FOR OFFICE USE ONLY

Name: Acct. # Date:

PATIENT INFORMATION

NAME _____ CALLED NAME _____

STREET ADDRESS _____ CITY _____

STATE _____ ZIP _____ BIRTHDAY _____ SOC.SEC.NO. _____

MAILING ADDRESS (check if same ☐) _____

HOME PHONE _____ WORK PHONE _____ EXT. _____

CELL PHONE _____ For text message reminders, list service provider: _____

EMAIL ADDRESS _____ SEX: ☐ M ☐ F

PREFERED CONTACT ☐ Home ☐ Work ☐ Cell ☐ Email INS. COMP: _____

YOUR EMPLOYER _____

EMPLOYER'S ADDRESS _____

MARITAL STATUS (circle one) Single Married Widowed Divorced Separated Number of children _____

SPOUSE'S NAME _____ SOC.SEC.NO. _____

SPOUSE'S BIRTHDATE _____ SPOUSE'S EMPLOYER _____

EMPLOYER'S ADDRESS _____ WORK PHONE _____

EMERGENCY CONTACT _____ PHONE _____

RELATION TO CONTACT REFERRED BY

I give Valley Chiropractic and its representatives permission to communicate with me via the contact information above.

_____ /_____

Patient signature Date

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PATIENT INFORMATION QUESTIONAIRE

CASE HISTORY

1. What are your primary complaints? _____
2. Symptoms are: ❒ Sharp ❒ Dull ❒ Ache ❒ Stabbing ❒ Shooting ❒ Burning ❒ Numbness ❒ Tingling ❒ Sore ❒ Stiffness ❒ Other: _____
3. Are there any additional complaints? ❒ Yes ❒ No List please: _____
4. How often do the symptoms occur? ❒ Occasional ❒ Frequent ❒ Constant ❒ Other: _____
5. Your condition is: ❒ Improving ❒ Getting worse ❒ Staying the same
6. Symptoms are *aggravated* by: ❒ Standing ❒ Walking ❒ Bending ❒ Turning ❒ Lifting ❒ Coughing / Sneezing ❒ Sleeping ❒ Driving ❒ Housework ❒ Working overhead ❒ Looking up / down ❒ Straining at stool ❒ Running ❒ Neck movement ❒ Other: _____
7. Symptoms are *relieved* by: ❒ Lying down ❒ Sitting ❒ Standing ❒ Bending ❒ Activity ❒ Stretching ❒ Exercise ❒ Heat ❒ Ice ❒ Pain medication ❒ Nothing ❒ Other: _____
8. Have you had recent treatment for this condition? ❒ Yes ❒ No If yes, please list dates, treatments and doctors:
9. Since your symptoms began, have you noticed a change in bowel function? ❒ Yes ❒ No
   Bladder function? ❒ Yes ❒ No Sexual function? ❒ Yes ❒ No ❒ Not applicable

PAST HISTORY

1. Have you had similar symptoms before? ❒Yes ❒No When? _____
2. If yes, what treatment did you receive? _____ Doctor's name: _____
3. Have you ever been to a chiropractor? ❒Yes ❒No With whom? _____
4. Do you have a family physician? ❒Yes ❒No Doctor's name: _____
5. Date of last physical examination: _____ Spine x-rays: _____ Urinalysis _____
6. Past hospitalizations dates & reasons: ❒None _____
7. Please list surgeries & dates: ❒None _____
8. Please list significant past injuries: Auto: ❒None _____
   Work: ❒None _____ Home: ❒None _____
9. Drug allergies? ❒Yes ❒No List: _____
10. List your current medications: _____
11. For what conditions are you taking medication? _____
12. Were you knocked unconscious in the past? ❒Yes ❒No Explain: _____
13. **WOMEN ONLY:** To your knowledge are you pregnant? ❒Yes ❒No
    Do you see an OB-GYN regularly? ❒Yes ❒No Past pregnancies were normal? ❒Yes ❒No

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PREVIOUS CONDITIONS

CONDITIONS	NOW HAVE	HAVE HAD	CONDITIONS	NOW HAVE	HAVE HAD	CONDITIONS	NOW HAVE	HAVE HAD
Arthritis	❒	❒	Asthma	❒	❒	Pacemaker	❒	❒
Fainting	❒	❒	Allergies	❒	❒	Thyroid Trouble	❒	❒
Dizzy Spells	❒	❒	Diabetes	❒	❒	Ulcer	❒	❒
Headaches	❒	❒	Heart Trouble	❒	❒	Cancer	❒	❒
Rheumatic Fever	❒	❒	Epilepsy	❒	❒	Polio	❒	❒
Broken Bones	❒	❒	High Blood Pressure	❒	❒	Prostate Trouble	❒	❒
Serious Injury	❒	❒	Low Blood Pressure	❒	❒	Kidney Trouble	❒	❒
Dislocated Joints	❒	❒	HIV	❒	❒	Tuberculosis	❒	❒
Scoliosis	❒	❒	AIDS	❒	❒	Sexually Trans. Disease	❒	❒
Fibroid Cysts	❒	❒	Endometriosis	❒	❒	Mental/Emotional Trouble	❒	❒

Other conditions: _____ ❒Have ❒ Have Had **❒ No Previous Conditions**

REVIEW OF SYSTEMS

Are you presently suffering (or recently suffered) from any of the following?

1. General

❒ **Normal**
❒ Fatigue
❒ Weakness
❒ Fever
❒ Loss of Sleep
❒ Chills
❒ Weight Change
❒ Night Sweats

Other: _____

2. Skin

❒ **Normal**
❒ Rash
❒ Redness
❒ Itching
❒ Bruise Easily
❒ Dryness
❒ Eczema
❒ Hair Changes
❒ Nail Changes

Other: _____

3. Neurologic

❒ **Normal**
❒ Headache
❒ Dizziness
❒ Fainting
❒ Convulsions
❒ Nervousness

Other: _____

4. Eyes

❒ **Normal**	Left	Right
Vision Trouble	❒	❒
Pain	❒	❒
Discharge	❒	❒

Other: _____

5. Ears

❒ **Normal**	Left	Right
❒ Hearing Trouble	❒	❒
❒ Ringing	❒	❒
❒ Pain	❒	❒
❒ Discharge	❒	❒

Other: _____

6. Nose

❒ **Normal**
❒ Pain
❒ Bleeding
❒ Sinus Problems
❒ Infections
❒ Absence of Smell

Other: _____

7. Gastrointestinal (Stomach / Digestion)

❒ **Normal**
❒ Decreased Appetite
❒ Increased Appetite
❒ Abdominal Pain
❒ Hemorrhoids
❒ Vomiting
❒ Diarrhea
❒ Constipation
❒ Excess Gas

Other: _____

8. Genitourinary

❒ **Normal**
❒ Painful Urination
❒ Impotence
❒ Bedwetting
❒ Sterility
❒ Prostate Problems
❒ Frequent Urination
❒ Inability to Hold Urine
❒ Irregular Menstruation
❒ Painful Menstruation
❒ Abdominal Vaginal Bleeding

Other: _____

9. Mouth / Throat

❒ **Normal**
❒ Sores
❒ Bleeding
❒ Tonsillitis
❒ Enlarged Glands
❒ Absence of Taste
❒ Abnormal Taste

Other: _____

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10. Heart / Lungs

❒ **Normal** ❒ Swollen Extremities
❒ Cough ❒ Blue Extremities
❒ Wheezing ❒ Varicosities
❒ Difficulty Breathing ❒ Murmur
❒ Palpitations ❒ Chest Pain
Other: _____

11. Breasts (Men Included)

❒ **Normal** ❒ Dimpling
❒ Lumps in Breast(s) ❒ Discharge
❒ Redness / Itching ❒ Pain
Other: _____

12. Endocrine (Metabolism)

❒ **Normal** ❒ Goiter
❒ Tremor ❒ Heat/Cold Intolerance
❒ ❒ Sugar in Urine
Other: _____

13. Psychologic

❒ **Normal** ❒ Depression
❒ Anxiety ❒ Phobias
❒ Mood Swings
Other: _____

FAMILY HISTORY

CONDITIONS	FATHER	MOTHER	BROTHER	SISTER	BROTHER	SISTER	BROTHER
Deceased	❒	❒	❒	❒	❒	❒	❒
Age currently or at time of death	_____	_____	_____	_____	_____	_____	_____
Cancer	❒	❒	❒	❒	❒	❒	❒
Diabetes	❒	❒	❒	❒	❒	❒	❒
Heart Trouble	❒	❒	❒	❒	❒	❒	❒
High Blood Pressure	❒	❒	❒	❒	❒	❒	❒
Scoliosis	❒	❒	❒	❒	❒	❒	❒
Arthritis	❒	❒	❒	❒	❒	❒	❒
Neck / Back Problems	❒	❒	❒	❒	❒	❒	❒

Please list other brothers & sisters, their age and health problems: _____

SOCIAL HISTORY

1. List recreational activities & hobbies you enjoy: _____
2. Have these been affected by your current condition? ❒ Yes ❒ No How? _____
3. Packs of cigarettes **per day**: ❒ Never ❒ <1 ❒ 1-2 ❒ 3-4 ❒ 5+ **4.** When did you quit? _____
5. Alcoholic drinks **per day**: ❒ Never ❒ <1 ❒ 1-2 ❒ 3-4 ❒ 5+ **6.** Recreational drug use? ❒ Yes ❒ No

OCCUPATIONAL HISTORY

1. Job Type: ❒ Full Time ❒ Part Time ❒ Temporary ❒ Other: _____
2. Hours per day: _____ **3.** Hours per week: _____ **4.** Length of time at present job: _____
5. Do your present complaints affect the number of hours you work per day? ❒ Yes ❒ No How much? _____
6. Does your work affect your present complaints? ❒ Yes ❒ No If yes, how? _____
7. What is your occupation? _____ **8.** Is lifting involved? ❒ Yes ❒ No
9. Average amount you lift? _____ **10.** How frequently? ❒ Occasionally ❒ Frequently ❒ Constantly
11. Maximum amount lifted? _____ **12.** What is your primary work position? ❒ Standing ❒ Sitting
13. Other job requirements: ❒ Bending ❒ Stooping ❒ Twisting ❒ Carrying ❒ Walking ❒ Other _____
14. Dominant hand: ❒ Right ❒ Left ❒ Neither **15.** Your stress level: ❒ None ❒ Minimal ❒ Moderate ❒ Great
16. How do you rate your work activity? ❒ Seated more than 50% of workday ❒ Light Manual Labor
❒ Moderate Manual Labor ❒ Heavy Manual Labor

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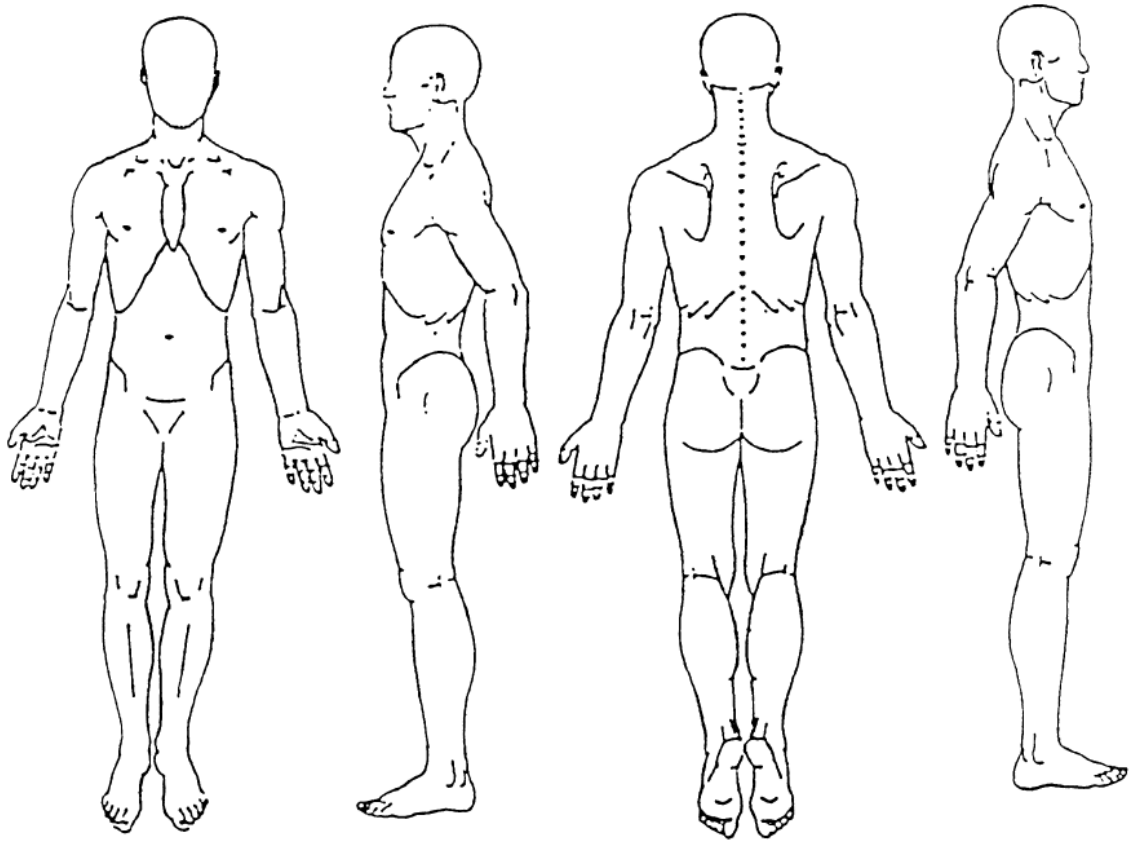
PAIN DRAWING

Using the following descriptive symbols, draw the location of your pain on the body outlines below

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^^^^^	======	000000	.....	//////////	XXXXXX
^^^^^^^	======	000000	.....	//////////	XXXXXX



CIRCLE THE PAIN LEVEL THAT BEST DESCRIBES YOUR CURRENT SYMPTOMS:

0 = NONE
1 = MINIMAL
2 = VERY MILD
3 = MILD
4 = MILD TO MODERATE
5 = MODERATE
6 = MODERATE TO SEVERE
7 = MILDLY SEVERE, RESTRICTS SOME ACTIVITY
8 = SEVERE, LIMITS MOST ACTIVITY
9 = VERY SEVERE
10 = SUICIDAL, UNBEARABLE PAIN

_____ /

Patient signature Date

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Name:	Acct. #	Date:

PAYMENT & COMMUNICATIONS POLICIES

- **Our office participates with many insurance companies and will submit claims for payment of our services to these insurance companies. Co-payments, deductibles, coinsurances, & services or supplies not covered by the insurance company, are the responsibility of the patient.**

- **Please check with your insurance company regarding our participation. Your insurance company will verify your benefits but it *WILL NOT GUARANTEE* PAYMENT FOR ANY SERVICES.**

- **If payment is not received from the insurance company within sixty (60) days of billing, the balance will become the patient's responsibility. You will be given thirty (30) days to settle the account or to set up an extended payment plan. Payment plans will not accrue interest as long as consecutive monthly payments are made. If payments are interrupted, a monthly interest fee will begin accruing at an interest rate of 1.5%.**

- **If your account becomes past due and no payment arrangements have been made, your account will be sent to a collection agency. Once an account is turned over for collection you will be released as a patient. In this event you may request, in writing, the transfer of your records to another doctor.**

- **Our agents or assignees may call by telephone regarding your account. You agree that our agents or assignees may place such calls using an automatic dialing/announcing device. You agree that our agents or assignees may make such calls to any telephone numbers you have provided including any mobile telephone or similar device. You agree that our agents or assignees may, for training purposes or to evaluate the quality of service, listen to and record phone conversations you have with our agents or assignees.**

Thank you for your understanding of our payment and communications policies and the need for such policies. Please let us know if you have any questions.

I understand that I am ultimately responsible for the balance of my account. If my account becomes assigned to a collection agency, I agree to pay collection agency fees of 25%, court costs, and attorney fees. I understand that all accounts with a balance due over 30 days will be assessed a 1.5 percent late charge per month on the unpaid monthly balance unless an extended payment plan is in effect as per above.

Signature of Patient and/or Guardian (SEAL) **Date**

Rev. 2/20

FOR OFFICE USE ONLY		
Name:	Acct. #	Date:

NOTICE OF MEDICARE ADVANTAGE PLAN BENEFITS FOR CHIROPRACTIC SERVICES

All Medicare Advantage plans follow Medicare rules. Services **not** covered by Medicare are **not** covered by Medicare Advantage plans.

The **only** chiropractic service covered under Medicare is **spinal** manipulation. Treatment other than spinal manipulation is **not** covered.

There are no exceptions.

Medicare, and Medicare Advantage plans, will only cover spinal manipulation if medical necessity is first established by performing a patient history, examination, and/or spinal x-rays.

However, as stated above, Medicare does not pay for any chiropractic services except spinal manipulation. Unfortunately, the services that Medicare, and Medicare Advantage plans, require for chiropractic benefits are **not covered** and are the patient's responsibility. Please refer to our office's "Payment Policy" page.

By my signature I hereby acknowledge that I have read and understand this Notice of Medicare Advantage Plan Benefits for Chiropractic Services:

Signature of patient or person acting on patient's behalf **Date**

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