TECUMSEH NECK & BACK FAMILY CHIROPRACTIC

NAME (last)_____(first)_____(MI)_____ **Date**_____

Address_____
(Street) (City) (State) (Zip)
Home Phone #_____**Work #**_____**Cell** #_____

Birth Date_____ **Email** (optional)_____

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

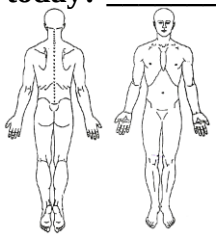
Number of Children _____ **Ages** _____ **Occupation** _____

Health INS: BCBS PPOM AETNA PARAMOUNT NONE OTHER_____

Policy Holder: _____ **Policy Holder's DOB:**_____

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

PLEASE MARK AN 'X' ON THE FIGURE TO SHOW AREAS OF COMPLAINT



AGE _____
HEIGHT _____
WEIGHT _____

PLEASE ANSWER ALL QUESTIONS AS FULLY AS POSSIBLE

Describe your pain: DULL SHARP ACHING SHOOTING NUMBNESS OTHER_____

What caused this? (**IF THIS IS WORK RELATED, PLEASE SEE FRONT DESK**)

_____

When did this begin? _____

What makes it worse? Bending Lifting Coughing Standing Sitting Walking Other_____

What makes it better? Rest Ice Sitting Standing Medication Nothing Other_____

How would you rate the pain? (No Pain is 0 – 10 is the Worst Pain Ever) _____

Is the pain Constant or does it Come & Go?_____

Have you seen any other health care professional for this condition? If so, what did they tell you?

_____

Are you taking any medications? If so, please list:_____

Have you had any major surgeries or hospitalization? If so, please list:_____

Have you had any auto accidents or serious injuries in the past? If so, please explain:_____

_____

Have you ever had a chiropractic care before? If so, **when** and **with whom**?_____

Is there anything else our doctors should be aware of before adjusting your spine?_____

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Place of Employment_____

What type of work do you do? (sitting, lifting, etc.)_____

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

TERMS OF ACCEPTANCE

The goal of the chiropractor is not to diagnose/treat any disease but to locate, analyze and correct vertebral subluxations in order to improve joint mechanics and to restore the innate healing mechanisms of the body through 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 Policy: 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. Legally, your EOB (Explanation Of Benefits) is what we have to follow to determine your benefits.

*_____
INITIALS

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check - made out to 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

SIGNATURE _____DATE_____

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

How did you hear about our office? Please Circle or Write

Friend/ Family (Name) _____ Yellowbook Frontier Sign Newspaper Ad

Other ________________________________ Massage Therapist (Name)______________________________