Beaumont Chiropractic New Patient Packet

Date: _____ Patient #_____ **Doctor: _____**

Name: _____ SSN:_____-_____-_____

Home Phone: _____ Cell Phone: _____

Address: _____City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____Race: _____ E-mail address: _____

Occupation: _____ Employer: _____Office Phone: _____

Marital: M S W D (circle one) How many children? _____

Spouse: _____ Occupation: _____ Employer: _____

Name of Nearest Relative: _____ Address: _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor: _____ Clinic Name: _____ Phone: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Yes No

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder	__Dizziness	__Circulatory
__Circulatory Problems	__Epilepsy	__Alcoholism	__Backaches	__Hypertension
__Arthritis	__Pace Maker	__Drug Addiction	__Heart Trouble	__Neuritis
__Rheumatoid Arthritis	__Strokes	__HIV Positive	__Diabetes	__Anemia
__A Congenital Disease	__Seizures/Convulsions	__Gall Bladder	__Sinus Trouble	__Hernia
__Excessive Bleeding	__Ruptures	__Depression	__Headaches	__Cancer
__High/Low Blood Pressure	__Coughing Blood	__Ulcers	__Nervousness	
__Numbness	__Asthma	__ Rheumatic Fever	__Digestive Disorders	

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Has a physician treated you for any health condition in the last year? Yes No (circle one)

If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? Yes No (circle one) describe: _____

Do you have any allergies of any kind? Yes No (circle one) describe: _____

Please list any other health problems you have, no matter how insignificant they may be: _____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages? _____ If so, how much per week? _____

Do you use any tobacco products? _____Do you smoke? _____ If so, packs per day: _____

Do you take vitamin supplements? _____ If so, please list: _____

Do you consume caffeine? _____ If so, how much per day: _____

Do you exercise? _____ If yes, what is the frequency and type of exercise? _____

What are your hobbies? _____

What percentage of time during the day (at home or at your job away from home) do you spend:

Lifting _____% Sitting _____% Bending _____% Working at a computer_____%

FAMILY HISTORY: Patient Name:_____

Father: living____ deceased____ (check one) Current age if still living: _____
Cause of death and age at death if deceased: _____
Mother: living____ deceased____ (check one) Current age if still living: _____
Cause of death and age at death if deceased: _____

Check if applicable to you: ____ *As an adopted child, little is known of my birth parents or family.*

Do you have any family members who suffer from the same condition you do? If so, please list:_____

FAMILY DISEASES (if applicable, indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis	____	Cancer	____	Mental Illness	____
Diabetes	____	Asthma	____	Heart Disease	____
Stroke	____	Kidney Disease	____	Lung Disease	____
Arthritis	____	Liver Disease	____	Other_____	

HISTORY OF PRESENT ILLNESS:

1. Chief Complaint / Purpose of this appointment: _____
2. Date symptoms appeared or accident happened: _____
3. If this is a recurrence, when was the first time you noticed this problem?_____
   How did it originally occur?_____
   Has it become worse recently? Yes No Same Better Gradually Worse (circle one)
   If yes, when and how? _____
4. Is this due to: Auto____ Work____ Other_____
5. What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting (circle one)
   Other _____
6. Is there anything you can do to relieve the problem? Yes No (circle one). If yes, describe_____
   _____
   If no, what have you tried to do that has not helped? _____
7. Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing (circle one)
   Other _____
8. How frequent is the condition? Constant Daily Intermittent Night Only (circle one)
   How long does it last? All Day Few Hours Minutes (circle one)
9. Are there any other conditions or symptoms that may be related to your major symptom? Yes No (circle one)
   If yes, describe _____
   Are there other unrelated health problems? Yes No (circle one) If yes, describe _____
10. Days lost from work: _____ Date of last physical examination: _____
11. Have you had any broken bones? Yes No (circle one). If yes, please list and give dates _____
    _____

12. **WOMEN ONLY:** Are you pregnant or is there any possibility you may be pregnant? Yes __ No __ Uncertain __

Doctor's Signature _____ Date _____

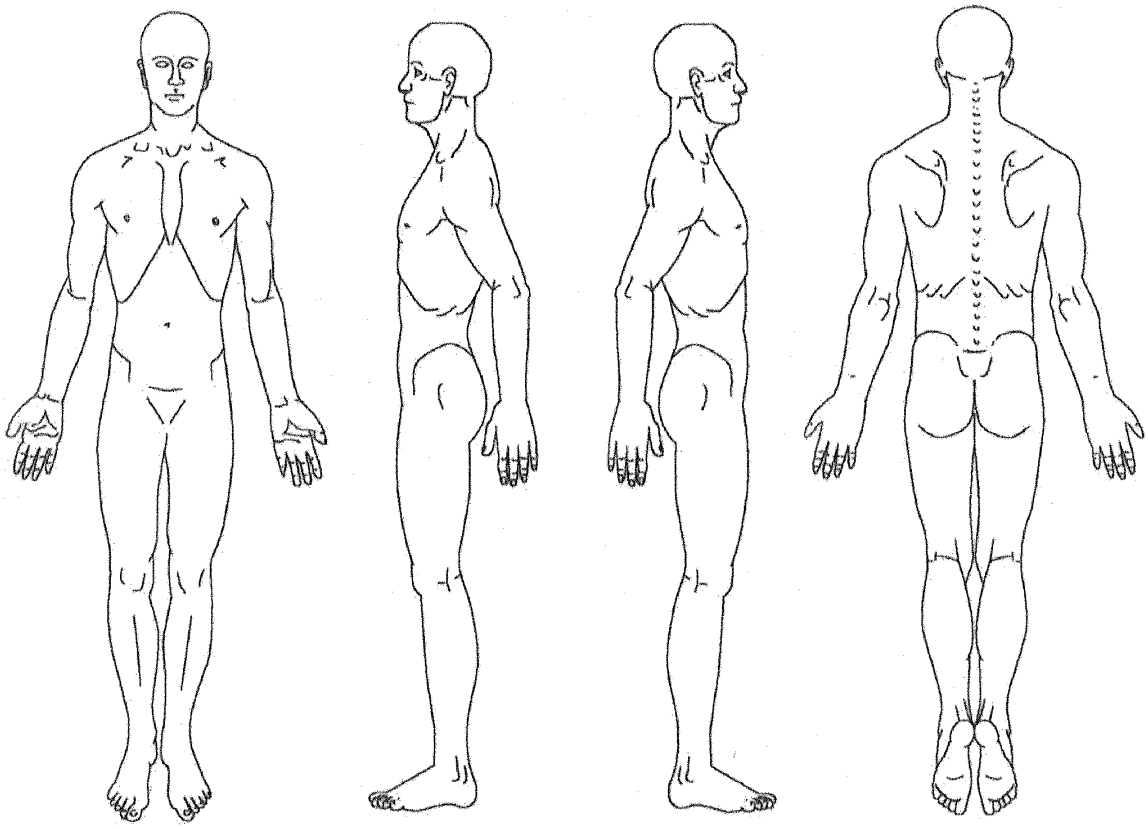
Beaumont Chiropractic

PAIN DRAWING

Name _____ **Date** _____

Using the following descriptive symbols, draw the location of your pain on body outlines below. In addition, mark the level of your pain on the pain line at the bottom of the page.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
≈≈	====	OOOO	.....	//////////	XXX



No Pain ——————————— Worst Possible Pain

Please make a slash through this line as to the level of your pain.

_____

Patient Signature

AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's/Guardian's Initial:_____

INFORMED CONSENT FOR CHIROPRACTIC CARE

In coming to the Chiropractic Physician, a patient 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 is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician 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 a physician at Beaumont Chiropractic Clinic accepts me as a patient, 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 Initial: _____

FINANCIAL POLICY FOR YOUR FIRST VISIT

Welcome to our office! We're happy you have chosen Chiropractic for your health care needs. Your health is your greatest asset and therefore one of the best things you can invest in financially.

All services rendered during the first visit **must** be paid for at that time. Patients without insurance coverage may pay by cash, check, electronic debit or credit card. Patients with insurance can pay for their deductible and/or co pay by cash, check, electronic debit or credit card provided their coverage has been verified. Patients with insurance that has not been verified are on a cash basis until coverage is confirmed. If this results in an overpayment, **we will credit your account or reimburse you when our office receives final payment from the carrier and care has been completed.**

I have read, understood and agree to abide by the terms of this office's Financial Policy for my first visit. Any portion of this agreement that is found to be void or invalid will have no effect on other portions of this agreement.

Patient Initial: _____

Patient's Printed Name:_____

Patient's Signature:_____ **Date:**_____