# NEW PATIENT INFORMATION

**Patient Information:**

**Legal Name:** _____ **Date:** ___/___/_____

**Preferred Name:** _____ **Sex:** Male ___ Female ___

**Address:**_____
Street Address City State Zip

**Cell Phone:** _____ **Email:** _____

**Birth Date:** ___/___/_____ **Martial Status:** Married Single Other

**Occupation:** _____ **Employer:** _____

**How Did You Hear About Us?:** Internet Social Media Insurance Drive-by
Referral/Event: _____

**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.**

**Emergency Contact:** Name: _____
Relationship: _____ Cell Phone: _____

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

# FINANCIAL AGREEMENT

## 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.**

**Signature:**_____ **Date:** ____/____/_____

# CONSENT

## Rules of Acceptance

### KEEP YOUR SCHEDULED APPOINTMENTS

To get the best results throughout care, it is important to keep your scheduled appointments. Emerson Chiropractic will notify you of any upcoming appointments and missed appointments. If you are ten minutes late, we have the right to cancel your massage or therapy appointment. Any missed therapy appointment may be subject to a $10 fee. Emerson Chiropractic charges a $30 fee for any missed massage therapy appointments without 24-hour notice.

### KEEP YOUR ACCOUNT CURRENT

Emerson Chiropractic has a Zero Balance Policy. Your payment is expected at the time of service unless the billing department has made special arrangements for your account. Any account with an outstanding balance over 30 days old, will be subject to a late collection fee of $20 and 1.5% every 30 days past that.

### MAINTENANCE CARE

After treatment, Emerson Chiropractic recommends you continuing on with a maintenance/wellness plan. The purpose of maintenance/wellness care being to continue to maintain and improve the function of the spine.

## Informed Consent

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both parties to be working towards the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you can make the decision whether or not to undergo chiropractic care.

Chiropractic is a science, philosophy, and art which concerns itself with the relationship between the spinal structures and the health of the nervous system. Vertebral subluxation can cause a disturbance to this system. The practice of spinal adjustments works to correct and/or reduce these subluxations to promote spinal alignment, joint mobility, nerve function, soft tissue compliance, decrease pain, decrease muscle spasms. Chiropractic care has been proven to be very safe and effective. Some procedures may carry a low risk of complication with them. It is not unusual to experience soreness after the patients first few spinal adjustments. In rare cases it is, not limited to, but possible to suffer from, muscle spasms, stiffness, rib fracture, disc injury, headaches, and dizziness. Problems seldom arise, but it is our policy to fully inform and educate the patient.

In addition to adjustments, the patient understands that as a part of care various techniques will be used to help in treatment. This may be but is not limited to; spinal decompression, intersegmental traction, deep tissue massage therapy, heat/ice, ultrasound, cold laser, therapeutic exercises and targeted muscle work.

All services offered in this office are all geared towards the patients care with the purpose and goal of facilitating the healing process. However, during the course of treatment, the patient may be referred out for further imaging or to a specialist in the case of unusual findings.

By signing below, I have read and fully understand the above and therefore accept chiropractic care.

**Signature:** _____ Date: _____/_____/_____

# HEALTH HISTORY

**Name:** _____ **Primary Doctor:** _____

**Are you on blood thinners?:** Yes ___ No ___ **FEMALE:** Are you pregnant? Yes ___ No ___ If yes, due date?: ___/___/____

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

- Heart Disease
- Diabetes
- High Blood Pressure
- Lung
- Other: _____
- Dizziness
- Stroke
- Pacemaker
- Hernia
- Migraine
- Herniated Disc
- Allergies
- Cancer

**What medications do you take?**

_____

_____

_____

_____

_____

_____

**List All Surgeries & Broken Bones with Dates:**

_____

_____

_____

**How did pain begin?:** _____

**What INCREASES pain?:** Bending Twisting/rotating Sitting Standing Walking Lifting Pushing/pulling Reaching overhead Exercise/physical activity Work Prolonged positions or activities Lying on back Lying on stomach Lying on side Driving/riding in a car Housework/chores Sleep Getting in/out of bed or chair Using stairs Coughing/sneezing Stress

Other:_____

**What DECREASES pain?:** Rest Stretching Exercise/movement Walking Changing positions Massage Chiropractic adjustments Heat Ice Bracing/support Prescription/OTC Medications TENS unit

Other:_____

**What does your pain prevent you from doing?:**_____

**Have you seen a chiropractor before?** Yes____ No____ **Results:**_____

# HEALTH HISTORY

Name: _____

**Primary Complaint:** _____ **Pain Level (1-10):**_____ **Previous Episodes?** Yes____ No____

**Pain Radiates?** Yes____ No____ **Frequency?:** intermittent occasional frequent constant

**Quality?:** dull sharp shooting tingling burning numb achey Other: _____

**Date Pain Began:** ___/____/_____

**Secondary Complaint:** _____ **Pain Level (1-10):**_____ **Previous Episodes?** Yes____ No____

**Pain Radiates?** Yes____ No____ **Frequency?:** intermittent occasional frequent constant

**Quality?:** dull sharp shooting tingling burning numb achey Other: _____

**Date Pain Began:** ___/____/_____

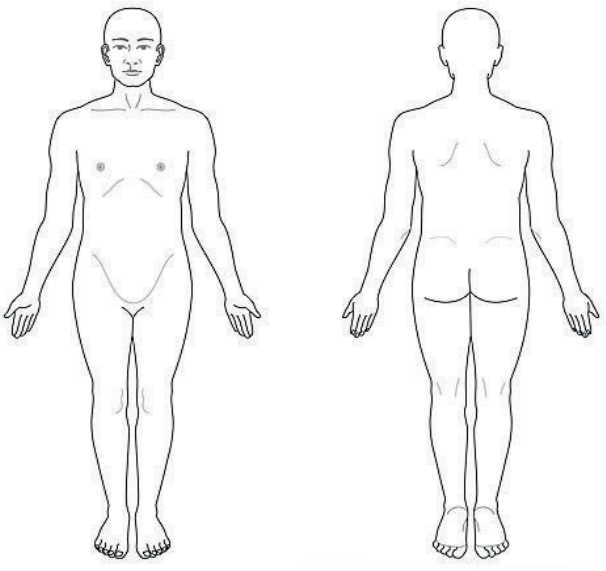
**Tertiary Complaint:** _____ **Pain Level (1-10):**_____ **Previous Episodes?** Yes____ No____

**Pain Radiates?** Yes____ No____ **Frequency?:** intermittent occasional frequent constant

**Quality?:** dull sharp shooting tingling burning numb achey Other: _____

**Date Pain Began:** ___/____/_____

**Shade Areas of Pain Below**



**Previous treatment for this same condition:** Physical Therapy Trigger Point Injection Massage Prescription Medication

**Results from above treatment?:**_____

# 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. Nopainwithheavy 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: _____

# RECORDS REQUEST

## EMERSON CHIROPRACTIC

7855 South Emerson Avenue, Suite Q Indianapolis, IN 46237
Phone: (317) 884-2636 | Fax: (317) 884-2633

### AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

I hereby authorize Emerson Chiropractic; Dr Christian J. Carter, to receive medical records pertaining to my treatment. I understand that this authorization is good through to the end of the year (12/31/2025).

Dated: _____

Patient Signature: _____

### Medical Records Requested:

Institution: _____

Fax: _____

Records: _____

_____

_____

_____

_____