SCHLENKER CHIROPRACTIC

Chiropractic • Sports Medicine • Massage

PATIENT INFORMATION

Patient Name_____ Today's Date _____

Birthdate_____ Sex: M / F Marital Status: Married / Single / Other Student: Y / N

Weight_____lbs Height_____ Smoking Status: Current Smoker / Former Smoker / Non Smoker

If a smoker, Frequency_____ Start Date_____ End Date_____

(For legal reasons, we do need the smoking status sections completed. It will not affect your care or treatment with us.)

Address_____ City_____ State____ ZIP_____

Home Phone _____ Cell _____ Work _____

E-mail Address_____ Please contact me at: Home / Cell / Work / E-mail

Number of Children_____ Referred to this Office By_____

If a Minor (under 18 years old), name and address of responsible parent/guardian:

Name_____ Birthdate _____

Address_____ City_____ State____ ZIP_____

Home Phone _____ Cell _____ Work _____

EMPLOYMENT INFORMATION

Employer_____ Professional Title_____

Address_____ City_____ State____ ZIP_____

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact_____ Relationship_____

Home Phone _____ Cell _____ Work _____

Please have insurance card available for receptionist to make a copy for your file.

INSURANCE INFORMATION

Insurance Company_____

Primary Insured_____Relationship to Insured: Self / Spouse / Child / Other_____

Member ID_____ Group No_____ Insurance Phone No_____

CHIEF COMPLAINT

Current Condition/Problem_____

_____

Any radiating symptoms? What/Where?_____

_____

When did this condition occur? _____

Please describe what happened:_____

_____

Since onset, is the condition getting: Better Worse Same

Anything similar ever happened before? If yes explain: _____

_____

Is Condition: Job Related____ Auto Related____ Home Injury____ Fall____ Other____

Other Doctors seen for this condition: Yes / No Who? _____

Type of Treatment_____ Results_____

Last Chiropractor seen_____

Have you been treated for any health conditions in the last year? Y / N If yes, please explain:

_____

PAST HEALTH

Other Conditions (current/past)_____

Surgeries_____

Fractures/Broken Bones_____

Major Trauma/Car Accidents_____

Medications/Supplements_____

Last Doctor Seen_____

Last Physical_____

Xrays/MRI/CT_____

FAMILY HISTORY

Please list family members affected by the following:

Cancer_____

Diabetes_____

Heart Disease_____

Osteoporosis_____

Genetic Diseases_____

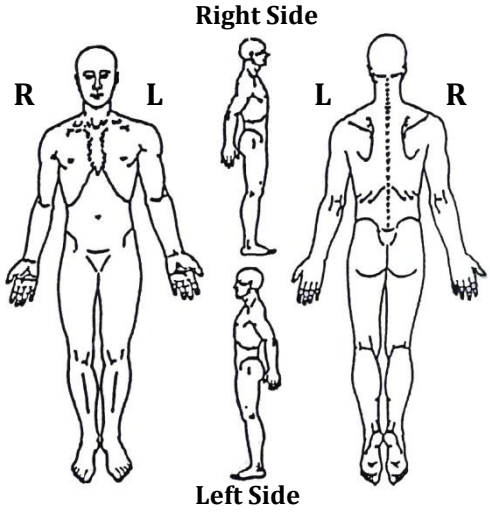
Please UNDERLINE conditions you have had PREVIOUSLY and (CIRCLE) conditions you have (NOW)

DIABETES	CANCER	HEART DISEASE
LOW BACK PAIN	PAIN BETWEEN SHOULDERS	NECK PAIN
ARM PAIN	JOINT PAIN/STIFFNESS	WALKING PROBLEMS
NUMBNESS	PARALYSIS	DIFFICULTY CHEWING/CLICKING JAW
DIZZINESS	FORGETFULNESS	CONFUSION/DEPRESSION
FAINTING	CONVULSIONS	COLD/TINGLING EXTREMITIES
ALLERGIES	LOSS OF SLEEP	FEVER
HEADACHES	SINUS TROUBLE	DIGESTIVE DISTURBANCES
LOSS OF CONSCIOUSNESS	ARTHRITIS	OSTEOPOROSIS

Mark the exact location of your symptoms on the diagram:

A = Ache
P = Pins & Needles
B = Burning
S = Stabbing
N = Numbness
O = Other

Comments:



Please indicate how your pain affects you in the six categories of daily living listed below. PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES HOW MUCH YOUR PAIN AFFECTS YOUR TYPICAL ACTIVITIES. **"0" signifies that your pain does NOT affect your activity level and "10" signifies that ALL activities in which you would normally be involved have been disrupted or prevented by your pain.**

1. Completing Family/Home Responsibilities. Ex. Chores and duties around the house (laundry) and errands or favors for other family members (driving the kids to school).

0 1 2 3 4 5 6 7 8 9 10

2. Recreation. Ex. Hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10

3. Social Activity. Ex. Activities which involve participation with friends and acquaintances other than family members (parties, theater, concerts, dining out, and other social functions).

0 1 2 3 4 5 6 7 8 9 10

4. Occupation. Ex. Activities that are part of or directly related to your job. This also includes non-paying jobs such as volunteer work.

0 1 2 3 4 5 6 7 8 9 10

5. Self Care. Ex. Activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.)

0 1 2 3 4 5 6 7 8 9 10

6. Life-Support Activity. Activities which support basic life behaviors (eating, sleeping, and breathing)

0 1 2 3 4 5 6 7 8 9 10

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Consent to Treatment

I wish to receive examinations and treatment provided at Schlenker Chiropractic and Associates. The diagnosis and methods of treatment have been explained to me.

I understand that individuals respond differently to treatment and that there is no guarantee of results during any treatment. I understand the examination and treatment involve certain risks and those risks have been explained or communicated to me.

I therefore authorize Dr. Schlenker to examine and treat me to the extent that he deems suitable.

Signature:_____Date:_____

Parent Signature:_____Date:_____

The patient is unable to consent for the following reasons:

_____

_____

I therefore give consent on the patient's behalf.

Signed:_____ Date: _____

Relationship:_____

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Financial and Cancelation Policies

Thank you for choosing our office to meet your chiropractic and massage healthcare needs. It is our optimal goal to provide you and your family with the highest quality of care, while maintaining a friendly and relaxing environment. In order to keep our standard of care at a level which best serves your healthcare needs, we ask you to please observe the following guidelines.

Office and Financial Policies

We require you to pay at the time we provide services to you. If your insurance covers chiropractic and/or massage therapy, we require you to pay any remaining deductible and the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. For your convenience, we accept cash, check, Visa, MasterCard, and Discover.

We cannot emphasize too strongly that the extent of your insurance benefits is a contract between you, your employer and your insurance company. WE are not a party to that contract. As your chiropractic and massage healthcare provider, our relationship is only with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend our clients, all charges are your responsibility from the date that the services were rendered. We will help you by processing your insurance claim form and sending it in promptly, however, we highly recommend that you know your specific chiropractic and massage therapy benefits before your care begins. This can be done by calling your insurance company, as you are financially responsible for any of the charges not covered by your insurance.

Cancellation Policy

The office requires a minimum of 24 hours notice if an appointment must be rescheduled. If less than 24 hours notice has been given a fee will be assessed. In the event that no notice is given and the client does not show up for their appointment, then you will be required to pay the full cost of the treatment booked.

I accept full financial responsibility for expenses incurred at Schlenker Chiropractic & Associates.

I accept full financial responsibilities for failures on my part to provide or know my insurance benefits information at the time services are rendered.

I have read and understand the above conditions.

_____ _____

Signature of Responsible Party **Date**

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Privacy Practices Acknowledgement Form

Per HIPAA (Health Insurance Portability and Accountability Act) regulations, we will protect and keep confidential your protected health information. A full copy of the Notice of Privacy Practice is available to read upon request.

Name (printed)_____ Date of Birth_____

Signature_____ Date_____