

Goals For My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning within their bodies (wellness care). Your doctor will weigh your needs and desires when recommending your treatment program. Please circle the type of care desired so that we may be guided by your best wishes whenever possible.

- Relief Care:* Symptomatic relief of pain or discomfort
- Corrective Care:* Correcting and relieving the cause of the problem as well as the symptoms.
- Wellness Care:* Bringing the body to the highest state of health possible with Chiropractic care.
- I want the doctor to select the type of care appropriate for my condition.*

Health Goals: 1. _____
 2. _____
 3. _____

Current Medications (please list)

Health Habits

Do you smoke?	Yes	No
Do you drink alcohol?	Yes	No
Do you drink coffee?	Yes	No
Do you exercise regularly?	Yes	No

If yes, explain: _____

Do you wear	Heel lifts	Sole lifts
	Inner soles	Arch supports

HEALTH CONDITIONS

Please circle each of the diseases or conditions you have now or had in the past. While they may seem unrelated to the Purpose of the appointment, they can affect the overall diagnosis, treatment plan, and outcome of care.

- | | |
|---|-------------------------|
| Severe or frequent headaches | Congenital Heart Defect |
| Sinus problem | Heart Surgery |
| Cancer | Psychiatric problems |
| Loss of sleep | Difficulty breathing |
| Hepatitis | Rheumatic fever |
| Pain between shoulders | Asthma |
| Frequent neck pain | Arthritis |
| Numbness or pain in arms / legs / hands | Alcohol / Drug use |
| Lower back problems | Venereal disease |
| Digestive problems | HIV / AIDS |
| Ulcers / Colitis | Diabetes |
| Heart Attack / Stroke | Tuberculosis |
| Kidney problems | Shingles |
| | Anemia |

Explain: _____

For Women Only

Are you pregnant?	Yes	No
Are you nursing?	Yes	No
Are you taking birth control?	Yes	No
Do you experience painful periods?	Yes	No
Do you have irregular cycles?	Yes	No

Children Only

Does your child experience any of the following?

Colic	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Ear infections	Yes	No
Acid reflux	Yes	No
Delayed development	Yes	No
Nursing difficulties	Yes	No

Other/Explain: _____

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, and/or other therapies as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payments. I agree that I am responsibly for all the bills incurred at the office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

Patient's signature

Date

Patient's signature

Date

Who should receive bills for payment on account?

Patient

Spouse

Parent

Worker's Comp.

Medicare

Personal Health Insurance

Auto Insurance

Ownership of X-Ray Films

It is understood and agreed that the payments to the Doctor for X-Rays is for examination of X-Rays only. The X-Ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

Emergency Contact

Name _____

Relationship _____

Work Phone _____

Home Phone _____

My Health Insurance

I understand and agree that health insurance and accident insurance policies are an agreement between an insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Insurance company _____

Policy # _____

Address _____

Group # _____

Phone Number _____

About the Insured Person

Name _____

Insured's SSN _____

Relation to insured _____

Date of Birth _____