May Family Chiropractic
Health Information and Health History

Patient Name:____________________________________ Gender: Male Female

Marital Status: (Circle one) M S D W Other: ________________ Date of Birth ____/____/____

Spouse Name: _______________________________ How many children: ___________

Patient Social Security Number: _______-_______-_________

Spouse Social Security Number: _______-_______-_________

Patient Address: ______________________________ City _____________Zip Code:_______

Patient Phone Number: _______-_______-_______ Cellular Number: _____-_____-____

Email:____________________________ ___ Employer:__________________________

Occupation: ________________________ Referred By:______________________________

Is this condition due to: Auto Accident Personal Injury Work Related Accident

Do you have health insurance? Yes No

Do you have more than one insurance? Yes No

Name of Insurance Company: _________________________ID #_______________________

Is your spouse employed? Yes No Is your spouse the primary insured? Yes No

Are you covered by Medicare? Yes No

I authorize Back & Body Chiropractic Center to release medical information to my insurance company:

Signature: ____Date__________________

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment if my insurance carrier does not pay. I also understand that payment of services is due at the time of service unless other financial arrangements have been made.

Signature: ____Date__________________

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COMPLAINTS

Primary Complaint? ____

Secondary Complaint? ____

When did your problem begin? ____

How did your problem begin? ____

Is this problem interfering with your: (circle one)

Activities of daily living   Work   Social Activities   Hobbies Sleep

Rate your pain: (Circle one) 0 being no pain or 10 being the worst pain

0   1   2   3   4   5   6   7   8   9   10

Is your health problem worse: (Circle one) Morning/ Day/ Evening/ Night

Does your health problem occur: (Circle one) Occasionally/ Intermittently/ Constantly Frequently

Is your problem getting: (Circle one) Better/ Worse/ No Change

Have you had this problem before? _____________________ When? _____________________

What aggravates your health problem: circle all that apply:

Coughing Sneezing   Walking   Reaching   Lifting   Bending   Sitting

Lying down   Standing   Neck movement   Straining at stool

What relieves your health problem: circle all that apply:

Nothing   Resting   Heat   Sitting   Standing   Ice

Have you had recent treatment for this condition? Yes No

Who did you see? __________________________________Treatment _____________________

Have you had any changes in bowel or bladder habits since your problem began? Yes No

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List your hobbies: 1) ______________________
2) ______________________
3) ______________________

What are your habits?

Smoking	never	packs per day ________
Alcohol	never	drinks per day________
Caffeinated Drinks	never	drinks per day________
Exercise	never	times per week_______
Drug/Substance Abuse	never	Yes, if yes discuss with your doctor

MEDICAL HISTORY

Have you seen a doctor of chiropractic? Yes No

Who is your Family Physician:____________________ Date of last physical exam:___________

Do you give us permission to send your family doctor your progress and treatment notes? Yes/No

Have you been hospitalized in the past five years? Yes No

Date and Reason: ____

Have you had any serious accidents in the past five years: Yes No

Date and Describe: ____

List your medications: ____

In the past 6 months have you suffered from: Circle all that apply or circle normal

General:	Fatigue	Weakness	Weight change	Loss of sleep	Normal
Neurological:	Headaches	Seizures	Dizziness	Nervousness	Normal
Eyes:	Vision trouble	Dryness	Redness	Cataract Glaucoma	Normal
Nose:	Pain	Bleeding	Sinus trouble	Infections	Normal
Mouth/Throat:	Sores	Bleeding	Enlarged	Glands Tonsillitis	Normal
Cardiovascular:	Coughing Palpitations	Sneezing Hypertension	Wheezing	Chest Pain	Normal
Gastrointestinal:	Diarrhea Constipation	Vomiting Gas	Appetite Change	Heartburn	Normal
Endocrine:	Goiter	Sugar in Urine	Heat Intolerance	Cold Intolerance	Normal
Psychologic:	Anxiety	Depression	Memory Loss	Mood Swings	Normal

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Have you ever had any of the following: Circle all that apply

Arthritis	Heart	Trouble	Pacemaker
Diabetes	Dislocated Joints	Hay Fever	Asthma
Bone Fracture	Tuberculosis	Epilepsy	High blood pressure
Serious Injury	Allergies	Low blood pressure	Prostate Trouble
Sinus	Rheumatic Fever	Kidney Trouble	Scoliosis
Spinal Disease	Polio Cancer	Thyroid Trouble	HIV
Ulcer	Sexually Transmitted Disease AIDS		

FAMILY HISTORY

Has any one in your family had any of the following: (if yes list relationship to patient)

Cancer:_____________________________ Diabetes:______________________________

Heart Trouble: ______________________ High Blood Pressure: __________________

Do any family members suffer from the following: please circle and list the relationship to you

Neck Problems: ___________________________________

Back Problems: ___________________________________

Headaches: _______________________________________

Arthritis: ____

Disc Problems: ____________________________________

Pinched Nerves: ___________________________________

Bad Posture: ______________________________________

Scoliosis: ____

Osteoporosis: _____________________________________

Doctor's Signature: ____

For Office Use Only:

Height_________________Weight_____________Pulse __________________Blood Pressure_________________

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AUTO ACCIDENT QUESTIONAIRE

Date of Accident: ______________________________

Time of Accident: ______________________________

To your knowledge what caused the accident? ____

____

What occurred following the accident? Circle all that apply

Received emergency care Felt confused Felt nervous Loss of consciousness

Felt weak Transported to the hospital via ambulance

After accident you were taken to? ____

Position in vehicle? Driver Front seat passenger Back seat passenger

Were you wearing a seat belt? Yes No

Was the accident: Expected Complete surprise

How was your vehicle struck? Front end Rear end Right side Left side

Did the air bags deploy? Yes No Did the seat break? Yes No

Did your vehicle have headrest? Yes No

What speed were you traveling? __________ What speed was other vehicle traveling? _______

What type of vehicle were you in? _______________Type of other vehicle involved?_________

Was visibility (circle one) Poor Good

What was the condition of the roadway? Wet Dry other: ____

Where did you feel pain immediately following the accident? ____

Do you or did you have any visible abrasions? Yes No Where? ____

What type of treatment have you had since the accident? ________________________________

____.

Are you taking medication due to injuries from this accident? Yes No
If yes, what type of medication?____

____.

Where x-rays or special test performed following the accident? Yes No

If yes, list name or facility where tests were performed:__________________________________

____.

Do you have additional symptoms or complaints that have occurred since the accident? Yes No

If yes, please list: ____

____.

Is there any additional information you would like us to know?
____

____

____

____

Doctor's Notes: ____

____

____

____

____

____

May Family Chiropractic
Work Injury Questionnaire

Date of injury: ______________________________

Time of injury: ______________________________

Did you report this injury to your employer? Yes No Who did you report it to? ___________

What caused the injury? ____

____

Describe in your own words what happened? ____

____

____

____

What is your major complaint? ____

____

____

Do you have any secondary complaints as a result of this accident? _______________________

____

____

Have you missed work due to this injury? Yes No How many days? ____________________

Describe your job duties: ____

____

Additional information: ____

____

Doctor's Notes: ____

____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any healthcare operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician has the right to refuse to give care.
8. I also give consent to allow this clinic to display my name of a patient referral board in the reception area of this office. I understand that if I make the referral to another patient my name will appear on such board.
9. I understand that upon entering this facility, my name will be signed on a sign-in sheet that will remain in the reception area of the office. I also realize that any person entering this office may read my name on the sign-in sheet as a patient.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

____________________________________ ___________________________

Patient Signature Date

TO: Medicare Patients

To make dealing with Medicare as simple as possible, we have established the following guidelines. Keep in mind that Medicare regulations change frequently and therefore, these guidelines may have to be updated.

1. We will file ALL Medicare claims.
2. We will file ALL Medicare secondary/supplemental insurance.
3. We are participating providers with Medicare, which means that Medicare pays us directly, however, Medicare patients must meet an annual $131 deductible, which we are required to collect at the beginning of services for each calendar year. Supplemental coverage may pay the deductible but if no such coverage is available, the patient is responsible for the deductible.
4. Medicare pays for 80% of allowed charges. Supplemental coverage may pay the 20%, but if no coverage is available, the patient is responsible.
5. Medicare does not pay for maintenance care. This will be your responsibility.
6. Medicare does not pay for all of your health care costs. The fact that Medicare does not pay for a particular item or service does not mean that you should not receive it.

Medicare Pays For:	Medicare Does Not Pay For:
Manual manipulation of spine	Examinations
IF SUPPORTED BY X-RAY AND/OR EXAMINATION	Physical Therapy
After the deductible is met	X-Rays
Depending upon the condition	Orthopedic Supplies
	Maintenance care

If you have questions regarding these guidelines, please ask, we are here to help you!!

I have read and understand the limitations of my Medicare coverage and agree to be personally responsible for the payment of non-covered services if I choose to receive those services.

________________________________ ____________________

Signature of patient or person acting on patient's behalf | Date

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to May Family Chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The Doctor of Chiropractic provides a specialized, non duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime. I understand that if I am accepted as a patient by a doctor at May Family Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature:_______________________________________ Date:____________