New Patient Information

Name: ____ SSN: ____________________ Age: _______ DOB: _____________

Address: ____ Apt: _____ City: ________________ State: _____ Zip Code: ________

Email Address: _________________________________ Cell Phone: __________________ Home Phone: _________________

Preferred Phone Number: Cell / Home / Work   Would you like text appointment reminders: Yes / No   If yes, carrier: ___________

Employer: ___________________________________ Occupation: ___________________ Work Phone: __________________

Sex: Male / Female   Marital Status: Single / Married/ Divorced / Widowed

Spouse: _______________________________________ DOB: _______________

Emergency Contact Name: _____________________________ Emergency Contact Number: ______________________________

General Physician: ____ Phone: _______________________________________

May we contact your doctor regarding care in our office: Yes / No

Have you seen a chiropractor before: Yes / No   If yes, when was your last visit: ____

Who can we thank for referring you to our office: ____

Is your present condition a result of a slip/fall: Yes / No Date: ________

Is your present condition a related to an auto accident: Yes / No Date: ________

Is your condition an injury that occurred on the job: Yes / No Date: ________

____   _____________________

Patient Signature (Legal Representative if patient is a minor)   Date

Case History

Patient Name: ____ Date: ________________________

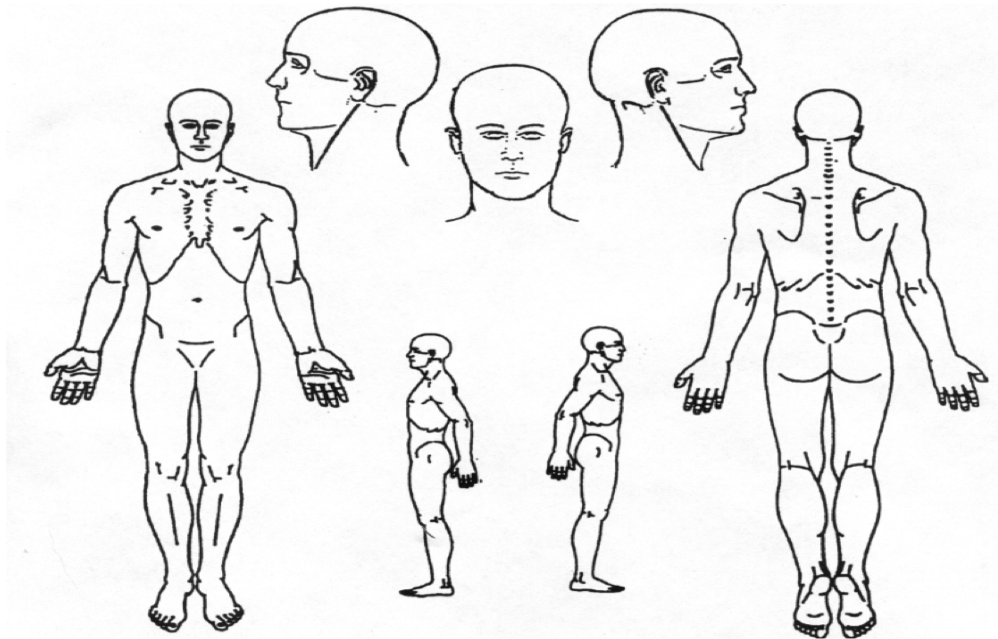
Height: ______ Weight: ______ Lenses: Y / N If yes, Far Sided / Near Sided Right Handed / Left Handed

Primary reason for seeking chiropractic care and rate your pain level on a scale 0 to 10 (10 being the worst possible pain):

1. ____

PLEASE IDENTIFY AND MARK YOUR AREA OF COMPLAINT AS FOLLOWS:
Please mark on the body to the right of the area of complaint(s) with the abbreviations:

A – ache B – Burning N- Numbness P – Pins and Needles S – Stabbing O - Other



What is the frequency of the discomfort you are feeling: Circle One

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How would you rate the discomfort **at it's best**: Circle One

0 1 2 3 4 5 6 7 8 9 10

How would you rate the discomfort **at it's worst**: Circle One

0 1 2 3 4 5 6 7 8 9 10

Describe the onset of the discomfort: Gradual / Sudden

When did the discomfort begin: ___hours ago ___days ago ___weeks ago ___months ago ___years ago

Case History

Complaint

Have you ever experienced this complaint before? ◯ NO ◯ YES

If yes, When? ________________________________

Have you received treatment from another healthcare provider for this complaint? ◯ NO ◯ YES

If yes, how long ago? And did you get relief?________________________________

Do you know the cause of your complaint(s)? ◯ NO ◯ YES If yes, please describe________________________________

____

What is the frequency of your pain / symptoms (time of day, how often occurs during the day or evening, etc):

____

____

What makes your symptoms better? ________________________________

____

What makes your symptoms worse? ________________________________

____

Do you have any previous illnesses or injuries which relate to these complaints/symptoms? ◯ NO ◯ YES

If yes, please describe: ________________________________

____

Have you ever been hospitalized or had surgery? ◯ NO ◯ YES

If yes, please describe: ________________________________

____

Are you currently taking medication(s) (prescription and non prescription)? ◯ NO ◯ YES If yes, please complete the following:

Name of medication: Dosage : Reason taking and for how long:

____

____

____

Are you taking any vitamins and/or supplements? ◯ NO ◯ YES If yes, please complete the following:

Name of Vitamin/supplement: Dosage: Reason for taking:

____

____

____

Lifestyle

Tobacco _____ Coffee (cups/day) _____ Tea (glasses/day) _____ Soft drinks: diet or reg (#/day) ______

Alcohol (drinks/day) ______ Sleep (hrs/day) ______ Do you feel rested after sleep? ◯ NO ◯ YES

Exercise: NONE Light (1-2 x/week) Moderate (3-4 x/week) Athletic (4 or more x/week)

Would you say your over diet is: Poor Fair Good Excellent

Any unexplained weight loss or gain in the past 6 months? ◯ NO ◯ YES If yes, how much gain / loss_____

Family History

Is there family history of any of the following conditions, if so please list immediate family relation (mother, father, sister, brother, grandmother (maternal or paternal) and grandfather (maternal or paternal):

Stroke:____

Trans-ischemic attacks (mini strokes):______________________________

Atherosclerosis:____________________________________

Heart disease:_____________________________________

Diabetes:_______________________________________

Cancer (type):_____________________________________

High blood pressure:___________________________________

Please **circle** the symptoms or conditions you **currently have** and **underline** the symptoms or conditions you **have had in the past.**

General
Loss of memory
Depression
Headache
Fever
Chills
Night Sweats
Fainting
Dizziness
Convulsions
Loss of sleep
Fatigue
Nervousness
Tingling/Numbness
Confusion

Gastro-intestinal
Upset stomach
Poor appetite
Excessive Hunger
Belching or gas
Poor digestion
Nausea
Vomiting
Vomiting blood
Pain over stomach
Constipation
Diarrhea
Hemorrhoids
Liver trouble
Gall bladder trouble

Eye/Ear/Throat/Nose
Sensitivity to light
Crossed eyes
Pain in eyes
Deafness
Earache
Ringing in ear
Loss of smell
Nose bleeds
Sore throat
Allergies
Asthma
Frequent colds
Sinus trouble

Respiratory
Chronic cough
Spitting up blood
Spitting phlegm
Chest pain
Difficulty breathing
Shortness of breath

Muscles and Joints
Heaviness of head
Weakness
Twitching
Stiff neck/pain
Swollen joints
Loss of balance

Urinary
Frequent urination
Painful urination
Blood in urine
Kidney infection
Bed wetting
Urine control inability
Prostate trouble

Cardiovascular
Rapid heart beat
Slow heart beat
High blood pressure
Low blood pressure
Swelling in ankles
Varicose veins
Cold hands/feet

Skin
Skin eruptions
Itching
Bruise easily
Dryness
Sensitive skin
Eczema

For Women Only
Breast Augmentation
Birth control
Painful periods
Excessive flow
Irregular cycles
Hot flashes
Miscarriage

I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

______________________________ ____________________

Patient or Legal Guardian Signature Date

Functional Rating Index

Patient Name: ______________________________

In order to properly assess your condition, we must understand how much neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle a number on the line which closely describes your condition right now.

0= No pain-------1 = Mild pain-------2 = Moderate pain-------3 = Severe pain-------4 = Worst possible pain

1. Pain Intensity: 0----------------1----------------2----------------3-----------------4

2. Sleeping: 0----------------1----------------2----------------3-----------------4

3. Personal Care: (washing, dressing, etc.) 0----------------1----------------2----------------3-----------------4

4. Travel (driving, etc) 0----------------1----------------2----------------3-----------------4

5. Work 0----------------1----------------2----------------3-----------------4

6. Recreation 0----------------1----------------2----------------3-----------------4

7. Frequency of pain 0----------------1----------------2----------------3-----------------4

8. Lifting 0----------------1----------------2----------------3-----------------4

9. Walking 0----------------1----------------2----------------3-----------------4

10. Standing 0----------------1----------------2----------------3-----------------4

______________________________ ____________________

Patient Signature Date

Consent to Chiropractic Treatment

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnostics, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The Doctor, of course, will not provide specific healthcare if he is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through healthcare procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or the patient named below for which I am legally responsible) which are recommended by Dr. Michael W. Hall, DC, FIACN.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications may include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of the manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgement during the course of the procedure(s) which the doctor feels at the time, based upon the facts known, and are in my best interest.

I have had the opportunity to discuss which the doctor and/or with the office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

_____ (please initial) I have read the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

____
Printed Name of Patient

______________________________________ ________________
Signature of Patient or Legal Guardian (if minor) Date

______________________________________ ________________
Witness of Patient's Signature Date

Financial and Office Policy

Our office is pleased to accept your insurance assignment as soon as your exact coverage is verified by the responsible party. We will file your claim forms and assist you in every way we can. It must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

1. By taking your insurance on assignment, we must wait for payment. This courtesy may be withdrawn if circumstances warrant it.
2. If you discontinue your care without the Doctor's authorization, the balance of your account is due and payable in full immediately, even if your insurance has been filed. If the insurance does pay, it will be refunded if you have a zero balance.
3. Your insurance should pay within 30 days. If your insurance has not paid within 60 days, you must pay the balance due and be reimbursed by your insurance company when and if it pays.
4. Our office does NOT guarantee that your insurance will pay. We will make every attempt at the beginning of your healthcare to receive verification of your policy and what it covers. However, if for some reason your insurance claim is denied, you are responsible for the full amount of your bill.
5. Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.
6. All special arrangements regarding finances must be signed by the Doctor, patient and/or other representative.
7. Any phone call during regular office times (and non-office hours) will be considered and Established Office Visit and may be filed to your insurance company for reimbursement. If it is not covered or you do not have insurance, you will be responsible for the fees.
8. Payment for services is due at the time of the office. Payment options include cash, check, MasterCard, Visa, American Express or Discover.
9. Missed appointment policy: If an appointment cannot be kept, please give a 24-hour notice to avoid a $55.00 fee.
10. Returned check policy: Our returned check fee is $35.00.

Consultation & Examination

On your first visit, we will collect some confidential health information as we sit and speak with you. After we learn more about your condition, we may perform some preliminary tests. If we believe that we may be able to help you, we may recommend an examination so we can more thoroughly evaluate your condition.

Report of Findings

Patients that are examined will receive a complimentary report of findings from the recorded history, consultation and examination. If we believe we can help you, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider. Some patients may receive their report of findings immediately following their examination. Others may receive it on a following appointment or other time as it may be necessary to review certain diagnostics, follow up with payer's insurance coverage or devote time to creating a specific treatment plan. Regardless of when the report of findings is delivered, there is no difference in fees or patient out-of-pocket expense.

Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs. A treatment plan may be created to address your short and/or long-term goals. As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I have read and understand the above.

______________________________ ____________

Patient Signature (or person acting on patient's behalf Date

______________________________ ____________

Staff/Witness Signature Date

Notice of Privacy

If you have any questions concerning our policies, forms, or procedures, please ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful and educational.

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used, disclosed, and how you can get access to this information. Please read about your health information and let us know if you have any questions.

What health information is protected?

-All personal and health information in your record
-Information about you in your health insurer's system
-Conversations your doctor has about you
-Billing information

How is this information protected?

-Healthcare providers must safeguard information
-Healthcare providers must limit who views information
-Healthcare providers must reasonably limit disclosure
-Through contracts with other entities

Health Insurers and Providers must comply with your right to:

-Request a copy of your health record
-Request to limit the information we share
-Learn when and why your health information was shared
-Have corrections added to your health record
-Request confidential communications
-Decide if you want your information released

Your health information may be used for:

-Health and safety disclosure
-Billing to payers
-Consulting with you in person, on phone and electronically
-Reporting to state and federal government programs
-Reporting to law officials
-Reporting victims of abuse
-Court requests

To learn more about privacy laws that concern you:

-Ask us to send the Summary of the HIPAA Privacy Rule to you
-Contact our office at 972.304.9146
-Visit www.hhs.gov/ocr/privacy

I understand and agree to the following:

-The privacy and patient practices have been satisfactorily explained to me

____

Patient Name

____

Patient (or guardian) Signature

____

Date