



For office use:
 Height: _____
 Weight: _____
 BPM: _____
 BP: _____

DEMOGRAPHICS

Patient name _____ Last _____ First _____ MI _____ SSN _____
 I would prefer to be called _____ Date of Birth ____/____/____ Age _____ M F
 When was the last time you saw a Chiropractor? _____
 Street Address _____
 City _____ State _____ Zip Code _____
 Cell Phone _____ Work Phone _____ Home Phone _____
 Email _____
 Occupation _____ How Long? _____
 Employer/Address _____
 Status: Minor Single Married Divorced Separated Widowed
 Spouse's Name _____ Number of Children? _____
 Who may we thank for your referral? _____ Primary Care Physician _____

HEALTH HISTORY

Are you currently taking any medications? Please list them below

Medication Name	Dosage and Frequency

Do you have any medication allergies? YES/NO If yes please list below

Medication Name	Reactions/Onset Date

Place a mark on "Yes" or "No" to indicate if you've had any of the follow:

AIDS/HIV	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fractures	Yes <input type="checkbox"/> No <input type="checkbox"/>	Osteoporosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gout	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Parkinson's Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pinched Nerve	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hernia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Prostate Issues	Yes <input type="checkbox"/> No <input type="checkbox"/>
Backaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Herniated Disk	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheum. Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Migraine Headache	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus Condition	Yes <input type="checkbox"/> No <input type="checkbox"/>
Concussion	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Multiple Sclerosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Issues	Yes <input type="checkbox"/> No <input type="checkbox"/>
Digestive Disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>	Muscular Dystrophy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Dizziness/Vertigo	Yes <input type="checkbox"/> No <input type="checkbox"/>	Neuritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tumors	Yes <input type="checkbox"/> No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Numbness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other: _____			

Exercise **Work Activity** **Habits**

None <input type="checkbox"/>	Sitting <input type="checkbox"/>	Alcohol <input type="checkbox"/>	Drinks/Week _____
Moderate <input type="checkbox"/>	Standing <input type="checkbox"/>	Caffeine <input type="checkbox"/>	Cups/Day _____
Daily <input type="checkbox"/>	Light Labor <input type="checkbox"/>	High Stress <input type="checkbox"/>	Reason _____
Heavy <input type="checkbox"/>	Heavy Labor <input type="checkbox"/>	Smoking <input type="checkbox"/>	Pack/Day _____
Are you pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>			Smoking Start Date: _____

Please describe any injuries or surgeries you have had: _____

FAMILY Hx : (for office use)

CONCERNS

What is your major complaint or concern? _____

When did your symptoms appear? _____

Are your symptoms: getting worse? getting better? staying the same?

What treatment have you already received for your condition?

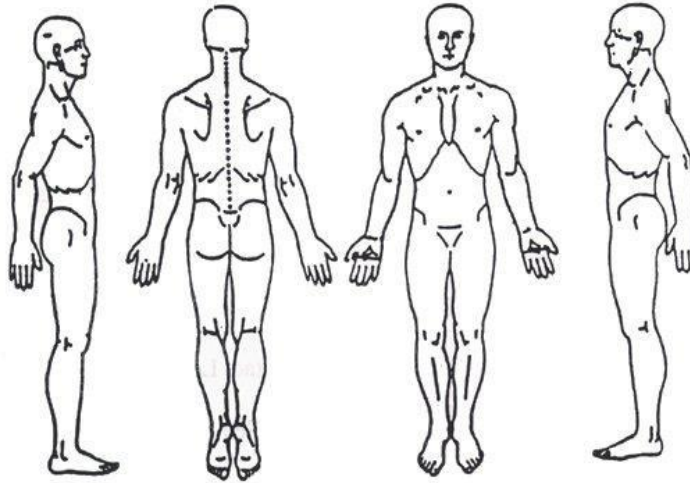
Medications Physical Therapy Chiropractic None Other: _____

Rate the Severity of your pain on a scale from 1 (least pain) to 10 (most pain): _____/10

Type of pain:

- S**harp **D**ull **T**hrobbing **A**ching **S**hooting
Burning **N**umbness **T**ingling **S**tiffness **O**ther

Place appropriate highlighted letters to mark the areas of discomfort



How often does this pain occur? Constant (+75%) Frequent (50-75%) Occasional (25-50%) Intermittent (<25%)

Does it interfere with: Work Sleep Daily Routine Recreation

Activities or movements that are painful: Sitting Standing Walking Bending Lying Down

Other comments or concerns regarding this condition: _____

INFORMED CONSENT WAIVER & AUTHORIZATION TO TREAT

I the undersigned, acknowledge by my signature that I am aware of the participating treating Doctor of Chiropractic (D.C.) listed below that she is a licensed chiropractor, and though rare, injury resulting from manipulation may include sprain/strain, disc herniation, stroke, death and other injuries or complications.

I agree to hold Dr. Amanda Buchanan; any and all associated co-sponsorships of any level or participation; free and harmless from any liability, claims, demands or suits for damages from any injury or complications whatsoever, which may result from such treatment. This document is binding and the parties hereto intend this Informed Consent Waiver and Authorization to Treat to be binding on and insure to the benefit of their respective principals, heirs, executors, administrators, successors, and assigns; includes any and all my successors and/or heirs. I further state that should complications arise from such agreed treatment with the treating Doctor of Chiropractic, that such individual and myself will be the only parties to engage in any and all recourse should that need arise foregoing any and all others.

Patient Signature _____ Date _____

If patient is under 18:

Guardian Signature _____ Date _____

Financial and Insurance Disclaimer

Financial Policy

Payment in full is expected at the time service is rendered. If you have insurance coverage for chiropractic care in our office, you will be responsible for your co-payment, deductible, and/or co-insurance payment at the time of each visit. If you do not have insurance coverage for chiropractic care, you will be responsible for payment in full at the time service is rendered. In order to make this convenient, we accept most major credit cards, cash and personal checks. If, on occasion, it is not possible to pay in full, we are willing to establish a payment schedule with you. However, the balance may not exceed \$250.00 and the full balance must be paid within 30 days. Personal balances over 30 days old may be handled by an attorney for collection. Costs of collections will be added to your account and will be your responsibility. A \$20.00 fee will be applied to appointments not canceled within 12 hours of the scheduled appointment time. Appointments Monday must be canceled Friday before closing.

Insurance Policy

Our office works with insurance companies to accept your coverage. Our staff will call the insurance company to verify your coverage and will explain to you the information they obtain. Upon receipt of payment and Explanation of Benefits (EOB) from your insurance company, we will know your final patient responsibility. We will then notify you of any changes or differences to the original verification quoted us. NOTE: Verification is not a guarantee of benefits. We assume no responsibility for the information we receive from your insurance company, concerning how much or what your insurance company will pay for. The final financial responsibility is yours. Should you have questions at any time, do not hesitate to contact the staff or office manager.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Dr. Amanda Buchanan will submit services rendered for my care for payment under the contract I have with my health and/or accident carrier. However, I understand and agree that verification of insurance is not a guarantee of benefits on all services rendered to me and I am ultimately responsible for payment. I also understand if I suspend or terminate my care and treatment, any unpaid fee for professional services rendered to me will be immediately due and payable.

Patient Signature _____ Date _____

If patient is under 18:

Guardian Signature _____ Date _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal law.

Patient Signature _____ Date _____

If patient is under 18:

Guardian Signature _____ Date _____

CMS requires providers to report both race and ethnicity:

Race (Circle One): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer **Preferred Language:** Eng Spanish Other