

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 any past injuries 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? _____

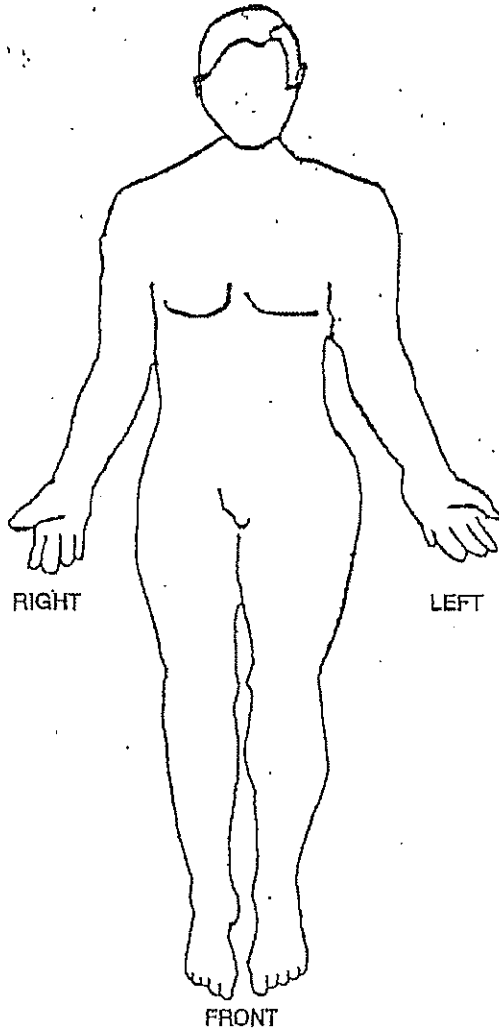
I have read the above information and answered to the best of my ability.

Date _____ Signature _____

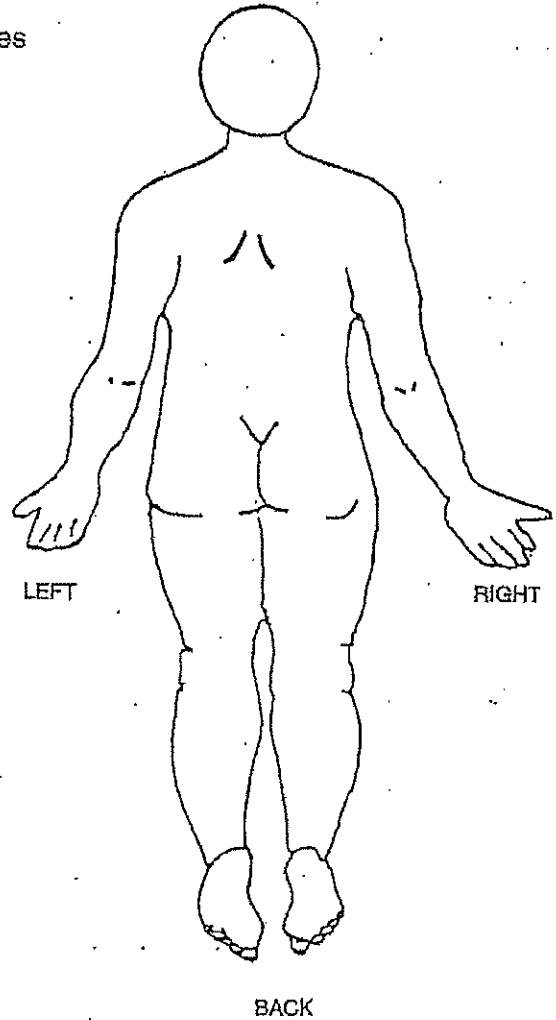
Women Only - Is there any chance you are currently pregnant? _____

BODY SHEET

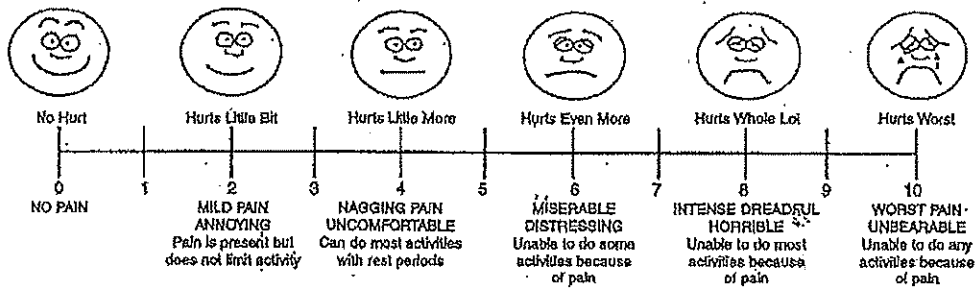
PATIENT INSTRUCTIONS: PLEASE INDICATE THE LOCATION, TYPE AND INTENSITY OF YOUR PAIN. USING SYMBOLS BELOW, SHOW WHICH AREA OF BODY THAT SYMBOLS EXIST.



000 pins & needles
 xxx burning
 /// stabbing
 *** aching
 — numbness



2. On the 0 - 10 pain scale and the Faces scale below, circle the number which best describes your pain.



ND-001

SIGNATURE

DATE