

Findlay Family Chiropractic Clinic

Present Complaint

What is the reason you are visiting our office today? _____

When did this begin? _____ Have you ever had this problem? **Y N** When _____

Did the problem begin () gradually () immediately after an event Explain: _____

Describe your pain (you may check more than one) () Sharp/stabbing () Dull/achy () Numbness
() Weakness () Shooting () Throbbing

How often are the complaints present? () Constant () Hours per day () Weeks () months

Since your problem began, is the pain: () Increasing () Decreasing () Not Changing

If your current complaints are associated with an old injury and were aggravated by a recent incident,
Please describe the incident and when it occurred:

Date _____ Description _____

Indicate how your symptoms are affected by physical activity:

- _____ Symptoms are unaffected by rest, exercise, ect.
- _____ Symptoms increase with, or are made worse by, exercise or physical activity.
- _____ Symptoms increase with, or are made worse by, rest or inactivity...

Are your complaints affecting your ability to work or otherwise be active?

- _____ No effect
- _____ Some physical restrictions (Able to perform light duty work and household tasks).
- _____ Need assistance often.
- _____ Have a significant inability to function without assistance.
- _____ I am totally disabled (impaired). Can not care for self.

Rate the severity of your pain, on a scale of 1-10

(Least) **0 1 2 3 4 5 6 7 8 9 10** (Most)

Have you seen another health care provider for this condition? _____ Who? _____

Were any of these tests preformed? X Rays MRI CT Scan EMG Other _____

Do you have any vomiting, nausea, fever, chills, or unexplained weight loss or weight gain? _____

Have you ever broken ribs or had any serious spinal injuries? _____ If yes, please explain to doctor upon examination

Have you ever had chiropractic care before? If so, when? _____

WOMEN: Is there any reason to believe that you may be pregnant? _____

PLEASE CONSIDER GETTING YOUR FAMILY UNDER CHIROPRACTIC CARE. STUDYS SHOW BOTH ADULTS AND CHILDREN CAN BENEFIT FROM A HEALTHY SPINE AND NERVOUS SYSTEM.

Please check any other the health problems/conditions that you HAVE or HAVE HAD in the past:

Headaches _____ Dizziness _____
Neck Pain _____ Pins/Needles in arms/hands _____ Pain b/w the shoulder blades _____
Low Back Pain _____ Pain in legs and feet _____ Pain in joints _____
Diabetic problems _____ Heart Problems _____ High Blood Pressure _____
Breathing problems _____ Asthma _____
Sinus problems _____ Allergies _____
Eye problems _____ Ear problems _____
Indigestion _____ Stomach problems _____
Skin problems _____ Gall Bladder problems _____ Thyroid problems _____
Constipation _____ Bladder problems _____ Bowel problems _____
Liver problems _____ Kidney problems _____ Menstrual problems _____
Weight problems _____ Fatigue _____ Sleeping problems _____

TERMS OF ACCEPTANCE

The goal of the chiropractor is not to diagnose/treat any disease but to locate, analyze, and correct vertebral subluxations. The purpose being to improve joint mechanics and to restore the innate healing mechanisms of the body via a nervous system free of irritation/interference.

* _____ INITIALS

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this clinic. Not limited to but including deductible, co-payment, and any services rejected by my insurance company.

Financial Policies:

- We will try our best to inform you of your insurance benefits, however we cannot be held responsible for what your insurance company tells us over the phone. Your EOB(Explanation Of Benefits) is what we have to legally go by.

* _____ INITIALS

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional/chiropractic expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as original

* _____ INITIALS

RELEASE OF INFORMATION

I authorize this clinic to release any patient information from my case to any insurance company, adjuster, and/or attorney involved in my case; and hereby release this clinic of any consequence thereof.

* _____ INITIALS

MISSED APPOINTMENT POLICY

Findlay Family Chiropractic Clinic reserves the right to bill any patient for a missed appointment with no advance notice of cancellation or reschedule.

* _____ INITIALS

SIGNATURE _____ DATE _____.

WE ARE GLAD YOU CHOSE OUR OFFICE FOR YOUR CHIROPRACTIC NEEDS!

How did you hear about our office? Circle or write.

Friend/Family (Name) _____ Yellow Pages Sign Other _____

Findlay Family Chiropractic Clinic
2303 N. Main St. Findlay, OH 45840
(419) 424-9922

NAME(last)_____ (first)_____ (MI)_____

Address_____

(Street) (City) (State) (Zip)

Home Phone #_____ **Work #**_____ **Cell #**_____

Birth Date_____ **Email (optional)**_____

Height_____ **Weight**_____ **Do you use tobacco?** _____

Marital Status: S M OTHER **SS#**_____

Health INS: BCBS Medical Mutual AETNA PARAMOUNT NONE OTHER_____

Policy Holder: _____ **Policy Holders DOB:** _____

Is this a **Workers' Comp claim?**_____ **Auto Policy Claim?**_____ **Personal Injury Lawsuit?**_____

List Medical doctors seen within past year:

Name_____ City_____ State_____ When_____

Name_____ City_____ State_____ When_____

Date of Last Physical Examination_____

List All Surgeries:

Type:_____ When_____

Type:_____ When_____

Type:_____ When_____

Past Accidents or injuries:

Type:_____ When_____

Type:_____ When_____

List All Medication and/or vitamins & minerals you are taking:

Type:_____ For_____ How long_____

Type:_____ For_____ How long_____

Type:_____ For_____ How long_____