

GENERAL INFORMATION

Patient Last Name: _____ First Name: _____
 Address: _____ Care of: _____
 (Parent or financially responsible person)
 City: _____ State: _____ Zip: _____ Phone(work) _____
 Driver's Lic #: _____ # Children: _____ Phone(home) _____
 Out of State Address: _____ Phone: () _____
 Spouse's Name: _____ Spouse's Employer: _____ Native Language: _____

Gender: M F	Marital Status: Married Single Widowed Divorced	Date of Birth: ___/___/___	Social Security # _____-_____-____
Patient's Employer's Name: _____	Address: _____	City: _____ State: _____ Zip: _____	EMPLOYED Full-Time Part-Time Retired Not employed STUDENT Full Time Part-time Non-Student
Phone: () _____	Occupation: _____		

Referred By: _____

INSURANCE INFORMATION

COMMERCIAL INSURANCE AND MEDICARE ONLY

Primary Insurance Company Name	<i>Complete only if patient is not the insured</i>
Type _____ Group _____ Private _____	Insured's name: _____
Membership/Cert #: _____	M F Married Single Widowed Divorced
Policy/Group #: _____	Patient's Relationship to Insured: _____
	Insured Date of Birth: ___/___/___
	Insured's Employer: _____
Secondary Insurance Company Name	Insured's Name: _____
Type _____ Group _____ Private _____	M F Married Single Widowed Divorced
Membership/Cert #: _____	Patients Relationship to Insured: _____
Policy/Group #: _____	Insured's Date of Birth: ___/___/___
	Insured's Employer: _____

AUTOMOBILE ACCIDENT/WORKER'S COMPENSATION ONLY

Insurance: _____	Claim #: _____	Policy #: _____
Address: _____	City: _____	State: _____ Zip: _____
Phone #: () _____	Adjuster's Name: _____	Contact Name: _____
Attorney's Name: _____	Address: _____	Phone #: () _____

RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Patient's Signature: _____ Date: ___/___/___

Patient History

PLEASE FILL IN THE APPROPRIATE SPACES. (All information you give is confidential.)

NAME: _____ **DATE:** ___/___/___

MAJOR COMPLAINT: _____

How long have you had this condition? _____

Date of Onset? _____

Have you lost workdays? Yes No If yes, how many? _____

Have you had a similar condition before? Yes No If yes, when? _____

Was the injury accident related? Auto Work If yes, when? _____

When was your last auto accident? _____ When was the one before that? _____

Previous Chiropractic Care? Yes No If yes, Chiropractic's Name: _____

What was the reason for your initial visit? _____

What spinal maintenance programs were you given to follow maximize the future stability of your spine? _____

Did you follow it? _____ If not, why? _____

Why are you changing Chiropractors? _____

What surgeries have you had? _____

List drugs you now take (prescription or non-prescription). _____

Name other doctors you have seen for this condition: _____

What are your health goals? _____

How do you expect to achieve these goals? _____

Please mark if you have had any of these symptoms in the last 12 months:

<input type="checkbox"/> Fractured Bones	<input type="checkbox"/> Neck Pain or stiffness R L	<input type="checkbox"/> Numbness, tingling, pain in buttocks, legs, feet, toes
<input type="checkbox"/> Auto Accidents ____ 0-1 years ago ____ 1-5 years ago ____ 5 years or more	<input type="checkbox"/> Numbness, tingling, pain in arms, hands, fingers R L	<input type="checkbox"/> Foot Trouble R L <input type="checkbox"/> Chest pain, asthma <input type="checkbox"/> Heart Problems <input type="checkbox"/> Stroke
<input type="checkbox"/> Other accidents, falls	<input type="checkbox"/> Jaw Pain or Click (TMJ) R L	<input type="checkbox"/> High/low blood pressure <input type="checkbox"/> Varicose veins <input type="checkbox"/> Liver trouble
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Difficulty in excessive standing, sitting, riding bending, lifting, twisting	<input type="checkbox"/> Gall bladder trouble <input type="checkbox"/> Digestive problems <input type="checkbox"/> Ulcers
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Shoulder pain R L	<input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Prostate problems <input type="checkbox"/> Impotence
<input type="checkbox"/> Skin problems	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Kidney trouble <input type="checkbox"/> Menstrual problems, PMS
<input type="checkbox"/> Cancer	<input type="checkbox"/> Ringing in ears R L	<input type="checkbox"/> Pregnant (now) <input type="checkbox"/> Bedwetting
<input type="checkbox"/> Convulsions, epilepsy	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Ear Infections <input type="checkbox"/> AIDS, HIV
<input type="checkbox"/> Frequent colds, flu	<input type="checkbox"/> Blurred or double vision	
<input type="checkbox"/> Depressed	<input type="checkbox"/> Upper back pain, stiffness	
<input type="checkbox"/> Irritable	<input type="checkbox"/> Mid back pain, stiffness	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Lower back pain/stiffness	
<input type="checkbox"/> Allergy, sinus	<input type="checkbox"/> Pain with cough, sneeze	
<input type="checkbox"/> Under stress	<input type="checkbox"/> Hip Pain R L	
<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Headaches	
<input type="checkbox"/> Trouble sleeping	<input type="checkbox"/> Mood changes	
<input type="checkbox"/> Trouble concentrating		
<input type="checkbox"/> Learning disability		

- Vertebral Subluxations can cause pain -

1. Which pain or condition have you marked the worse? _____

2. How long has it bothered you? _____

3. Vertebral Subluxations can cause irritation to different fibers within nerves. Are your pains sharp or dull? _____

4. Subluxations can put pressure on the spinal cord which can be constant or occasional. Which do you feel? _____

5. Pressure on the spinal cord or nerves can be worse in the AM or PM. Which is worse for you? _____

6. Does this pain radiate into an extremity or stay in one area?

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral Subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral Subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to complete satisfaction.

I, therefore, accept chiropractic care on this basis. _____
Signature Date

Consent to evaluate and treat a minor child:

I, _____, being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my
child to receive chiropractic care.

Pregnancy Release:

This is to certify that to best of my knowledge I am not pregnant and the above doctor and his/her
associated have my permission to perform an x-ray evaluation. I have been advised that x-rays can
be hazardous to an unborn child. Date of last menstrual period _____
Signature _____ Date _____

ADDITIONAL TERMS OF ACCEPTANCE

We are committed to education and great levels of service. In order to achieve this, the following is our policy regarding x-ray reports:

Should the Doctor determine that you have a Subluxation, nerve damage or dysfunction, or degeneration (or any other serious conditions on your x-ray(s), YOUR SPOUSE will be required to attend the doctor's report of the exam findings.

This is your safety and benefit.

This is also because:

1. The vital nature of the information being given to you at this report.
2. We would discuss and make insurance or other financial arrangements at the time.
3. To help with any treatment choices and options.
4. Your spouse can help with supportive home care.

In order for us to accept you as a patient. THIS IS A REQUIREMENT. NO EXCEPTIONS.

This will also prevent having to go over an x-ray/exam finding more than one time per patient and minimize charges and costs to you.

Currently we go over x-rays on Tuesday at 6:00 pm and Friday at 11:30 am. The doctor is willing to contact any employers for excused absence needs.

Your cooperation is appreciated.

I have read, understand, and agree to the above additional terms of acceptance.

Signature _____ Date _____

Bailey Family Chiropractic is committed to maintaining the privacy of your protected health information. Our Privacy notice information is contained in the white folder located on the front desk counter for you to review.

Notice of Receipt of Privacy Notice of Bailey Chiropractic

By signing below, I acknowledge that I have received and reviewed the Privacy Notice of Bailey Family Chiropractic, in force of April 14, 2003 and all of my questions have been answered to my satisfaction in language that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative
(e.g., Attorney-In-Fact, Guardian,
Parent if a minor):

Relationship

Date Signed ____ / ____ / ____

Witness: _____