



Chiropractic & Nutritional Healing

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CONFIDENTIAL PATIENT INFORMATION

Personal Information

Form with fields for Full name, Date, Street Address, City, State, Zip, Home phone, Work phone, Cell phone, Email, Best time / place to contact you, Date of birth, Age, Social Security #, Height, Weight, Marital status, Spouse/guardian name, Emergency Contact Name, Phone number, Your Occupation, Employer's name & address, Spouse's Occupation/Employer, Name of person responsible for account, Do you have insurance that covers Chiropractic care?, Name of Insurance Company, Insurance Policy number, Insurance Company phone number, Insurance Company address.

Who may we thank for referring you? _____

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General Health History".

Health Concerns

Table with 6 columns: Please list your health concerns according to their severity, Rate of severity (1 = mild, 10 = worst imaginable), When did this episode start?, If you had this condition before, when?, Did the problem begin with an injury?, % of the time pain is present. Rows 1-4.

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

Since the problem started is it: About the same? [] Getting better? [] Getting worse? []

What have you done for this condition? Was it of benefit?

I do (do not) have a family history of this or similar symptoms (Please explain):

Which activities aggravate your condition?

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	<input type="checkbox"/>
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	<input type="checkbox"/>
Medical Doctor	<input type="checkbox"/>
Dentist	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

Is this condition interfering with any of the following:

Work <input type="checkbox"/>	Sleep <input type="checkbox"/>	Daily routine <input type="checkbox"/>	Sports/exercise <input type="checkbox"/>	Other <input type="checkbox"/> (please explain):
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General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>

Have you ever had x-rays taken?

Area of body:	When?	Where?
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Do you wear orthotics or heel lifts? Yes No

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If dietary changes are indicated would you be willing to make changes in your diet?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
Would you take whole food supplements if indicated?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If specific exercises or stretching would help would you consider adding them to your program?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If reducing stress would help you would you like to know ways to reduce stress?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>

Diet

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day | **W** - Consume this weekly | **FW** - Consume this a few times per week
FM - Consume a few times per month (less than weekly) | **M** - Consume this monthly | **O** - Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables			

The type of diet I usually follow is classified as: _____

Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Allergy	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Constipation	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Eczema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gout
<input type="checkbox"/> Gall Bladder Problems	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> HIV (Aids)
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Malaria	<input type="checkbox"/> Measles	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Migraines
<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Neuritis
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Stroke
<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough

Other (please explain) _____

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

- 1. Physical stress (falls, accidents, work postures, etc.)
 - a. _____
 - b. _____
 - c. _____

- 2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
 - a. _____
 - b. _____
 - c. _____

- 3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
 - a. _____
 - b. _____
 - c. _____

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:
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On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:
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How do you grade your physical health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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How do you grade your emotional/mental health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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Is there anything else which may help to better understand you which has not been discussed?

Why are you here at this point in time?

I consent to a professional and complete chiropractic examination. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date. (If you are using health insurance, please be sure to complete our Financial Policy and Insurance Assignment forms.)

Print Patient Name: _____ Date: _____

Signature: _____

FINANCIAL POLICY

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility before treatment begins. We offer the following financial arrangement:

1. **Patients with Insurance:** We accept many different insurance plans. Please ask at the desk for a list of accepted plans. The estimated portion not covered by insurance, including deductibles and co-payments, is due at the time of service, or on your last visit of each week.

2. **Patients without Insurance:** Payment for chiropractic treatment is due at the time of service. To save your valuable time, you may also pre-pay for a series of visits.

We accept Visa, MasterCard, Discover Card, personal checks, and cash as payment for chiropractic services.

Returned checks and balances over 60 days may be subject to additional collection fees and interest charges of 1% per month.

A minimum \$5.00 statement fee will be charged on all balances over 60 days.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for our mutual benefit.

I have read and understand the above financial policy. Regardless of insurance coverage, I am responsible for payment of all chiropractic fees for myself and/or dependents. By my signature below, I agree to the above, acknowledge receipt of Burick Chiropractic's **Notice of Privacy Practices**, and I authorize Burick Chiropractic to collect unpaid balances over 90 days past due with the following credit card:

Type of Card: Visa MasterCard Discover

Card Number: _____ / _____ / _____ / _____ Exp Date _____ CCV code _____

Signature _____ Date _____

****Your Credit Card WILL NOT Be Charged Prior To Notifying You Of A Past-Due Balance****

Method of payment for today's charges: ___ CASH ___ CHECK ___ CREDIT CARD ___ OTHER _____

Name of Insurance company: _____ Phone #: _____

Policy/Claim/ID number: _____ Group #: _____

Name policy is under (i.e. Spouse, Parent, Etc.): _____

*****IF WE ARE BILLING YOUR INSURANCE, PLEASE SIGN BOTH AREAS BELOW*****

I authorize the release of medical information as it pertains to the processing of a specific claim.

I authorize ('assign') payment of medical benefits to my physician for Services provided.

Signed: _____

Signed: _____

For Our Patients with Health Insurance

Insurance Assignment Policy

Because we understand that insurance plays a role in assisting with some of the costs of chiropractic care, we would like to share with you the following information about health insurance and our policies regarding the privilege of insurance assignment.

Today's health plans are only meant to assist with the costs of care. The benefits your plan pays are largely determined by how much your employer/union pays in premiums for the plan.

The care that you need and receive from our office is based on our professional judgment, not on the specifics of any particular insurance plan. Our responsibility is to provide you with the care that best meets your needs, not to try to match your care to insurance plan limitations. Health insurance plans do not correspond to individual patient needs, and many chiropractic services are not covered.

As a courtesy to you, my staff will assist you by submitting your insurance claims. However, please understand that regardless of insurance coverage, that you are financially responsible for all fees. All deductible payments and co-payments must be made prior to insurance submittal. This office does not file for or accept co-payment for secondary insurance coverage.

Since we do not own your policy, and, occasionally, we experience difficulty in collecting from the carrier, we may ask for your active assistance in rectifying this situation.

I have read and understand the above insurance assignment policy. Regardless of insurance coverage, I am responsible for payment of all chiropractic fees for myself and/or dependents.

Signature _____ Date _____