APEX CHIROPRACTIC

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Address: _____

Home Phone: _____ Cell Phone: _____ Phone Carrier: _____

Best telephone number to reach you during the day: ☐ Cell ☐ Work ☐ Other: _____

Email: _____ Age: ____ DOB: _____ Height: ____ Weight: _____ Male/Female

Marital Status: ☐ S ☐ M ☐ W ☐ D How many children: ____ Names, Ages & Gender: _____

_____

Occupation: _____ Employer: _____ Phone: _____

Spouse Name: _____ Employer: _____ Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Who may we thank for referring you in? FACEBOOK, INSTAGRAM, OTHER: _____

Health History

Main symptom you feel: _____ Average Pain Level: 0-10 (10 being worst) _____

What caused your condition: ☐ Auto Accident ☐ Work Accident ☐ Overexertion, Lifting, Pulling, Etc.

☐ Repetitive Movement/Posture ☐ Fall/Slip/Trip ☐ Gradual Onset ☐ Other: _____

DOI: _____ Date symptom appeared: _____ Is symptom: ☐ Better ☐ Worse ☐ Same

PLEASE LIST YOUR HEALTH CONCERNS BELOW Evaluation: _____ Member ID: _____

Health Concerns: List Worst First	Rate Severity 1=Mild 10=Unbearable	When did this episode start?	Did you have the condition before? when?	Did the problem begin with an injury?	Constant or Intermittent?

CIRCLE ANY CONDITIONS YOU HAVE CURRENTLY OR IN THE PAST:

STROKE – CANCER – HEART DISEASE – SPINAL SURGERY – SPINAL FRACTURE – SCOLIOSIS – DIABETES

Have you seen any other doctors for this condition?

☐ Chiropractor ☐ Medical Doctor ☐ Other

If so, Who & When: _____

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List Surgeries and Date: _____

_____

List all MEDICATIONS you are currently taking: _____

When was your last AUTO ACCIDENT? _____

Have you had previous chiropractic care? ☐ YES ☐ NO If YES, When & Who: _____

Have you ever been knocked unconscious? ☐ YES ☐ NO

Fractured any bones? ☐ YES ☐ NO If YES, Please describe _____

Any other bodily trauma? _____

CIRCLE ANY & ALL OF THESE PROBLEMS YOU'VE HAD IN THE LAST 2 YEARS

DIZZINESS	ASTHMA	KIDNEY PROBLEMS	CHRONIC FATIGUE
HEADACHES	ULCERS	BLADDER PROBLEMS	LUPUS
VERTIGO	CHEST PAINS	IRRITABLE BLADDER	FYBROMYALGIA
EAR INFECTIONS	ARM NUMBNESS	SCIATICA	ADD / ADHD
GRATING OF NECK	ARM PAIN	LEG NUMBNESS	GERD
TMJ	HAND NUMBNESS	FEET NUMBNESS	ANXIETY
NECK PAIN	SHOULDER PAIN	LOW BACK PAIN	NERVOUSNESS
MIGRAINES	HEART DISORDERS	HIP PAIN	EPILEPSY
STIFFNESS IN NECK	MID BACK PAIN	LEG PAINS	DISC PROBLEMS
CHRONIC SINUS	STOMACH DISORDERS	KNEE PAIN	INFERTILITY
THROAT ISSUES	NAUSEA	LIVER DISEASE	OTHER_____
THYROID ISSUES	REFLUX	MENSTRUAL ISSUES	_____
ANXIETY	DEPRESSION	ADDICTION	

The information I have provided is accurate and I know it will be used to determine appropriate chiropractic care. I authorize the performance of X-rays and all of their diagnostic and therapeutic procedures for myself and/or for my dependent(s). I acknowledge receipt of the Notice of Privacy Practices. I also give my consent to receive important email correspondence from this office.

Signature of responsible party: _____ Date: _____

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Circle **ONLY ONE POINT VALUE** for the question in each section that most applies to your situation.

Section	Questions	Pain
My pain at this moment	None	0
	Mild	1
	Moderate	2
	Severe	3
	Very Severe	4
	Worst Imaginable	5
Looking after Myself currently	Normal without extra pain	0
	Normal but with some pain	1
	Painful and slow	2
	Need help but manage mostly	3
	Need help with most of it	4
	Cannot do much and stay in bed	5
Lifting weight right now	Heavy weight without pain	0
	Heavy weight but some pain	1
	No heavy weights unless positioned conveniently	2
	Light to medium weight if positioned conveniently	3
	Only very light weight	4
	None what so ever	5
Reading for me	No pain no matter how long	0
	Mild pain no matter how long	1
	Moderate pain no matter how long	2
	Difficult due to moderate pain	3
	Difficult due to severe pain	4
	Not possible right now	5
Pain with headaches	None	0
	Slight and infrequent	1
	Moderate and infrequent	2
	Moderate and frequent	3
	Severe and frequent	4
	Most or all of the time	5
My ability to concentrate	Full with no difficulty	0
	Full with slight difficulty	1
	Fair degree of difficulty	2
	A lot of difficulty	3
	Great degree of difficulty	4
	Not able at all	5
Performing my usual work	Easy to do as much as I want	0
	Can do but no more	1
	Can do mostly but no more	2
	Hardly can do	3
	Cannot do	4
	Cannot do any work	5
Driving my car	Easy and without pain	0
	As long as I want with only slight pain	1
	As long as I want with moderate pain	2
	Cannot do long because of pain	3
	Hardly do because of severe pain	4
	Cannot do at all	5
Sleeping for me	No trouble at all	0
	Slightly disturbed (less than 1 hour sleepless)	1
	Mildly disturbed (1-2 hours sleepless)	2
	Moderately disturbed (2-3 hours sleepless)	3
	Greatly disturbed (3-5 hours sleepless)	4
	Completely disturbed	5
My recreational activities	Cause no pain	0
	Cause some pain	1
	Cannot do all of them because of pain	2
	Can only do a few of them because of pain	3
	Can hardly do any of them because of pain	4
	Cannot do any at all	5

Oswestry Pain & Disability Index

Name: _____ Date: _____ OFFICE USE ONLY: Points _____ % _____

Circle ALL levels you are experiencing any symptoms listed.

	SYMPTOMS	INNERVATION
C1	HEADACHES, MIGRAINES, POOR METABOLISM, NERVOUSNESS, HYPERACTIVITY, INSOMNIA, CHRONIC FATIGUE, DIZZINESS, IMMUNITY	SYMPATHETIC NERVOUS SYSTEM, BRAIN, PITUITARY GLAND, INNER/MIDDLE EAR, BLOOD SUPPLY TO HEAD, SINUSES
C2	SINUS TROUBLE, ALLERGIES, PAIN AROUND EYES, EAR ACHES, DEAFNESS, BLINDNESS, CROSSED EYES, FAINTING	AUDITORY NERVE, OPTIC NERVE, TONGUE, SINUSES
C3	ACNE, PAIN OR LOSS OF SENSATION IN THE FACE	TRIGEMINAL NERVE, OUTER EAR, CHEEKS, TEETH
C4	WATERY EYES, RUNNY NOSE, HEARING LOSS	EAUSTACHIAN TUBE, MOUTH, NOSE, LIPS, ADENOIDS, MUCOUS MEMBRANES
C5	LARYNGITIS, HOARSENESS, THROAT PROBLEMS	PHARYNX, LARYNX, VOCAL CORDS
C6	NECK STIFFNESS, SHOULDER PAIN, TONSILLITIS, CROUP	NECK AND SHOULDER MUSCLES, TONSILS
C7	ARM/HAND PAIN, NUMBNESS OR TINGLING, THYROID CONDITIONS, POOR WEIGHT REGULATION, SLUGGISHNESS, NERVOUSNESS	THYROID GLAND, ARMS, HANDS
T1	DIFFICULTY BREATHING, SHORTNESS OF BREATH, ASTHMA, CHRONIC COUGH	ESPHAGUS, TRACHEA, HEART, FOREARMS, HANDS
T2	HEART CONDITIONS	HEART, CORONARY ARTERIES, LUNGS
T3	BRONCHITIS, PLEURISY, PNEUMONIA, INFLUENZA, CONGESTION	BREASTS, LUNGS, BRONCHI, HEART
T4	GALLBLADDER PROBLEMS, JAUNDICE	GALLBLADDER, HEART, LUNGS
T5	LIVER PROBLEMS, FEVERS, BLOOD PRESSURE PROBLEMS, POOR CIRCULATION, ARTHRITIS	ESOPHAGUS, GALLBLADDER, LIVER, HEART
T6	STOMACH PROBLEMS, NERVOUS STOMACH, INDIGESTION, HEARTBURN, DYPEPSIA	STOMACH, ESOPHAGUS, DUODENUM
T7	IRREGULAR CARBOHYDRATE METABOLISM, ULCERS, GASTRITIS, MID-BACK-PAIN	PANCREAS, DUODENUM, SPLEEN
T8	IMMUNITY ISSUES	SPLEEN, PANCREAS, ADREANAL GLANDS, DIAPHRAGM
T9	POOR SYMPATHETIC RESPONSE, POOR METABOLISM	ADRENAL GLANDS, SPLEEN, PANCREAS, OVARIES, UTERUS
T10	KIDNEY PROBLEMS, HARDENING OF THE ARTERIES, CHRONIC FATIGUE, NEPHRITIS, PHYLITIS	KIDNEYS, SPLEEN, PANCREAS, OVARIES, UTERUS, BLADDER
T11	ACHNE, PIMPLES, ECZEMA OR BOILS	KIDNEYS, OVARIES, UTERUS, BLADDER
T12	RHEUMATISM, GAS PAINS	SMALL INTESTINES, BLADDER, UTERUS
L1	CONSTIPATION, COLITIS, IRRITABLE BOWEL, DIARRHEA, HERNIAS	LARGE INTESTINES
L2	CRAMPS, DIFFICULTY BREATHING	ABDOMEN, APPENDIX, CECUM, BLADDER, UPPER LEG
L3	BLADDER TROUBLE, MENSTRUAL TROUBLE, MISCARRIAGES, BEDWETTING, IMPOTENCY	BLADDER, GENITALIA, PROSTATE
L4	SCIATICA, LOW-BACK PAIN, DIFICULT PAINFUL OR FREQUENT URINATION	SCIATIC NERVE, MUSCLES OF LOWER BACK, PROSTATE
L5	LEG/FOOT PAIN NUMBNESS OR TINGLING, POOR LEG CIRCULATION, SWOLLEN ANKLES, COLD FEET, LEG CRAMPS	LOWER LEG, SCIATIC NERVE, ANKLES, FEET, TOES, PROSTATE
S	SACRO-ILIAC CONDITIONS, SPINAL CURVATURES	BUTTOCKS, FASCIA OF HIP, BLADDER, PROSTATE, SCIATIC NERVE
C	HEMORRHOIDS, PRURITUS, LOW-BACK PAIN	RECTUM, ANUS

APEX CHIROPRACTIC

AUTO ACCIDENT

Patient Name: _____ **Date of Accident:** _____

Year, Make, and Model of the car you were in: _____

Please describe where in the vehicle you were: (ex. Driver, front passenger, ect.)_____

Others in the car with you: _____

Road conditions: ☐Dry ☐Wet ☐Icy ☐Gravel Road **Visibility outside:** ☐Good ☐Moderate ☐Poor

At Impact, was your vehicle: ☐Stopped ☐Moving (Speed ____ MPH) **Direction headed:** North/South/East/West

Did the vehicle you occupied strike something during the collision? ☐Yes ☐No If yes, what did you hit? _____

If you struck another vehicle, was the vehicle: ☐Stopped ☐Moving If moving estimate speed: ___ MPH

What was the estimated cost of repair to the vehicle you were in? $_____ ☐Unknown

Who was at fault for the accident? ☐You ☐Driver of the car you were in ☐Other driver ☐Undetermined

Was your head facing forward at the time of the accident? ☐Yes ☐No If not how was it turned?_____

Were you wearing a seatbelt? ☐Yes ☐No If so, what kind? ☐Shoulder ☐Lap **Did an airbag inflate?** ☐Yes ☐No

Did your body hit any part of the vehicle? ☐Yes ☐No Describe: _____

Did you lose consciousness? ☐Yes ☐No If so, how long? _____ **Did you brace yourself for impact?** ☐Yes ☐No

Did you go to the hospital? ☐Yes ☐No **Did you ride in an ambulance?** ☐Yes ☐No

Did you lose any days off work? ☐Yes ☐No How many? _____

Have you been in previous auto accidents? ☐Yes ☐No

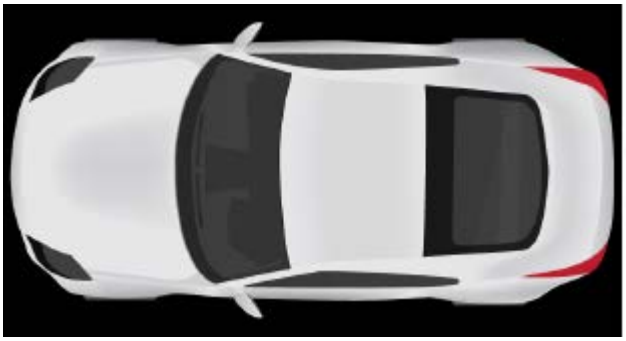
Please Circle and Damage to your car:

Describe: _____ Date: _____

Injuries: _____

_____

_____



APEX CHIROPRACTIC PRIVACY POLICY

Your protected health information may be used and disclosed to carry out treatment, payment, or health care operations. You may revoke this consent at any time by notifying Apex Chiropractic in writing except to the extent Apex Chiropractic has taken action and reliance on your consent. Please refer to the Notice of Privacy Policy Practices for Protected Health Information (Privacy Notice) for a more complete description of the uses and disclosures that Apex Chiropractic may use of your protected health information. You have the right to review the Privacy Notice prior to signing the consent. In accordance with the law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

You have the right to request Apex Chiropractic to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. Apex Chiropractic is not required to agree to requested restrictions. If Apex Chiropractic agrees to the requested restriction, Apex Chiropractic will honor the request and it will be binding on the office.

I herby consent to the use and disclosure by Apex Chiropractic, its workforce, and its business associates of my protected health information for the purposes of treatment, payment, and health care operations

I _____ (print name) do here by give Apex Chiropractic permission for

1: _____ 2: _____ 3: _____

to receive patient medical records and accounting information on my behalf.

Dates effective: _____/_____/_____ to _____/_____/_____

Patient Name: _____

Patient Signature: _____ Date: _____

Apex Employee: _____ Date: _____

MedPay (AUTO) INSURANCE VERIFICATION FORM

Auto Insurance: _____ Phone: _____ Fax: _____

Adjuster: _____ Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Guarantors name: _____ DOB: ____/____/____

Address: _____ Phone: _____

ASSIGNMENT OF BENEFITS:

I authorize that any insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance, pre-paid health care plan, or Medicare be made directly to: Apex Chiropractic.

RELEASE OF INFORMATION:

I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan, or Medicare.

PAYMENT AGREEMENT:

I understand that there is no guarantee that my insurance companies, pre-paid health plan, or Medicare will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

Patient Signature: _____ Date: _____

Apex Chiropractic: _____ Date: _____

OFFICE USE ONLY

MedPay: _____

Used: _____

APEX
CHIROPRACTIC

Consent to Initiate Care

At our office, we have one simple goal. We want to change your life by rendering the highest quality Chiropractic care. We do this by specific scientific chiropractic adjustments designed to remove vertebral subluxations affecting your nervous system and interfering with your inborn given innate ability to be healthy. To accomplish this goal, we must work together. We believe good Chiropractic care requires a partnership between you and us. Please read over our clinic's procedures to understand how our clinic functions, so that you can be an active participant in your care. If you have any questions please feel free to ask us.

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc, and although rare, minor fractures have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures, provided at Apex Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996. (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Print your name: _____ Today's date: _____

Sign your name: _____

IRREVOCABLE ASSIGNMENT & NOTICE OF DOCTOR'S LIEN

I do hereby irrevocable assign, transfer, and set over to Apex Chiropractic any sums that may be due and owing for chiropractic services rendered, including interest, and to be rendered hereafter to me, or to the persons(s) named below by reason of the accident dated below. I authorize Apex Chiropractic to furnish my attorney and insurance company with a full report of my examinations, diagnosis, treatment, prognosis, etc., of myself and/or dependents(s) in regard to the accident dated below.

I fully understand that I am directly and fully responsible to Apex Chiropractic for all medical benefits, including major medical, submitted by Apex Chiropractic for service rendered to me and this agreement is made solely for Apex Chiropractic's protection. I further understand that such payment is not contingent upon any settlement, judgment or verdict by which I may eventually recover said fee. If this account is assigned for collection and/or suit, I agree to pay collection costs, interest (1.5% monthly), attorney fees, and court costs added as necessary to the total amount.

I hereby authorize and direct my attorney and/or insurance company/third party payer to pay to Apex Chiropractic such sums as may be due and owing for medical service rendered to and for me by reason of this accident and by reason of any other bills that are due at Apex Chiropractic, including cost of reproducing records, and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Apex Chiropractic.

I _____ (Print Name) hereby further give to Apex Chiropractic a lien on any and all proceeds of any settlement, judgment or verdict which may be paid to my attorney or myself as the result of the injuries for which I have been treated or injuries in connections therewith.

I agree to never rescind this document and that a recession will not be honored by my attorney or Apex Chiropractic. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney will honor this lien as inherent to the settlement and enforceable upon the case as if it were executed to him/her.

Signature below implies agreement with the above terms and confirms the understanding that if my attorney does not wish to cooperate in protecting Apex Chiropractic's interest, Apex Chiropractic will not await payment but may declare the entire balance due and payable immediately.

Patient Name: _____ Date: _____

Patient Signature: _____ Accident Date:_____