PATIENT INFORMATION

Date _____

Patient _____

Email Address _____

Address _____

_____

Sex: ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Occupation _____

Employer _____

How Did You Find Us?

❑ Google
❑ Facebook
❑ Yelp
❑ Website
❑ Friend / Family Member
❑ Other _____

Whom may we thank for referring you? _____

_____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Moss all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

PHONE NUMBERS

Home _____ Cell _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home Phone _____

Work Phone _____ Ext. _____

ACCIDENT INFORMATION

Is condition due to an accident? ❑ Yes ❑ No Date _____

Type of accident: ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Worker Comp. ❑ Other

Attorney Name (if applicable): _____

PATIENT CONDITION

Chief Complaint: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

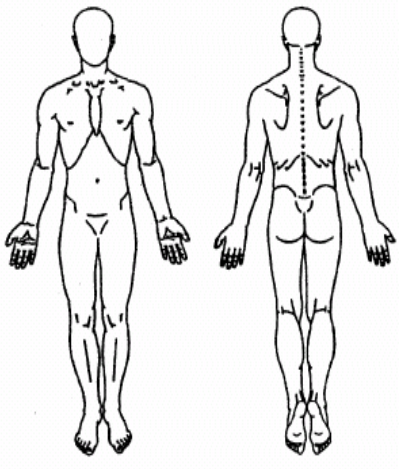
Circle on the picture where you continue to have pain, numbness, or tingling

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching
❑ Shooting ❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling

How often do you have this pain? _____

Is it constant or does it come and go? _____

On a scale from 1 – 10, where 1 feels great and 10 is the worst pain possible, please rate your pain: 1 2 3 4 5 6 7 8 9 10



HEALTH HISTORY

What treatment have you already received for your current condition? (*circle all that pertain*)

Medications Surgery Physical Therapy Chiropractic Adjustments None Other _____

Names of Medication: _____

Name and address of other doctor (s) who have treated you for your condition: _____

Please list any accidents or falls and the date of the incident: Car Accidents: _____

Falls: _____ Sports: _____ Other: _____

List any broken bones (fractures) or dislocations: _____

Are you being treated for any other conditions that you have not told us about? _____

Date of last physical exam: _____ Doctor's Name: _____

Are you presently taking any mediation –prescription or over-the-counter? Please list them here: _____

_____

Activities of Daily Living: *Check all the activities that you are unable to do or have difficulty with because of this problem.*

- ❑ Sitting
- ❑ Standing
- ❑ Bathing
- ❑ Riding in car
- ❑ Dressing
- ❑ Grooming
- ❑ Bending at waist
- ❑ Twisting or turning neck
- ❑ Twisting or turning back
- ❑ Lifting
- ❑ Carrying
- ❑ Reaching
- ❑ Sexual relations
- ❑ Kneeling
- ❑ Pulling
- ❑ Pushing
- ❑ Moving Arms
- ❑ Moving legs
- ❑ Lying/sleeping
- ❑ Turning over
- ❑ Moving to/from bed
- ❑ Going to the bathroom
- ❑ Cough/sneeze
- ❑ Moving to/from chair
- ❑ Transfer to/from shower
- ❑ Walking
- ❑ Golfing
- ❑ Recreational activities
- ❑ Going up/down stairs
- ❑ Laundry
- ❑ Household chores/Housework
- ❑ Other _____

Place an "X" in the boxes that pertain to your health history. Please mark any conditions that you currently have or conditions that you have had in the past:

- ❑ AIDS/HIV
- ❑ Prostate Problems
- ❑ Asthma
- ❑ Osteoporosis
- ❑ Heart Disease
- ❑ Migraines
- ❑ Hernia
- ❑ Heart Attack
- ❑ Other _____
- ❑ High Cholesterol
- ❑ Heartburn/Acid Reflux
- ❑ Herniated Disc
- ❑ Headaches
- ❑ Multiple Sclerosis
- ❑ Stroke
- ❑ Cancer Type: _____
- ❑ Thyroid Condition (Hyper / Hypo)
- ❑ Rheumatoid Arthritis
- ❑ Osteoarthritis
- ❑ Pneumonia
- ❑ Vaginal Infections
- ❑ Epilepsy/Seizures
- ❑ Diabetes
- ❑ Pacemaker
- ❑ High Blood Pressure

Current Symptoms:

- ❑ Headaches
- ❑ Neck Pain
- ❑ Sleeping Problems
- ❑ Low Back Pain
- ❑ Pain Between Shoulders
- ❑ Depression
- ❑ Lights Bother Eyes
- ❑ Loss of Memory
- ❑ Shoulder Pain
- ❑ Neck Stiff
- ❑ Joint Swelling
- ❑ Fever
- ❑ Loss of Balance
- ❑ Nausea
- ❑ Pain in Hands or Arms
- ❑ Numbness in Hands or Arms
- ❑ Pain in Legs or Feet
- ❑ Numbness in Legs or Feet
- ❑ Fatigue
- ❑ Painful Urination
- ❑ Thirsty
- ❑ Frequent Urination
- ❑ Constipation
- ❑ Diarrhea
- ❑ Shortness of Breath
- ❑ Sinus pain
- ❑ Allergies
- ❑ Swelling
- ❑ Chest Pains
- ❑ Inability to concentrate
- ❑ High Blood Pressure
- ❑ Weight Loss/Gain How Much _____
- ❑ Tension
- ❑ Irritability
- ❑ Dizziness
- ❑ Nervousness
- ❑ Loss of Smell or Taste
- ❑ Stomach Upset
- ❑ Menstrual Cramps
- ❑ Jaw pain/clicking
- ❑ Flashes in eyes
- ❑ Loss of vision

Notes: _____

_____

_____

DIAGNOSTIC HISTORY

Has any other doctor/hospital taken any X-rays, MRI, CT Scans because of your present condition? _____ Yes _____ No

If Yes, When? _____ Date Where? _____

Were the x-rays taken while standing? _____ Yes _____ No

Is there any chance that you are pregnant? _____ Yes _____ No Date of Last Menstrual Cycle: _____

SURGERIES OR PROCEDURES

DATE		DATE		DATE	
_____	Tonsillectomy	_____	Tubes in Ears	_____	Sinus
_____	Gall Bladder	_____	Kidney Stones	_____	Hernia
_____	Spinal Surgery	_____	Hysterectomy	_____	Cosmetic
_____	Knee (s) (Lt / Rt)	_____	Hip (Lt / Rt)	_____	Carpal Tunnel
_____	Other: _____	_____	Other: _____		

❑ **I have never had any surgeries** **Notes:** _____

SOCIAL HISTORY/HABITS

Smoking	Packs/Day:	_____	**Exercise:**	_____ None	**Days per week:**	**Describe Exercise:**
Drinking	Alcohol:	_____		_____ Mild	1 – 2	_____
Caffeine	Cups/Day:	_____		_____ Moderate	3 – 4	_____
Water	Glasses/Day:	_____		_____ Active	5 – 7	_____

Sleep: **Hours per night** (circle one) 3 – 5 5 – 7 8 – 10 **Do you wake up tired?** _____ Yes _____ No

FAMILY HISTORY

	Headaches	Back Pain	Neck Pain	Carpal tunnel	Scoliosis
Mother	❑	❑	❑	❑	❑
Father	❑	❑	❑	❑	❑
Brother, # of _____	❑	❑	❑	❑	❑
Sister, # of _____	❑	❑	❑	❑	❑
Children	❑	❑	❑	❑	❑

Does anyone in your family have an medically diagnosed conditions? If so, whom? _____

_____ **N/A or None**

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The Doctor's office will prepare reports and forms necessary to assist me in the filing of my claim with the insurance company but cannot guarantee reimbursement from the insurance company. Direct payments made from the insurance company to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account.

I authorize the Doctor to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care, and I give authorization for these procedure to be performed. The amount paid to the Doctor's office for X-rays is for the examination only; the X-ray negatives will remain the property of the Doctor's office and will remain on file at the Doctor's office as long as I am a patient. I am the responsible party for payment of any treatment received or incurred on this account. This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Patient's/Guardians Signature: **X** _____ **Date:** _____

Witness' Signature: **X** _____ **Date:** _____

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Release of Information: Your Protected Health Information (PHI) will be used by this office and/or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information: You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent: You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I, _____**(print)** acknowledge that I have reviewed the above information and I authorize this office to release information concerning my condition and treatment to my insurance company, attorney, insurance adjuster and/or other health care providers deemed necessary for treatment purposes, processing my claim, benefits and payment of services rendered to me as well as coordinated treatment. I do understand that if I choose to refuse release of this information, that my PHI will be used **within** the office for purposes of my care, to those individuals designated by the doctor.

Patient or Guardian Signature: X_____ Date: _____

Informed Consent for Treatment

I hereby request and consent to the performance of chiropractic procedures, various forms of physio-therapy, physical examination, x-ray studies, and/or any clinical services that are deemed necessary in my case to be administered by the doctor and/or any support staff employed or contracted by this office or clinic. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as “rare” and include, but are not limited to, muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fracture, disc injury, stroke, dislocations and sprains.

I understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also be used to alleviate other symptoms through a conservative approach with hopes to avoid more invasive procedures. I further understand that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has the right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I further understand that there are other treatment options available for my condition, and that I have the right to a second opinion should I have concerns as to the nature of my symptoms and/or treatment options. If during the course of my care my insurance company requires me to take an examination from any other doctor, I will notify this facility/physician immediately. I understand that failure to do so may jeopardize my case.

I, _____**(print)** have read the above consent and I have had an opportunity to ask questions regarding its content. By signing below, I agree to the above-named procedures and intend this consent to cover my entire course of treatment for my present condition and for any future condition(s) for which I seek treatment with this office.

Patient or Guardian Signature: X_____ Date: _____