Life Chiropractic Center

Patient Case History

Name_____ Date_____
Address_____State_____Zip_____
Cell Phone (_____)_____ H. Phone_____Date of Birth_____Age_____
Referred by_____
Occupation_____Employer_____
Marital Status S M D W Spouse Name_____Number of Children/Ages_____
Have you ever received Chiropractic Care? Yes No If Yes, by whom? _____When?_____
Will you be using insurance? Yes No. Ins. Company. _____Please allow us to photocopy card
Name on Primary Ins (ie: spouse) _____ Insur Date of Birth _____

Please circle for each of the following:		Patient Comment If answer is Yes	Chiropractor's Comments
1. Growth and Development/ Childhood:			
Childhood illnesses?	Y N	_____	_____
Ear infections/ Colic/ Asthma?	Y N	_____	_____
Attention Deficit Disorder?	Y N	_____	_____
Antibiotics?	Y N	_____	_____
Auto accidents?	Y N	_____	_____
Did you ever break any bones?	Y N	_____	_____
2. Current Health Habits:			
Did/do you smoke?	Y N	_____	_____
Did/do you drink alcohol?	Y N	_____	_____
Diet, do you eat healthy foods?	Y N	_____	_____
Have you been in accidents/trauma?	Y N	_____	_____
Exercise regularly?	Y N	_____	_____
Hobbies/Sports injuries?	Y N	_____	_____
Do you sleep well, hours of sleep?	Y N	_____	_____
Sleeping posture? O side O stomach O back		_____	_____

Symptoms and Present State of Health
Present Complaint/Reason for Seeking Care in this Office:

_____
Pain or Problem started on_____
Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other_____
Does this pain shoot, radiate, or travel in your body? Where?_____
Are you experiencing numbness or tingling in any area of your body? Where?_____
Since it began, is it: O Same O Better O Worse
What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is this condition worse during certain times of the day?_____
Is this condition interfering with Work?_____ Sleep?_____Routine?_____Other?_____
Is this condition progressively getting worse?_____
Other Doctors you've seen for this condition_____
Any home remedies? _____

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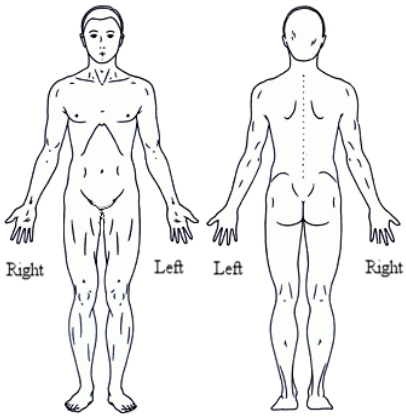
Doctor's Notes

Please Circle where you are at on the pain scale below:
(No Comp./Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Poss. Comp./Pain)

Using the symbols below, mark on the pictures where you feel pain.



Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

Please mark any of the following conditions or symptoms that you have now or have experienced:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps
O Jaw/TMJ Problems	O Cold Feet	O Menopause

Other Symptoms:_____

Are you under medical care for any condition?_____
What medications are you taking?_____How long?_____
Have you had surgery?_____ What?_____ When?_____
What, if any side effects have you experienced from the drugs and surgery?_____
Females Only – Date last Menstrual Period began on_____ Are you possibly Pregnant?_____

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Patient Signature_____Date_____

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by a doctor of chiropractic.

I have had an opportunity to discuss with the doctor or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian
Print name _____

Patient/Guardian
Signature _____ Date_____

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OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. Payment is due at time of service.
3. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed with you during your report of findings or with the office manager.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations provided that we have prior certification from your insurance company.
2. We accept assignment for the initial treatment plan only. Any follow up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment each visit.
3. We accept assignment as a courtesy to you. You are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.
4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into this office. If any over payment exists after all insurance billing has been done, we will issue you an over payment check. It will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.
5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.
6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
7. If the patient is referred to another specialist or discontinues care for any reason other than a discharge by the doctor, the bill is due and payment in full expected immediately regardless of any claims submitted.
8. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor.
   Thank you.
   I have read and understand the Office Financial Policy and agree to abide by these terms.

Patient/Guardian
Print name _____

Patient/Guardian
Signature _____ Date_____