PATIENT INFORMATION

DATE:_____

Name _____Age _____
Address _____ City _____ State_____ Zip_____
Phone (Cell) _____Cell Phone Carrier_____Email_____
Social Security # _____ Date of Birth ___/_____/_____ Sex: M F Marital Status: S M D W
Occupation:_____ Phone (Work)_____
Employer: _____
Spouse's Name _____Spouse's Occupation _____
Spouse's Employer _____Spouse's Phone (Work) _____
In Case of Emergency call: _____ Phone Number_____

FINANCIAL AGREEMENT & INSURANCE INFORMATION

Please present your insurance card to the receptionist.

Who is responsible for this account? _____
Relationship to the patient? _____

If you are not the card holder, we must have:

The subscriber's name: _____ Birth Date: ___/___/_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or the dependent) have insurance coverage and assign directly **to Action Chiropractic Inc.**, 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Date

Relationship: ( ) Self ( ) Guardian of a Minor

ACCIDENT INFORMATION

Present condition due to an injury? __Yes __ No __ On the Job __ Auto Accident __ other _____
Has the accident been reported? __ Yes __ No __ To Employer __ Auto Carrier __ Other _____
Attorney's name if any? _____

HEALTH CARE GOALS

Reason(s) for today's visit: _____

How did you hear about us? ( ) Internet search ( ) Our Web Site ( ) Doctor/surgeon
( ) Social Media ( ) Google reviews ( ) Attorney
( ) Insurance Network ( ) Friend/Family ( ) Drove by ( ) Other

Are you interested in: ( ) Weight Loss ( ) Nutritional Advises ( ) Reformer Pilates
( ) Health Class ( ) Diabetes Management
( ) Group Fitness Classes – Spinning, rowing, TRX, Boxing etc...)

Do you exercise? ( ) Never/rarely ( ) Mildly ( ) Moderately ( ) Daily ( ) Heavily

If so, what type of exercise? ( ) Pilates ( ) Yoga ( ) Cycling ( ) Cross Fit ( ) Weight Lifting ( ) Swimming ( ) Other

Daily activities: ( ) Sitting ( ) Standing ( ) Light labor ( ) Heavy labor

Do you smoke? ( ) Yes ( ) No ( ) Former If yes, for how many years? ___ If you quit, how many years ago? ____

HEALTH HISTORY:

List any other doctors seen for your condition: _____
List any diagnosis and type of treatment: _____
Have you had similar accidents or injuries before? __ Yes __ No If yes, explain: _____
Have received: ( ) CT scan ( ) MRI ( ) Injections ( ) Spinal Implants ( ) Physical Therapy ( ) Surgery
( ) Chiropractic ( ) Medication
If yes, explain:
_____
List major Injuries/Falls: _____
List fractures: _____
List Surgeries:_____

MEDICATION	DOSAGE	TIMES DAILY	VITAMINS / SUPPLEMENTS

ALLERGIES_____ _____ _____

Please mark each items below for the signs and symptoms you presently have or previously

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles

SYSTEMIC
__ HIV/AIDS
__ HEPATITIS A
__ HEPATITIS B / C

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Breast Pain

Pregnant at this Time Y/N

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

.

Patient Signature: _____Date:____/____/_____

List the areas of pain from most to least painful:

(Neck, Low Back etc…)	1.	2.	3.
1. What side is the pain?	( ) Left ( ) Right ( ) Both	( ) Left ( ) Right ( ) Both	( ) Left ( ) Right ( ) Both
2. Grade the pain (1-10 with 10 being worst)			
3. How did the pain start?	( ) Gradual ( ) Sudden ( ) Accident/ or Fall	( ) Gradual ( ) Sudden ( ) Accident/ or fall	( ) Gradual ( ) Sudden ( ) Accident/ or Fall
4. When did it start?	Date _____	Date _____	Date _____
5. How severe is the pain?	( ) Mild ( ) Moderate ( ) Severe ( ) Unbearable ( ) Progressing ( ) Recurrent	( ) Mild ( ) Moderate ( ) Severe ( ) Unbearable ( ) Progressing ( ) Recurrent	( ) Mild ( ) Moderate ( ) Severe ( ) Unbearable ( ) Progressing ( ) Recurrent
6. Describe the pain:	( ) constant ( ) Intermittent ( ) Deep ( ) Sharp ( ) Burning ( ) Radiating	( ) constant ( ) Intermittent ( ) Deep ( ) Sharp ( ) Burning ( ) Radiating	( ) constant ( ) Intermittent ( ) Deep ( ) Sharp ( ) Burning ( ) Radiating
7. It Interferes with:	( ) Daily Routine ( ) Normal Life Style ( ) Household Activities ( ) Sleep ( ) Work ( ) School	( ) Daily Routine ( ) Normal Life Style ( ) Household Activities ( ) Sleep ( ) Work ( ) School	( ) Daily Routine ( ) Normal Life Style ( ) Household Activities ( ) Sleep ( ) Work ( ) School
8. What makes it worse?	( ) Sitting/Driving ( ) Standing Still ( ) Walking ( ) Movement/Exercise ( ) Sleeping ( ) Coughing/Sneezing	( ) Sitting/Driving ( ) Standing Still ( ) Walking ( ) Movement/Exercise ( ) Sleeping ( ) Coughing/Sneezing	( ) Sitting/Driving ( ) Standing Still ( ) Walking ( ) Movement/Exercise ( ) Sleeping ( ) Coughing/Sneezing
9. What makes it better?	( ) Sitting/Driving ( ) Standing Still ( ) Walking ( ) Movement/Exercise ( ) Sleeping ( ) Cold / Hot Compress	( ) Sitting/Driving ( ) Standing Still ( ) Walking ( ) Movement/Exercise ( ) Sleeping ( ) Cold / Hot Compress	( ) Sitting/Driving ( ) Standing Still ( ) Walking ( ) Movement/Exercise ( ) Sleeping ( ) Cold / Hot Compress

FINANCIAL AGREEMENT - AUTHORIZATION - ACKNOWLEDGEMENT

FINANCIAL AGREEMENT

I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees and any other charges incurred in the collection of any and all balance due to Action Chiropractic Inc.

Initials_____

AUTHORIZATION TO TAKE X-RAYS

I was advised that x-=rays were a necessary component of a thorough spinal examination and a key component to aid in establishing the accurate diagnosis of my condition. I have also been informed that all x-rays will be destroyed after 7 years.

Initials_____

FEMALE ONLY

To the best of my knowledge, I am not pregnant and the doctor has my permission to take x-rays for diagnostic purposes.

Initials_____

FOR TREATMENT OF MINOR

I hereby authorize the doctor to perform any necessary examination and treatments, including x-rays as deemed necessary to treat me:

_____ (Relationship to minor)

_____ (Full name of minor)

_____ (Parent or Guardian signature) _____ (Date)

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 the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. 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 am seeking treatment

.

Patient (Or Guardian) Signature_____ Date _____

Acknowledgment of Receipt of Privacy Practices (HIPPA)

I, _____, have received a copy, read a copy or have been offered a copy of Action Chiropractic, Inc.'s Notice of Privacy Practices with an effective date of January 1, 2011.

Release of Information

I authorize the release of information including the diagnosis, records: examination rendered to me and claims information to:

( ) Spouse_____
( ) Children_____
( ) Other_____
( ) Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing

Name of Patient_____

Patient Signature Date

_____
(Parent, Legal Guardian, Caretaker

This questionnaire helps us to understand how much your pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 – Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain is severe and does not vary.

SECTION 2 – Personal Care

- ☐ I would not have to change my way of washing or dressing in order to avoid pain
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some Washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are positioned conveniently.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 – Walking

- ☐ I have no pain walking.
- ☐ I have some pain when walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 – Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ I avoid sitting because it increases pain immediately

SECTION 6 – Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing, but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain immediately.

SECTION 7 – Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain, my normal night's sleep is reduced by less than ½.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 – Social Life

- ☐ My social life is normal and gives me no pain
- ☐ My social life is normal, but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 – Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling, which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain restricts all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow.
- ☐ My pain is neither getting better nor getting worse.
- ☐ My pain is gradually worsening.

PERSONAL INJURY / WORK INJURY

PATIENT NAME: _____DATE OF BIRTH_____ DATE _____

Date of Accident: _____ **Time of Accident: _____**

Weather conditions during accident (Circle One): RAIN SNOW FOG ICE CLEAR

Traffic Conditions (Circle One): NORMAL CONGESTED HEAVY

What body part(s) are injured since the accident? _____

Did any body parts strike the inside of the vehicle? YES NO
If yes, which body part(s): _____

Have you had similar injuries before this injury? YES NO

Were you taken by Ambulance to the Emergency room? YES NO

Did you take yourself to the Emergency room or other Health Clinic? YES NO

If yes, where did you go? _____ Date: _____

Name of other physician who treated you for this condition? _____

Where were you sitting in the car during the accident? _____

What part of your vehicle was impacted? _____

What part of the other vehicle impacted your vehicle? _____

Have you retained an attorney? YES NO His/her name _____

Under your home owner's policy, your insurance company may be responsible for payment of care rendered.
Name of InsuranceCompany_____

Describe the accident in your own words:

_____

_____

_____

DOCTOR'S LIEN

To (Attorney)**:**

Doctor:

ACTION CHIROPRACTIC INC
6935 OLD CANTON RD
RIDGELAND, MS 39157

RE: Patient Records and Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his case history, examination, diagnosis, treatment, prognosis of myself in regard to the accident I was involved in on

.

I hereby give a lien to said doctor on any settlement, judgment, or verdict as a result of said accident, and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for services rendered to me, and to withhold such sums from such settlement, judgment, or verdict as may be necessary to protect said doctor adequately.

Dated: _____ **Patient Signature:** _____

The undersigned, being attorney of record for the above patient, does hereby acknowledge of receipt for the above lien, and does agree to honor the same to protect adequately said above named doctor.

Dated: _____ **Attorney Signature:** _____

NOTICE OF INSURANCE COMPANY ASSIGNMENT

TO: **DATE:**

You are instructed to pay directly to the doctor at his office for all professional services rendered to me by this office.

This instruction to you is an assignment of my rights under medical coverage to the extent of this bill.

I hereby irrevocably transfer any cause of action for failure to pay benefits for this claim to Action Chiropractic Inc. This includes punitive damages, if applicable.

I do hereby authorize Action Chiropractic Inc., to release any information acquired in the course of my examination or treatment.

Please note that any and all photocopied reproductions of this and the foregoing authorization are to be accepted as if they were the original documents.

PAY TO: **ACTION CHIROPRACTIC INC.**
6935 OLD CANTON RD
RIDGELAND, MS 39157

Patient Name: _____

Patient Signature: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Claim #: _____