



Patient Information

Date _____
 SS# _____
 Name First _____ MI _____ Last _____
 Nickname _____
 Address _____
 City _____ State _____ Zip _____
 Birthdate _____ Age _____
 Gender Male Female
 Language English Other _____
 Race _____ Ethnicity _____
 Single Married Divorced Separated Widowed
 Occupation _____
 Employer/School _____
 Spouse Name _____
 Spouse Birthdate _____
 How did you hear about our office?

Contact Information

Primary Phone # _____ Cell Home Work
 Secondary Phone # _____ Cell Home Work
 E-mail Address _____
 The primary way I would like you to contact me for appointment reminders is: Phone call Text E-mail
 My Cell Carrier is:
 AT&T Verizon
 Metro PCS Virgin Mobile
 Sprint Other _____
 T-Mobile
 Emergency Contact Name _____
 Phone # _____ Relationship _____

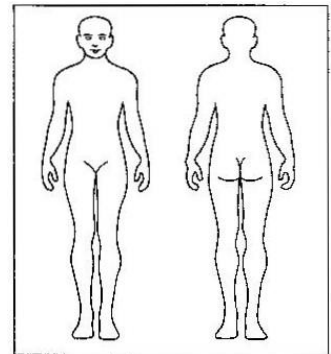
Accident Information

Is condition due to an accident? Yes No
 Date of accident _____
 Type of accident Auto Work Home Other
 To whom have you made a report of your accident?
 Auto Insurance Employer Workers Comp. Other
 Attorney Name (if applicable) _____

Patient Condition

Reason for Visit _____
 When did your symptoms appear? _____
 Is this condition getting progressively worse? Yes No Unknown
 Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____
 Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other
 How often do you have this pain? _____
 Is it constant or does it come and go? _____
 Does it interfere with your: Work Sleep Daily Routine Recreation
 Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down
 What treatment have you already received for your condition? Medications Surgery Physical Therapy
 Chiropractic Services None Other _____
 Name and address of other doctor(s) who have treated you for your condition _____
 Date of Last: Physical Exam _____ Spinal X-Ray _____ Spinal Exam _____
 Chest X-Ray _____ MRI _____ CT-Scan _____ Bone Scan _____

Mark an X on the picture where you have any pain, numbness or tingling



Patient Name _____

Date _____

Health History

Place a mark on "Y" for Yes or "N" for No to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Measles	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatoid	
Alcoholism	<input type="checkbox"/> Y <input type="checkbox"/> N	Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N	Migraine		Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N
Allergy Shots	<input type="checkbox"/> Y <input type="checkbox"/> N	Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Fractures	<input type="checkbox"/> Y <input type="checkbox"/> N	Miscarriage	<input type="checkbox"/> Y <input type="checkbox"/> N	Scarlet Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Anorexia	<input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N	Mononucleosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N
Appendicitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Goiter	<input type="checkbox"/> Y <input type="checkbox"/> N	Multiple Sclerosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Suicide Attempt	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N	Gonorrhea	<input type="checkbox"/> Y <input type="checkbox"/> N	Mumps	<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Gout	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteoporosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Tonsillitis	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Breast Lump	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Parkinson's Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Tumors, Growths	<input type="checkbox"/> Y <input type="checkbox"/> N
Bronchitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Hernia	<input type="checkbox"/> Y <input type="checkbox"/> N	Pinched Nerve	<input type="checkbox"/> Y <input type="checkbox"/> N	Typhoid Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Bulimia	<input type="checkbox"/> Y <input type="checkbox"/> N	Herniated Disk	<input type="checkbox"/> Y <input type="checkbox"/> N	Pneumonia	<input type="checkbox"/> Y <input type="checkbox"/> N	Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N	Polio	<input type="checkbox"/> Y <input type="checkbox"/> N	Vaginal Infections	<input type="checkbox"/> Y <input type="checkbox"/> N
Cataracts	<input type="checkbox"/> Y <input type="checkbox"/> N	High Cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N	Prostate Problem	<input type="checkbox"/> Y <input type="checkbox"/> N	Venereal Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Chemical Dependency	<input type="checkbox"/> Y <input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Prosthesis	<input type="checkbox"/> Y <input type="checkbox"/> N	Whooping Cough	<input type="checkbox"/> Y <input type="checkbox"/> N
Chicken Pox	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Psychiatric Care	<input type="checkbox"/> Y <input type="checkbox"/> N	Other _____	<input type="checkbox"/> Y <input type="checkbox"/> N
		Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N				

Are you pregnant? Yes No Due Date _____

Family History

<u>Disease/Condition</u>	<u>Parents</u>	<u>Grandparents</u>	<u>Siblings</u>
Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer (Type) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Major Health Issues _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

<u>Exercise</u>	<u>Work Activity</u>	<u>Habits</u>
<input type="checkbox"/> None <input type="checkbox"/> Daily	<input type="checkbox"/> Mostly Sitting <input type="checkbox"/> Light Labor	<input type="checkbox"/> Smoking Packs/Day _____
<input type="checkbox"/> Moderate <input type="checkbox"/> Heavy	<input type="checkbox"/> Mostly Standing <input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Alcohol Drinks/Week _____
		<input type="checkbox"/> Coffee/Caffeine Drinks Cups/Day _____

<u>Injuries/Surgeries you have had</u>	<u>Description</u>	<u>Date</u>
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones/Dislocations	_____	_____
Surgeries	_____	_____

<u>Medications</u>	<u>Allergies</u>	<u>Vitamins/Herbs/Minerals</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name _____

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- Y N If you are taking supplements, do you feel they are effective?
- Y N Have you ever had bloodwork done regarding your nutritional needs?
- Y N Are you interested in Nutritional Counseling by one of our Doctors?

Insurance

Insurance Co. _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above referenced insurance company and assign directly to Clearwater Spine & Rehabilitation all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Clearwater Spine & Rehabilitation may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X _____
Signature of Patient, Parent, Guardian or Personal Representative

Please print name of person signing above

Date Relationship to Patient

Office Financial Policy

By executing this agreement, you are agreeing to pay for all services that are received. You are considered a cash patient until you bring in your completed insurance forms and we qualify and accept your insurance coverage. Payments are expected at the time of service or by an authorized payment plan.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, it must be paid at the time of service. It is the insurance co. that makes the final determination of your eligibility.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one percent (1%) per month or an **ANNUAL PERCENTAGE RATE** of twelve percent (12%).

There is a fee of \$25 for any checks returned by the bank.

X _____
Signature of Patient, Parent, Guardian or Personal Representative

Please print name of person signing above

Date Relationship to Patient

Informed Consent for Examination and Treatment

I hereby consent to the performance of examination and treatment on me or on _____ by the licensed doctor of chiropractic, licensed massage therapists and/or registered chiropractic assistants who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks & complications & an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected, but rather I wish to rely on the doctor to choose & recommend the best course of treatment based upon facts known that is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to: fractures, disc injuries and strain/sprains. I am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

X _____
Signature of Patient, Parent, Guardian or Personal Representative Date

Please print name of person signing above Relationship to Patient