Healthcare Partners #________
Chiropractic

First Name ______ Middle Initial ______ Last Name ______

Home Address ______ City ______ State ______ Zip Code ______

E-mail address ______ SS# ______

Date of Birth ______ Age ______ Male or Female ______

Please circle: Single Married Widowed Divorced

Home ph. ______ Work ph. # ______ Cell ph. # ______

Medical Doctor Name ______ Phone # ______

Preferred Pharmacy Name ______ Phone # ______

Employer ______ Occupation ______

Employer Address: ______

In case of emergency contact ______ Phone # ______

Nearest relative not living with you ______

Home ph. # ____/____/____ Cell ph. # ____/____/____

Please name the person who referred you here ______

HEALTH INSURANCE INFORMATION

Ins. Co. name ______ Ins. carried under Self, Spouse, or Parent?

Name of insured ______ Date of Birth ______

Insured Address ______ City ______ State ______ Zip ______

The employers name that covers the insured ______

ID / Group # on insurance card ______

I authorize the use of this information for insurance billing, the release of information to the insurance company, I am responsible for my charges for services, and authorize payment to Spine & Neuromuscular Assoc. of S.E.I., P.S.C., and permit a copy of this authorization to be used in place of the original. Your insurance policy is between you and your insurance company. We will file your claims as a courtesy to you however; you are ultimately responsible for all bills and may be responsible for out of network charges and deductibles. Co-payments are due at the time of service. We accept cash, personal checks, Visa, MasterCard, and American Express. The fee for returned checks is $25 cancellation of less than 24 hrs. notice or "NO SHOWS" WILL BE BILLED an office visit charge of $75 that is not covered by insurance and must be paid before further services are provided by our practice subject to the discretion of the practice.

INSURANCE AUTHORIZATION, ASSIGNMENT OF BENEFITS AND HIPAA NOTICICATION
I authorize payment of medical benefits directly to the provider(s) who have treated me or rendered services or materials. My signature below also serves as my consent to treatment and verifies that I have received a copy of this practice's HIPAA policy and Required Disclosure for Medicare Conditions of Coverage for any physician owned entity where this practice delivers care and that any questions that I may have concerning these documents have been adequately answered.

Signed ______ Date____/____/____

File#________

First Name ______________________ Middle Initial ___ Last Name ____________________

Please list your Chief Complaints:

- ➢ ____
- ➢ ____
- ➢ ____

Do you feel your symptoms are mild, moderate, or severe? ____________________
What worsens your symptoms? ____________________
How long have your symptoms been present? ____________________
What makes your symptoms better? ____________________
How did your symptoms start Suddenly__Gradually___Long-standing problems__
Are your symptoms: Constant ___ Progressive___ Intermittent___
Have you had the *same or similar symptoms* in the past? Y / N If so please explain

____

Have you had any prior treatment or testing regarding this problem? ____________
Are your symptoms due to recent Injury? Y/N Date of Injury ____________
Type of Injury: Auto Accident __ Personal Injury ___ Workers Compensation ___
Please describe your accident ____________________
Have you had <u>any past injuries</u> we should know about? ____________
Please list the year and type of injury____________________
Do your symptoms interfere with daily living? Y or N, with your sleep? Y or N
Do your symptoms interfere with your lifestyle? Y or N, with your work? Y or N
Please list *all medications* you are currently taking

____

Please list *all surgeries* you've ever had (including breast implants)

____

Do your symptoms interfere with daily living? Y or N with your sleep? Y or N
Do your symptoms interfere with your lifestyle? Y or N with your work? Y or N
Have you had any past illnesses you feel are significant? ____________________
Family history of illness? Example: Dad-diabetic, Mom-high B/P, Sister-scoliosis

____

Please circle the condition that describe your work environment

Loud—Lung Pollutant—Extreme Hot/Cold—Constant Sitting—Constant Standing
Requires Lifting—Heavy Data Entry—Stressful No Problems
Alcohol use: none rarely social drinker abuses recovering alcoholic________
Tobacco use: none cigarettes cigars pipe chew dip Quit ________
Do you exercise? None—occasional—regularly—type of exercise________________

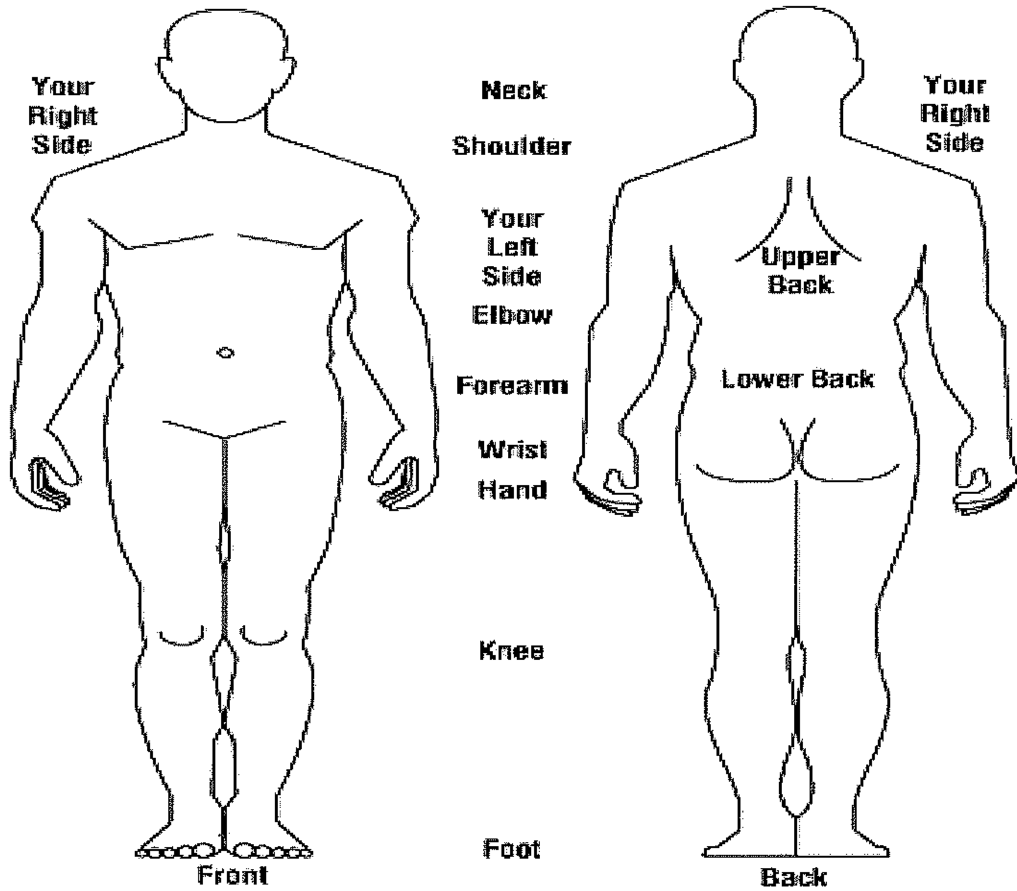
Have you tested Positive for HIV/Aids or Hepatitis ?
Have you experienced any recent traumas such as divorce, death of family or friend, job loss, change in residence? ____________________
Please circle your race: Asian Black Hispanic White Other________________
Have you been treated by a chiropractor before? ________ Dr.________________
Were your results satisfactory? ____________________
I have read the above information and answered to the best of my ability.

Date ______________ **Signature** ______________________________

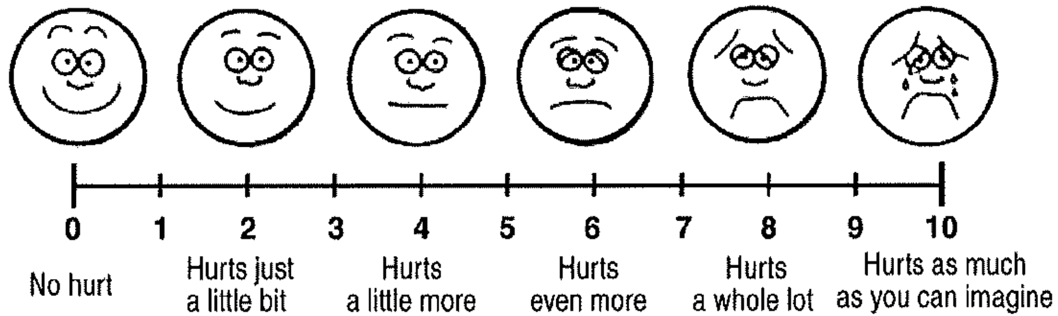
Women Only - Is there any chance you are currently pregnant? ______________

PLEASE INDICATE THE LOCATION, TYPE AND INTENSITY OF YOUR PAIN USING THE SYMBOLS BELOW.

0000 PINS & NEEDLES XXXX-BURNING //// STABBING ** ACHING ++++ NUMBNESS**



On the 0-10 Pain Scale and the faces below, circle the number which best describes your pain.



Signature ______________________________ Date__________________