All insurance deductibles and co-payments must be paid in full. Payment in full is required for each visit.
All sections MUST be completed if we are to submit any insurance billing for you and wait for payment of your bill.
*** We accept Cash or Credit Card (Visa / MasterCard only)** ** NO CHECKS **A $1.00 charge is added if under $10.00 charge.***

How where you referred to our office? ☐Lecture ☐Yellow Pages ☐Ads ☐Ins. Book ☐Web site ☐Drive by
☐Current Patient ☐MD ☐Attorney ☐ Lecture Please Provide Name:

PERSONAL INFO **Patient Name**_____ Soc. Sec#_____
Hm.Phone _____ Cell Phone _____ Work Phone_____
◯Male ◯Female ◯Married ◯Single ◯Divorced ◯Widow Date of Birth ____/_____/_____ Your Age:____
Home Address_____ Height _____Weight _____
City_____Zip_____ST____Emergency Contact & Phone_____
Employer _____ Occupation_____
Your Family Medical Doctor's Name_____ Phone_____

YOUR PRIMARY HEALTH INSURANCE Company Name:_____
Policy #:_____Group #:_____Claim#_____ Phone #:_____
Address:_____
City:_____ State:_____ Zip:_____Effective Policy Date: _____
Insured's Name & Relationship: _____ Insured's SSN:_____
Insured's Birth Date:_____Insured's Employer: _____

YOUR AUTO INSURANCE (if Injury is due to Auto Accident) Company Name:_____
Claim#_____Policy #_____ Phone #:_____
Address:_____
City:_____ State:_____ Zip:_____Effective Policy Date: _____
Adjuster Name_____ Phone_____
Insured's Name & Relationship: _____

OTHER INSURANCE* ***The other Vehicle's Insurance if due to Auto Accident*** Company Name:_____
Claim#_____Policy #_____ Phone #:_____
Address:_____
City:_____ State:_____ Zip:_____
Adjuster Name_____ Phone_____
Insured's Name & Relationship: _____

ATTORNEY NAME **(if Injury is due to Auto Accident) _____
Phone #:_____ Fax #:_____ Date of Accident_____
Address:_____
City:_____ State:_____ Zip:_____

Help Us to Better Help You and Your Family. ***Refer your friends and family, they need chiropractic too.***

Please Choose the type of Care you are most interested in Receiving or learning about.

☐ Chiropractic - Short-Term / Pain Relief - Treat and Release.....until next time.
☐ Chiropractic - Preventative / Wellness Care - It's better to stay well, your health is your most valued possession.
☐ High Power **PEMF** Therapy Program - We have the most powerful PEMF Therapy Program for Acute & Chronic Pain
☐ High Power **Laser/LED** Therapy Program - We have the most powerful Class IV Laser & LED Therapy Program for Acute & Chronic Pain
☐ **Knee on Trac** Knee Therapy Program - We have the only Knee Traction Therapy Program for Acute & Chronic Pain
☐ **Neuropathy** Therapy - We offer Affordable, Safe, Non-Surgical Neuropathy Treatments for Chronic Pain and Neuropathy Conditions
☐ **Spinal Decompression** Therapy - We offer Affordable, Safe, Non-Surgical Spinal Decompression for Neck & Low Back Conditions
☐ **Massage Therapy** - We have Professional, Licensed Massage Therapists for Swedish/Relaxing or Sports/Deep Tissue massage.
☐ **Nutritional Assessment** - We offer Professional, Pharmaceutical Grade, Nutritional Products. Safe alternatives to many drugs

If you Can't Afford Health,…… How Will You Afford Sickness

Our goal is to treat the individual patient's needs, provide you with the best care possible and recommend an appropriate treatment plan to most efficiently resolve your complaints and improve and maintain your health *safely* and *naturally*. We provide exceptional, experienced chiropractic care, spinal decompression therapy, massage therapy and the best professional nutrients. All Insurance Billing will be processed under Larry Basch Chiropractic Inc. /Larry Basch, D.C. Office Policies are necessary for any office to run effectively. However, it's important to keep in mind the goals of this office. We are here to help improve your health naturally and make positive changes. Ultimately, your health is your own responsibility. Our job is to facilitate your progress to better health naturally. We will recommend treatment and nutritional supplements to help achieve your health goals as quickly as possible. But remember, nature takes time and the longer the problem has been there, the longer it takes to return to health, please follow the doctors recommendations for the best result. Failure to follow these recommendations may delay your recovery, result in permanent damage and could result in dismissal from care. ***We treat people, not health plans***. We do not treat the insurance company or its dollar limits and restrictions. If you have an insurance plan with restrictions, limitations, and excessive paperwork, you will need to assist us in verifying your insurance benefits and getting your recommended care approved and reimbursed. We are here to help you and others. Please Tell others.

OFFICE POLICIES - Part 1

*Our Clinic **Purpose** is to help get you Well, Naturally.*
*Our Clinic **Policy** is to never let money be a barrier to your health care goal of Natural Wellness.*
You must tell us of any barriers you may have in advance, we will work with you to help achieve your health goals.

PATIENT FINANCIAL RESPONSIBILITY I understand that as a *courtesy* to me and at no charge, this office will attempt to verify & bill any & all insurance for payment of my treatment bill, however, this may not be a guarantee of full payment. Until insurance benefits are confirmed & payment is received in full, I am responsible for payment or any balance due. All co-payments and deductibles must be paid at the time of service, we do not bill patients. All insurance non-covered benefits or insurance denied benefits are the patient's responsibility & payment in full at the time of service is required. I understand I am ultimately responsible for full payment. We may offer alternative financing options.
If I am here due to a Personal Injury case & my attorney offers less than the full amount of my bill, I agree to pay the balance due in full**.** I agree that I am responsible for any & all legal, collection agency service fees, and other expenses incurred by this office in collecting on my account. I understand I am responsible to inform this office of any address changes, any insurance or attorney changes. It is my responsibility to ensure proper payment is made for my care, including co-pay, deductible & balance due after any insurance payment or settlement has been received. I hereby request the staff of this office to verify, bill & collect any & all payment from my health insurance company on my behalf. * I understand that I am responsible for FULL and complete payment of my treatment bills, all deductibles, co-payments, and any collection fees regardless of any type of insurance, attorney lien or settlement.

PAST DUE COLLECTIONS I hereby agree to cooperate with this office in settling my debit and any balance due for my treatment received. Any balance due after 60 days after treatment ends or patient is released from active care, will be assessed a monthly late fee of 10% of the outstanding balance and your account will be sent for collections and/or legal actions to our collection service, unless other arrangements have been made with this office, such as an auto accident / Attorney Lien agreement. I hereby agree to cooperate with this office, agree to pay my debit and any balance due, pay all collection fees, legal fees & late fees assessed to my account in addition to the balance owed if my balance is sent to collections / small claims court.

INSURANCE PATIENTS Health Insurance plans vary in benefits, deductible and co-payment. As a courtesy to you we will attempt to verify your insurance chiropractic benefits allowed, however, this is not a guarantee of insurance payment. We suggest you also call to avoid any misinformation. If you want us to bill your insurance for you, we will bill your insurance as long as your insurance company accepts assignment and we will make payment directly to Larry Basch Chiropractic Inc. and Associates. You will be required to pay in full for services rendered while meeting your deductible (discounts will not apply). After your deductible has been met, you will be responsible for paying non-covered items at the time of service and for the percentage not covered by your insurance. Verification of your insurance benefits does not guarantee payment. We will bill your insurance company as a courtesy to you & will estimate you patient portion (the percentage not covered by your insurance) as closely as possible based upon the benefits as explained to us by your insurance company. If at any time your insurance does not pay, you will be responsible for making payment within 30 days. Any balance due after 60 days will be accessed late charges & subject to collections and/or legal action.****** I understand that *Insurance, HMO & Medicare **WILL NOT PAY** for the following: Spinal Decompression, Neuropathy Therapy, Laser & LED Therapy, PEMF, Supplements, Massage therapy. If you choose to receive any of these uncovered therapies, there will be a charge a fee for those therapies. I understand I must pay for these therapies if I elect to receive those therapies.*

DIRECT ASSIGNMENT I hereby instruct and authorize assignment of my Health and/or Auto insurance company right, benefits and to make full payment by check made out to and mailed directly to Larry Basch Chiropractic Inc. and Associates. If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct my insurance company, to make the payment check to me and mail it to the address above. This is a direct assignment of my rights and benefits under my insurance policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. By my signature below, I also authorize the release of any personal & health information pertinent to my case to any insurance company, insurance adjustor or reviewer, attorney, collection service involved in this case. I agree that if any payment is sent directly to me, the patient, I will immediately (within 14 days) forward full payment to Larry Basch Chiropractic Inc. and Associates.

CASH PATIENTS / TIME OF SERVICE FEES Payment is required at the time of service for this fee. You will be required to pay in full for any deductible, co-payments for all services rendered upon each visit. As long as you pay in full upon each visit and keep your balance at zero, we will offer a time of service fee discount for spinal manipulations and physical therapy modalities. Itemized statements will not be furnished, please keep your receipt. We do not bill your insurance company for cash discount accounts.

MASSAGE PATIENTS Massage therapy is available on a Cash basis only. We will never bill any insurance for this elective service.
Massage cancellation requires 24 - hour notice. $40.00 charge for missed appointments without notification and /or loss of pre-paid massage fees.
** No refunds on Pre-paid massages. Tipping the Therapist is encourage & allowed, they work hard for you.*

PRE-PAID SERVICE
No refunds on any Pre-paid Chiropractic, Massage, Laser Therapy, Decompression Therapy, PEMF or other Wellness Services offered in the clinic.

MISSED APPOINTMENTS *We set aside time especially for your care.* So that we may help others, kindly give us **24 hour advanced notice** if you cannot keep your scheduled appointment. **** 40.00 charge*** *for missed appointments or no-shows without notification may be added to your account.*

NOTE We accept Cash or Credit Card (Visa / MasterCard only) A $1.00 charge is added if under $10.00 charge.****

* ALL PATIENTS MUST SIGN HERE

Thank you for your cooperation.

X _____ _____ _____

Patient or Guardian - Signature | Patient - Printed Name | Date

My signature verifies that I have read and fully understand and agree to All of the New Patient Office Policies, and Policies listed on Part 1, II, III for this office and I willingly agree to and consent to receive Chiropractic treatment, give authorization for Request and/or Release of my Health Records, and I accept full responsibility for all payment of deductibles, co-payments, uncovered services and authorize insurance assignment on my behalf. Missed Appointments are charged at $40 per no show, so please call to reschedule. Thank you

OFFICE POLICIES - Part 2

MEDICARE PATIENTS *Medicare will NOT pay for the following: Annual Deductible, Co-Payment, New Patient Exams, Re-Exams, Any Therapies, Decompression, Neuropathy, Massage, Laser, PEMF, Nutrition. Our Office Fees are clearly posted in the office / front desk. Unfortunately, Medicare will **only** pay for Chiropractic manipulation of the Spine, *nothing more*. Additionally, Medicare only pays at 80% of the allowable amount, leaving 20% as the patient's responsibility / co-payment; unless a Secondary Insurance has been verified for deductible or co-payment re-imbursement. New government policies have resulted in regular Medicare audits requiring you to complete progress forms regularly. Medicare Billing Codes Allowed are: 98940 Manipulation 1-2 Spinal Regions, 98941 Manipulation 3-4 Spinal Regions.

If Treatment is denied by Medicare, we will attempt to appeal on your behalf, however, you will be Responsible for payment at Posted Fee.
Advance Beneficiary Notice (ABN) The following Services are NOT COVERED by MEDICARE, and are the Patients Responsibility for the fee posted in this Clinic. If you voluntarily elect to receive any of the following therapies, you accept to self- pay and will be charged the usual clinic fee for each of these therapies / Uncovered Services: 99201-New Patient Exam / Consultation

97124 Massage Therapy	98943 - Manipulation of Upper / Lower Extremity	97110 Whole Body Vibration WBV
97012 Spinal Traction	97014 Electrical Muscle Stimulation	97140 Myofascial Therapy / Trigger point / ART
97110 Rehab Attended	97110 Therapeutic Exercise	97802 Nutrition & Consultation PEMF Therapy
S9090 Spinal Decompression	S8948 Class IV Laser or LED	S8990 Chiropractic Elective / Preventative / Maintenance or Monthly Care

All Medicare Patients must sign below for acknowledgement of Medicare policies and financial charges of non-covered / elective services.

HIPPA By my signature below, I consent to the use or disclosure of my protected health information by Larry Basch Chiropractic Inc. and Associates for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me. I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at Larry Basch Chiropractic Inc. and Associates. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by asking for one at the time of my appointment.

We are pleased to accept your insurance assignment subject to verification of your coverage. We will file your claims as a courtesy to you in every way we can. However, it must be fully understood that the contract is between you and your insurance company and you, the patient, are fully responsible for any amount not paid for your treatment by any insurance policy, attorney or third party. I authorize payment of medical benefits directly to Larry Basch Chiropractic Inc. and Associates. I authorize the release of any medical information necessary in the processing of my insurance claims. I agree that I will pay the percentage of charges not covered by my insurance company at the time of service. (Example: If my insurance pays 80% of my charges, then I pay 20% at the time of charge.) I agree that I will pay in full for charges for items or services, which Larry Basch Chiropractic Inc. and Associates believes, will not be covered by my insurance company at the time they are incurred. I agree that I am totally responsible for any charges in this office and, if for some reason my insurance company does not cover charges within sixty (60) days or a claim is denied, I will pay those charges immediately or within 14 days. After 60 days I will be subject to collection and/or legal action for this amount plus late fees and collection / legal fees. I agree that if my insurance company refuses to accept assignment of benefits or for some reason sends the payments to me, I will bring or send those payments to Larry Basch Chiropractic Inc. and Associates immediately or face collection / legal action from this office. I understand and agree that Larry Basch Chiropractic Inc. and Associates will not enter into any dispute with my insurance company regarding a claim and that this is my responsibility and obligation. I agree to keep this office informed of any changes in any of my personal information, address, phone #, health insurance coverage, attorney information. I agree that a copy of this document can be considered that same as an original when used for insurance billing purposes.

REQUEST FOR RECORDS/ RELEASE OF RECORDS

I hereby Authorize Larry Basch Chiropractic Inc. and Associates to request any necessary medical records pertaining to my current or past condition as it may related to my treatment at this clinic, including diagnosis, treatment records, examination findings, diagnostic tests, x-rays, MRI / CT reports, billing records. I hereby Authorize the Release of My Treatment Records including any & all information on my diagnosis, treatment records, examination findings, diagnostic tests, x-rays, MRI / CT reports, billing records from Larry Basch Chiropractic Inc. and Associates to the requesting Insurance companies & Attorneys involved in my case pertaining to my current or past condition as it may related to my treatment at this clinic.

CONSENT TO TREATMENT OF MINOR CHILD By my signature below, I hereby authorize Larry Basch Chiropractic Inc. & Associates, and/or whomever they may designate as assistants, to administer treatment as deemed necessary to my minor child who is under the age of 18 years old. * MINOR CHILDS NAME: _____

* ALL PATIENTS MUST SIGN HERE

Thank you for your cooperation.

X _____ _____ _____

Patient or Guardian - Signature Patient - Printed Name Date

My signature verifies that I have read and fully understand and agree to All of the New Patient Office Policies, and Policies listed on Part 1, II, III for this office and I willingly agree to and consent to receive Chiropractic treatment, give authorization for Request and/or Release of my Health Records, and I accept full responsibility for all payment of deductibles, co-payments, uncovered services and authorize insurance assignment on my behalf. Missed Appointments are charged at $40 per no show, so please call to reschedule. Thank you

OFFICE POLICIES - Part 3

INFORMED CONSENT

In our clinic, we utilize an open treatment area for many of our treatments. In this clinic, we may also use trained clinic staff to assist the Doctor with portions of your consultation, examination, therapy, traction, massage, Laser, LED, PEMF etc. Occasionally when the Doctor is unavailable, other clinic staff may provide you with your recommended and desired therapy.

Every type of health care is associated with some type of risk of a potential reaction or problem. This includes Chiropractic health care. We want you to be informed about potential problems associated with Chiropractic manipulation therapy and our other services before consenting to any treatment. This is called Informed Consent and *your signature is required prior to us to provide any care.*

Chiropractic Manipulation Therapy (CMT): Adjustments / Manipulation is moving of bones via the Doctors hands or with the use of an instrument. Frequently, Chiropractic adjustments or manipulation create a "pop" or "clicking" sound or sensation in the area being treated.

Soreness: It is common for Chiropractic manipulation (CMT), traction, massage exercises, etc. to result in a temporary increase in soreness in the region being treated or surrounding areas. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic changes. It is not dangerous, but please do tell us about it.

Sprain / Strain: Soft tissue primarily refers to muscles, tendons and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, Chiropractic treatments such as manipulation, tractions, massage, etc. may overstretch some muscles or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statics to quantify their incidence.

Disc Herniation: In the neck and back, discs that create pressure on the spinal nerve or in the spinal cord are frequently successfully treated with Chiropractic treatments and therapies. Yet occasionally, Chiropractic treatments can aggravate the problem and rarely surgery may become a necessary correction. These problems occur so rarely that there are no available statistics to quantify their incidence.

Rib and other fractures: The ribs are found in the thoracic spine or middle back. They extend from your back to your front chest area, Rarely, Chiropractic manual manipulation could crack a rib bone, and this is referred to a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis which may be noted on x-rays. We manually adjust all patients carefully, and especially those who have osteoporosis on x-ray. These problems occur so rarely that there are no available statics to quantify their incidence. We have alternative methods of treatment as an option for those with concerns.

Therapy Burns: Some of the equipment / medical machines we use generate heat. We use ice and heat, and recommend them for home use on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, both heat and ice can burn or irritate the skin. The result is a temporary increase in pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statics to quantify their incidence. Never put a home ice pack directly on the skin, always use an insulating towel layer between your skin and the ice or heat when at home.

Stroke: Stroke means that a portion of the brain or spinal cord does not receive enough oxygen from blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The research literature is mixed or uncertain as to the weather chiropractor adjustments are even associated with stroke or not. The most recent evidence suggests that it is not (2008, 2015, 2016), although the same evidence suggests that the patient may be entering the Chiropractic office for neck pain/headache or other symptoms that may be in fact, be a spontaneous dissection of the vertebral artery. If we think this is happening, you will be immediately refereed to the emergency services. Anecdotal stories suggest that Chiropractic adjustments may be associated with strokes they arise from vertebral artery; this is because the vertebral artery is actually found inside the neck vertebrae. The adjustment is suggested to increase the strain on the vertebral artery is called the" extension-rotation-thrust atlas adjustment" We do not do this type adjustment on patients. Other type of neck adjustment may also potentially be related to vertebral artery strokes, but no one is certain. It is estimated that the incident of this type of stroke ranges between 1 per 400,000 -3,000,000 upper neck adjustments. This means that an average Chiropractor would have to be in practice for hundreds of years before they statistically be associated with a single patient stroke. Patients do have strokes on their own for a variety of reasons, including neck rotation or extension on their own. Two other rare potential problems that are not quantifiable because they are so extremely rare and may have association with chiropractic adjusting are carotid artery injury and spinal dura tear resulting in a leak of the cerebral spinal fluid.

Cauda Equina Syndrome: This is a very rare condition, occurs when a low back problem puts pressure on the nerves that control bowel, bladder and sexual function. Representative symptoms include leaky bladder, leaky bowels, or loss of sensation around the pelvic sexual organs, or the inability to urinate or start bowel movements. This condition is a medical emergency because the nerves controlling these functions can be permanently damaged and those functions may be lost or compromised forever. The standard approach is to surgically decompress the nerves and that window to do so is only 12-72 hours. If you have any of these symptoms, tell us immediately or go directly to the emergency room. Don't delay.

Other problems: There are other problems or complications that might arise from Chiropractic or other therapies we use which are not listed above. These other complications occur so rarely that it is not possible to anticipate / and /or explain them all in advance of treatments.

Chiropractic is a very safe, natural system of health care delivery, however, as with any health care delivery system, we cannot promise a cure or complete resolution of any symptom, disease or condition as a result of treatment in this clinic. We will always give you our best care and recommendations, and if results are not acceptable we may refer you to another provider whom we feel may assist your situation.

If you have any questions, please ask. We do require all patients to read and sign this consent to treat prior to any treatment.

* ALL PATIENTS MUST SIGN HERE

Thank you for your cooperation.

My signature below verifies that I have read and fully understand this consent form and I willingly agree to and consent to receive Chiropractic manipulation and other therapies at this clinic.

X _____ _____ _____

Patient or Guardian - Signature | Patient - Printed Name | Date

HEALTH STATUS

****INSURANCE PAYMENT REQUIRES YOU ANSWER ALL SECTIONS COMPLETELY****

Patient Name_____ ◯Male ◯Female Height _____ Weight _____Age ____

1. ANY PREVIOUS CHIROPRACTIC CARE ◯No ◯Yes, When_____

2. WHERE IS YOUR PAIN OR AREA OF COMPLAINT Check All that apply

☐HEADACHE ☐Pressure / Sinus ☐Behind Eyes ☐Temples ☐Migraine ☐Nauseous ☐Stress / Tension ☐Wake up with

☐NECK PAIN	LEFT	☐SHOULDER PAIN	LEFT	☐FINGER PAIN	LEFT
☐ARM PAIN	LEFT	☐HAND PAIN	LEFT	☐MID BACKPAIN	LEFT
☐LOW BACK PAIN	LEFT	☐LEG PAIN	LEFT	☐KNEE PAIN	LEFT
☐HIP / GLUTEAL PAIN	LEFT	☐ANKLE PAIN	LEFT	☐FOOT PAIN	LEFT

☐OTHER _____

3. IS THIS PROBLEM ☐Sudden/Acute Onset ☐Chronic Problem ☐Off / On, Past History of Similar Condition ☐Unknown Cause ☐Gradual Onset ☐Current Auto Accident Claim ☐Current Workmen's Comp. Injury Claim

Date Problem Began _____ Describe How Problem Began_____

_____

_____

4. DESCRIBE YOUR PAIN ☐Constant ☐Intermittent ☐Occasional ☐Varies

☐Dull ☐Sharp ☐Achy ☐Stiffness ☐Numbness ☐Stabbing ☐Burning ☐Tingling

☐Muscle Spasm ☐Grinding Sounds ☐Decreased Motion ☐Pain on Movement ☐Pinched Nerve

☐Radiating Pain to_____ ☐Worse when _____

5. DO YOU HAVE PAIN WHEN ☐Sleeping ☐Performing Daily Personal Care ☐When Bending

☐Getting up from seated / lying down position ☐When Lifting /Exercising ☐ When Sitting ☐ When Resting

6. ANY OTHER TREATMENT FOR THIS CURRENT CONDITION ☐No ☐Yes, Describe

☐Medical _____ ☐Physical Therapy_____

☐Other_____

_____

☐Pain Medication _____ ☐X-Rays ☐MRI ☐CT Date Taken_____

7. RATE YOUR CURRENT PAIN

Current Pain Severity Scale **0 = No PAIN 10 = Worst PAIN**

(Circle one)

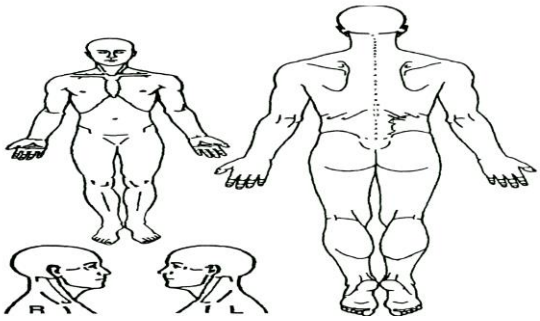
0 1 2 3 4 5 6 7 8 9 10

No Pain Mild Moderate Severe

HOW OFTEN ARE THESE SYMPTOMS PRESENT?

☐0-25% ☐26-50% ☐51-75% ☐76-100% ☐Constant

Mark where you have Pain or other Symptoms



8. PAST HEALTH HISTORY Please check all that apply to you or add:

☐**OTHER**_____

■****Medication used**_____

☐Past Sports / Other Injuries_____

☐Fractures, Sprains/Strains Describe_____

☐Past Auto Accidents / Dates_____ Injuries _____

☐Past Surgeries / Illness/ Dates_____Describe_____

☐Current Diagnosed Disease _____

☐Smoking	☐Stroke	☐Stress	☐Epilepsy/Seizures
☐Arthritis	☐Birth Control Pill Use	☐Ringing in the Ears	☐Are you Currently Pregnant
☐Cancer	☐Osteoporosis	☐Difficulty Sleeping	☐Constipation
☐Diabetes	☐Prostate Problems	☐Dizziness / Fainting	☐Heartburn/ Indigestion
☐High Blood Pressure	☐Menstrual Problems	☐Nauseous	☐Food Allergies
☐High Cholesterol	☐Urinary Problems	☐Difficulty Swallowing	☐Sore / Achy Muscles
☐Heart Disease	☐PMS Symptoms	☐Fatigue	☐Poor Sleep

*** ALL PATIENTS MUST SIGN HERE X** _____ DATE_____

I certify to the best of my knowledge, the above info is complete and accurate. If the info is not accurate, I understand that I am liable for all charges for services rendered and I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage. I give authorization for this clinic and my health insurance and/or attorney to discuss my care and Request and/or Release of my Health Records as needed. I consent to receive Chiropractic treatment & authorize this office to bill & collect insurance payment.