1. PATIENT DEMOGRAPHICS

Date:____/____/_____

Name_____

Address_____

_____

City State Zip

Sex: M___ F___ Age___

Birth Date_____/_____/_____

SS #_____

Occupation_____

Employer_____

How did you hear about us? _____

2. CONTACT NUMBERS

Home: _____

Cell Phone: _____

Work Phone: _____

Email: _____

3. INSURANCE

We will copy your insurance card; however, we do need the following information.

Are you the subscriber to the insurance?

Yes____ No____

If the subscriber is someone other than yourself, please fill in the following:

Subscriber's Name:_____

Relationship:_____

Birth Date____/____/_____

4. EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone Number: _____

Is this related to a Personal Injury Claim, Car Accident, or Workman's Comp?
Yes: ____
If yes, Date of Injury: _____
No: ____

FINANCIAL AGREEMENT

1) I authorize payment directly to this office of my group insurance benefits. As a courtesy to you, we will submit insurance claims on your behalf. Please realize that insurance companies do not guarantee payment. Therefore you understand that you are personally responsible for all payments on all services.
2) If you are an insurance patient, you agree to first meet your deductible in full and pay your co-insurance or co-payment. We require that you pay your estimated portion of the total fee at the time of service.
3) Your time as well as the Doctor's at Emerson Chiropractic is very valuable. If the need arises that you have to reschedule an appointment, please provide us with a courtesy call so that we may have time to contact other patients that may be waiting for that time frame. Failure to notify us within 24 hours of a missed massage appointment will be assessed a $25 fee which will be added to your account. Balances outstanding 30 days are subject to additional collection fees, a $20 late fee, applicable interest charges of 1.5% per month and may be debited to your credit card. Original x-rays and records will remain the property of this clinic.

Signing this document acknowledges that I have read the above information, I understand my responsibilities, and Authorize Emerson Chiropractic to bill my credit card as outlined above.

Your credit card on file: VISA__ MASTERCARD__ DISCOVER__

Credit Card #_____ EXP DATE_____/_____/_____ CVV_____

Signature_____ **Date**_____/_____/_____

PATIENT HEALTH HISTORY

Name_____

Who is your primary doctor? _____ **Phone**:( )_____

List <u>all</u> surgeries:

Date: _____ Type: _____
Date: _____ Type: _____
Date: _____ Type: _____

Medications:

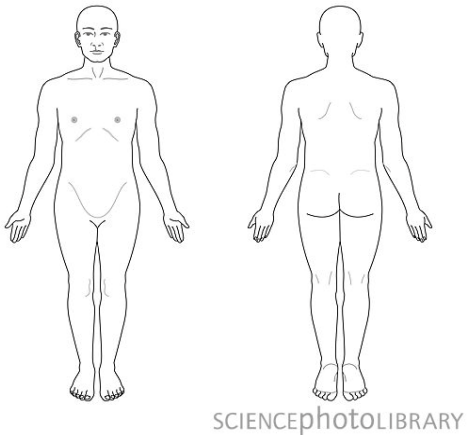
Type: _____
Type: _____
Type: _____

Do you have/had any other medical conditions? (circle all that apply)

Heart Disease Diabetes High Blood Pressure Lung Pacemaker Hernia Dizziness
Stroke Migraine Herniated Disc Allergies Cancer_____

Chief Complaints:	**Pain Level:**	**Pain Began:**
1_____	low 2 4 6 8 10 high	_____
2_____	low 2 4 6 8 10 high	_____
3_____	low 2 4 6 8 10 high	_____

SHADE AREAS OF PAIN **FRONT** **BACK**



Quality: (circle all that apply) occasional frequent constant dull sharp shooting
tingling burning numb spasm

What increases pain?_____ **What decreases pain?**_____

What activities can you no longer do or have difficulty performing?

grooming bathing dressing driving sitting standing walking
cooking yard work childcare school biking sports stairs

Previous treatment for this same condition:

Physical Therapy Chiropractic Trigger Point Injection Epidural Prescription Medication

Results: Good Fair No help

Functional Rating Index

Patient Name: _____

In order to properly assess your condition and accurately grade your response to treatment, we must understand how much your neck and/or back problem(s) have affected your ability to manage everyday activities (ADLs).

For each section below, please circle the **ONE** number which most clearly describes your condition right now.

Pain Intensity:
0. No Pain
1. Mild Pain
2. Moderate Pain
3. Severe Pain
4. Worst Possible Pain

Pain Frequency:
0. No Pain
1. Occasional pain, 25% of the day
2. Intermittent pain, 50% of the day
3. Frequent pain, 75% of the day
4. Constant pain, 100% of the day

Sleeping:
0. Perfect Sleep
1. Mildly Disturbed Sleep
2. Moderately Disturbed Sleep
3. Greatly Disturbed Sleep
4. Totally Disturbed Sleep

Recreation:
0. Can do all activities
1. Can do most activities
2. Can do some activities
3. Can do few activities
4. Cannot do any activities

Personal Care (washing, dressing, ect.):
0. No pain; no restrictions
1. Mild pain; no restrictions
2. Moderate pain; need to go slowly
3. Moderate pain; need some assistance
4. Severe pain; need 100% assistance

Lifting:
0. No pain with heavy weight
1. Increased pain with heavy weight
2. Increased pain with moderate weight
3. Increased pain with light weight
4. Increased pain with any weight

Travel (driving, ect.):
0. No pain on long trips
1. Mild pain on long trips
2. Moderate pain on long trips
3. Moderate pain on short trips
4. Severe pain on short trips

Walking:
0. No pain, any distance
1. Increased pain after 1 mile
2. Increased pain after ½ mile
3. Increased pain after ¼ mile
4. Increased pain with all walking

Work:
0. Can do usual plus unlimited extra work
1. Can do usual work, no extra work
2. Can do 50% of usual work
3. Can do 25% of usual work
4. Cannot work

Standing:
0. No pain after several hours
1. Increased pain after several hours
2. Increased pain after 1 hour
3. Increased pain after ½ hour
4. Increased pain with any standing

Patient Signature: _____ Date: _____

Raw Score: _____ Percent Impairment: _____ Dr. Initials: _____

Emerson Chiropractic

Doctor and Patient Goals from Care

Dr. Christian and Dr. Pete both want to set goals so that they know you're getting the most out of care and that progress is being made. Your health is the utmost important to us here at the office and we are passionate about helping keep you out of pain and functioning at your best.

Patient Oriented Goals

What are your goals from receiving Chiropractic Care? What health goals do you have established for yourself that we could help with? What do you want to be able to do again that you have been unable to?

_____
_____
_____
_____
_____
_____
_____
_____

Name:_____ **Date:**_____
Signature:_____

Doctor Established Goals for Patients

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Doctor:_____ **Date:**_____

Emerson Chiropractic
Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "My" refer to the patient,
and "the Clinic" refers to Emerson Chiropractic

I consent to the use or disclosure of my protected health information by the Clinic for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of the Clinic. I understand that analysis or treatment of me by the Clinic may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Clinic is not required to agree to the restrictions that I may request. However, if the Clinic agrees to a restriction that I request, the restriction is binding on the Clinic.

I have the right to evoke this consent, in writing, at any time, except to the extent that the Clinic has taken action in the reliance on this consent.

My "protected health information" means health information, including my demographic information, collected for me or created by my physician, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the "Notice of Privacy Practices" and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the Clinic. The Notice of Privacy Practices also describes my rights and the duties of the Clinic with respect to my protected health information.

The Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Clinic and requesting a revised copy be sent in mail or asking for one at my next appointment.

Signature:_____ Date:____/____/_____