Patient Information

Full Name _____ Date of Birth _____
First M.I. Last

Gender M F Height _____ Weight _____ SS# _____

Address _____ City _____ State _____ Zip _____

email _____ Contact Number _____
Circle to indicate: Home Mobile Office

Married ☐ Single ☐ if Married Spouse's name: _____

Do you have children? No ☐ Yes ☐

Are you a student? No ☐ Yes ☐

Occupation _____ Employer (and or School) _____

Employer Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Contact Number _____

Name of Primary Care Physician _____

How did you hear about us? _____

INSURANCE INFORMATION

Do you have insurance? ☐ Yes ☐ No

Please allow our staff to photocopy your health insurance card and a photo ID

Are you the policy holder? ☐ Yes ☐ No **If no:** Name of Policy Holder _____

DOB of Policy Holder _____ Relation to Policy Holder _____

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I hereby authorize and direct you, my insurance carrier, to pay directly to Shelby County Chiropractic such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident, Worker's Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect Shelby County Chiropractic. I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by Shelby County Chiropractic. This is to act as an assignment of my rights and benefits to the extent of the office's services provided. I hereby instruct and direct any and all insurance companies, lawyers, or emplyers liable for my healthcare benefits to pay by check made out to: Shelby County Chiropractic, 1713 Midland Trail, Shelbyville, KY 40065. Or, if my current policy prohibitis direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows: c/o Shelby County Chiropractic, 1713 Midland Trail, Shelbyville, KY 40065

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option. A photocopy of this assignment shall be considered as effective and valid as the original.

I hereby give permission for Shelby County Chiropractic to contact my PCP regarding my healthcare. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case to facilitate collection under this Assignment, Lien and Authorization.

I understand I am ultimately responsible for payment to this office. If for any reason my insurance company should pay me for services received in this office instead of paying directly to Shelby County Chiropractic, I understand that payment is for services performed here, and I must bring the payment in immediately upon receipt.

I have read and understand the foregoing.

Patient Name _____ DOB: _____

Patient Signature _____ Date _____

Case History

History of Present Injury / Illness List the complaints you are here to have treated and how long you have had each:

1. _____ How Long? _____ 2. _____ How Long? _____
3. _____ How Long? _____ 4. _____ How Long? _____

Please fill out the following for the primary condition for which you are here to be treated:

Circle the number that best matches your level of pain at its worst. (0=no pain, 10=most severe) **0 1 2 3 4 5 6 7 8 9 10**

1. Is your condition related to a car accident? ☐ Yes ☐ No If yes: Date of Accident _____ ☐ at Work ☐ Other
2. How did pain or condition start? _____ When did it start? _____
3. What words best describe your condition? (example: sharp, burn) _____
4. When is it most severe? _____ least severe? _____
5. What makes it better? _____ worse? _____
6. What activities are difficult? _____
7. Have you seen any other health care provider for your present condition? ☐ Yes ☐ No If yes, who? _____
8. Personal Habits: ☐ Tobacco ☐ Alcohol ☐ Vitamins ☐ Exercise
9. Medications: _____
10. Family history related to present condition: _____

Examination may indicate that x-rays to accurately diagnose your condition.

Female History: **Are you pregnant at this time?** ☐ Yes ☐ No ☐ Unsure but could be

Date of last menstrual cycle _____ ☐ regular ☐ irregular Using birth controll: ☐ Yes ☐ No

Are you experiencing or do you have any of the following: (check all that apply)

☐ A sore that won't heal	☐ Difficulty swallowing	☐ Persistent cough / hoarseness	☐ **None of the above**
☐ Any bleeding / discharge	☐ Lump / thickening anywhere	☐ Wart / mole changes	
☐ Bladder / bowel problems	☐ Night Pain	☐ Weight loss without trying	

Review of Systems

In addition to the symptom(s) / dysfunction(s) listed above, are you experiencing any of the following?

Neuromusculoskeletal System (check all that apply)

☐ Sensory changes	☐ Facial drooping	☐ Loss of balance	☐ Seizures	☐ Anxiety
☐ Atrophy	☐ Vision trouble	☐ Memory loss	☐ Dizziness	☐ Limited range of motion
☐ Joint deformity	☐ Mood swings	☐ Speech problems	☐ Twitiches	☐ Depression
☐ Psychiatric disorders	☐ Joint locking	☐ Muscle weakness	☐ Tremors	☐ Concussion
☐ Difficulty walking	☐ Joint swelling	☐ Numbness	☐ Stiffness	☐ Cancer
☐ Lack of coordination	☐ Popping noises	☐ Epilesy	☐ Headache	☐ **None of the above**

Cardiovascular System (check all that apply)

☐ Ankle swelling	☐ Known vascular disease	☐ Chest pain	☐ Rapid heart rate	☐ Fainting
☐ Mitral valve prolapse	☐ Changes in skin color	☐ Jaw pain	☐ Dizziness	☐ Pin stroke
☐ Carotid blockage	☐ Shortness of breath	☐ Previous stroke	☐ Phlebitis	☐ Blood clots
		☐ Hypertension	☐ Varicose veins	☐ **None of the above**

Past History List any surgeries you have had (including: pacemakers, appendix, tonsils, wisdom teeth. Etc.)

1. _____ When? _____ 2. _____ When? _____
3. _____ When? _____ 4. _____ When? _____

List any hospitalizations other than surgeries, when & for what: _____

List any diagnosed conditions: (examples: diabetes, cancer, etc.) _____

List any current Dr.'s & conditions not previously listed: _____

List any major or minor falls or accidents & when they occurred: _____

List any cracked or broken bones & when they occurred: _____

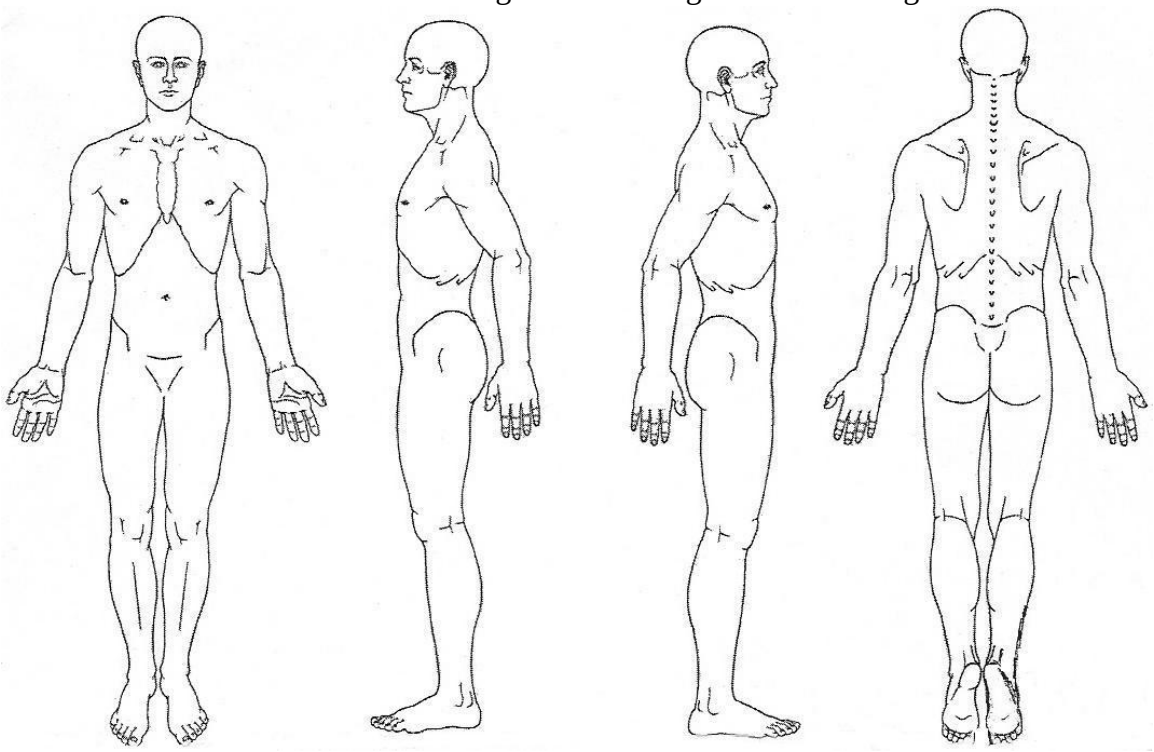
Patient's Name _____ DOB: _____

Patient's Signature _____ Date _____

Pain Diagram

Please mark the areas on the picture below where you are having any problems.

Numbness ---- Burning xxxx Aching **** Stabbing ////



Please place a **vertical mark on the line below** to indicate the severity of your complaint.

Headache No Pain_____ Worse Pain Experienced

Neck Pain No Pain_____ Worse Pain Experienced

Middle Back Pain No Pain_____ Worse Pain Experienced

Low Back Pain No Pain_____ Worse Pain Experienced

Other _____ No Pain_____ Worse Pain Experienced

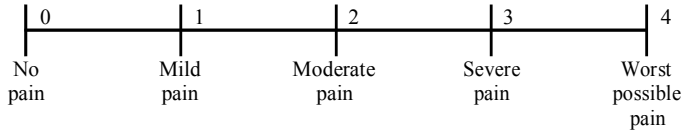
Patient's Name _____ DOB _____

Patient's Signature _____ Date _____

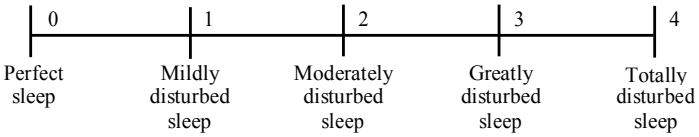
Functional Rating Index

For each item below, please circle the number which most closely describes your condition right now.

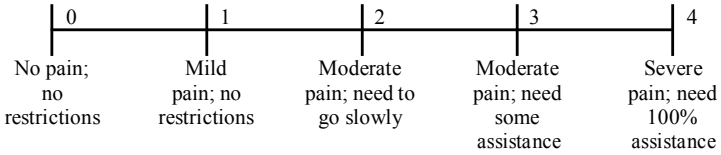
1. Pain Intensity



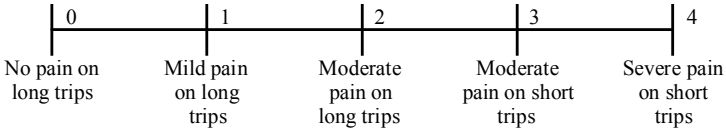
2. Sleeping



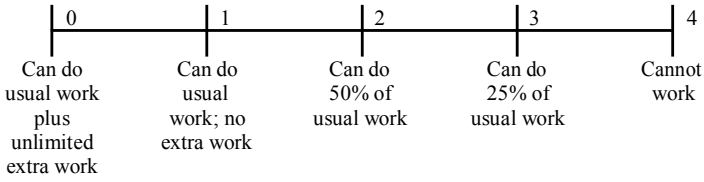
3. Personal Care (washing, dressing, etc.)



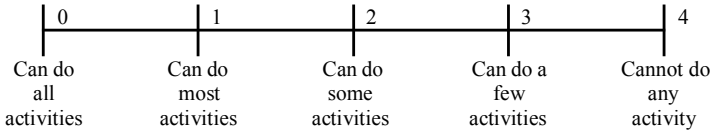
4. Travelling (driving, etc.)



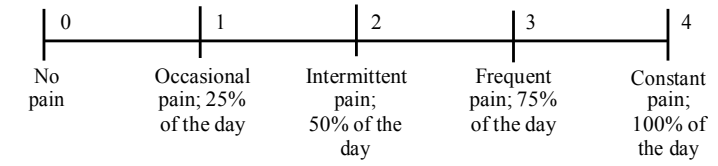
5. Work



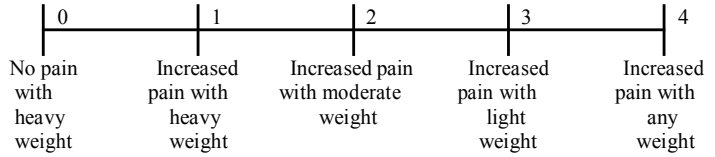
6. Recreation



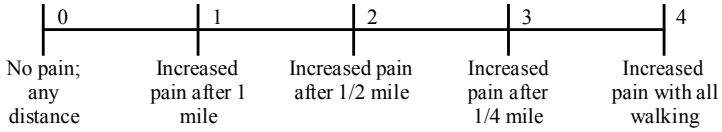
7. Frequency of Pain



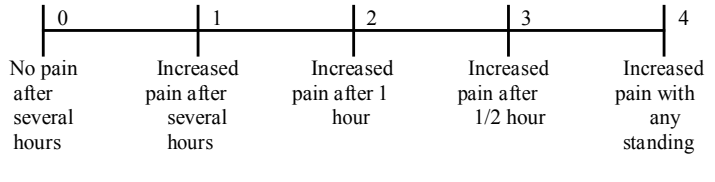
8. Lifting



9. Walking



10. Standing



Total Score _____/40

Patient Name _____ DOB _____

Patient Signature _____ Date _____

Consent to Treat

I request and consent to examination, adjustment/manipulation and any and all other chiropractic procedures permitted by our State Law. Including medical records review, various modes of physiotherapy, and necessary diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible) by any of the treating chiropractors on staff and/or any licensed chiropractor deemed appropriate by the office. I understand that results of treatment are not guaranteed. I further understand and informed that, as in the practice of medicine, in the practice of chiropractic there are risks associated with treatment, although rare, including, but not limiting to, fractures, disc injuries, strokes, dislocations, strains, and worsening symptoms. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest. This const form covers the entire course of treatment for my present condition and for any future condition(s) for which I see treatment.

I understand it is my responsibility to fill out my case history completely and to the best of my knowledge, and to inform the doctor of any information that is not listed on my case history. I also understand that it is my responsibility to inform the doctor of any changes to may occur one I have filled out that information. **I authorize Shelby County Chiropractic, LLC to treat me.**

I have read and understand the foregoing.

Patient Name: _____ DOB: _____

Patient Signature: _____ DOB: _____

Consent to Treat a Minor

I hereby request and authorize **Shelby County Chiropractic, LLC** to perform diagnostic tests and render chiropractic adjustment and other treatment to:

Patient Name: _____ DOB: _____

As of this date I have the legal right to select and authorize health care services for the minor child named above.

If applicable, under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

_____ _____

Printed Name Relationship to Patient

Signature: _____ Date: _____

Disclosure of Protected Health Information

1. I am aware that I have the right to ask for a copy of Shelby County Chiropractic Notice of Privacy Policy.
2. I am aware I can contact the Privacy Officer at any time regarding any questions I may have concerning Notice of Privacy Policy.
3. I understand I can request a limitation to the disclosure of my protected health information at any time in writing.
4. I expressly acknowledge that this authorization is voluntary and, I also understand that my healthcare can payment for my healthcare will not be affected if I do not sign this form.
5. I understand I may get a copy of this form by request after I sign it.
6. I understand that the information used or disclosed pursuant to this authorization, may be subjected to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
7. I hereby authorize Shelby County Chiropractic to use and or disclose my protected health information in accordance with the procedures outline in the Notice of Privacy.
8. I understand the practice treats in an open adjusting area, where privacy is limited. I understand that I can meet with the doctor privately in a closed room upon my request. Unless a request is made, it is understood that I will be treated in the open adjusting room.
9. I understand that at some point in the future that if I refer someone to the practice, which my name and image may appear on a thank you board or other notation(s) throughout the practice, which is in plain view of other individuals that are in the practice.
10. I understand x-rays taken at this office are considered part of a patient's original health care record and like all other records having originated at this practice, they are the absolute sole and legal property of Shelby County Chiropractic. We are required by Kentucky State Law to retain patient records for a period of no less than ten (10) years. We will provide they x-rays to be checked out to the patient or patient's representative upon request. We are happy to provide our patients a copy of their written x-ray report upon request, one time, at no charge. A minimum of forty-eight (48) hour written notice is required for production of this report and or any other records requested. If any imaging center in our community has the equipment necessary to copy your films, we will cooperate in facilitation this process; however, a fee will be charged for this service.
11. I hereby authorize this office to use my name, picture (still or video), and patient testimonial in any in-office publication and also publication for advertising such as newspaper, newsletter, website, etc.

Patient's Name: _____ DOB: _____

Patient's Signature: _____ Date: _____