1. PATIENT DEMOGRAPHICS

Date: ____/____/_____

Name: _____

Address: _____

_____

City State Zip

Sex: M___ F___ Age: ___

Birth Date: _____/_____/_____

Marriage Status: Married Single Other

Occupation: _____

Employer: _____

How did you hear about us? _____

2. CONTACT NUMBERS

Cell Phone: _____

Other Phone: _____

Email: _____

3. INSURANCE

I, the patient, have health insurance that I wish Emerson Chiropractic to file with:

Yes: _____ No: _____

If yes, my insurance company is:

_____

Emerson Chiropractic will make a copy of your health insurance card in order for any health benefits to be filed.

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 & PRIVACY AGREEMENT

1) Your time, as well as the Doctor's at Emerson Chiropractic, is very valuable. If the need arises 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 an appointment during that time frame. A $30 fee will be added to your account when failure to notify us within 24 hours of a missed massage appointment. Any account with an outstanding balance over 30 days old, will be subject to a late collection fee of $20. If any balance is still unpaid after 60 days, the account will accrue 1.5% interest per month. After 180 days, Emerson Chiropractic may elect to send any account with an outstanding balance in for collections.
2) Emerson Chiropractic will submit insurance claims on the patient's behalf. The patient is responsible to meet their deductible and to pay their co-insurance or co-payment, whichever may apply with their health insurance policy. I authorize Emerson Chiropractic to bill my insurance on my behalf and receive payments for the services rendered.
3) Payment for all services rendered is expected to be paid in full at the time of service unless other arrangements have been made with. Emerson Chiropractic at the patient's request will hold a credit card on file, for the patient's convenience.
4) Emerson Chiropractic is responsible to maintaining current records. All x-rays and records are to remain the property of this clinic.
5) Emerson Chiropractic follows all current **HIPPA Guidelines and Practices**. The office's notice of privacy practices is available for review upon request.

By signing this document, I acknowledge that I have read the above information, and understand the financial and privacy agreement put in place by Emerson Chiropractic.

Your credit card on file: VISA __ MASTERCARD __ DISCOVER __

Credit Card #_____ EXP DATE_____/_____/_____ CVV_____

Signature_____ Date_____/_____/_____

PATIENT HEALTH HISTORY

Name _____

Who is your primary doctor? _____ **Are you on BLOOD THINNERS? Y N**

List all surgeries:

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

Medications:

Type: _____
Type: _____
Type: _____

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

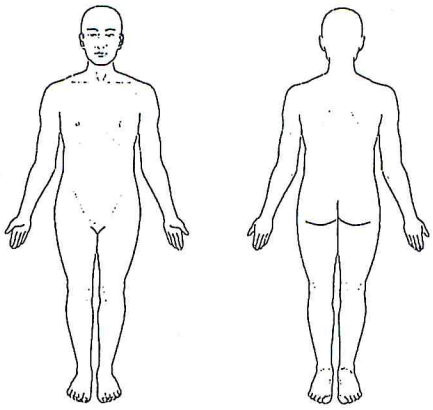
Heart Disease Diabetes High Blood Pressure Lung Pacemaker Hernia Dizziness
Stroke Migraine Herniated Disc Allergies_____ Cancer_____**Pregnant Y N**

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

How did the pain begin?_____

SHADE AREAS OF PAIN

FRONT BACK



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

What movements increase pain?_____

What activities can you no longer do or have difficulty performing?
bathing dressing driving sitting standing walking yardwork childcare stairs sports

Previous treatment for this same condition: Prescription Medication_____
Physical Therapy Chiropractic Trigger Point Injection Epidural OTC drugs
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: _____