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_____________________________________

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________________