

WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____ City State Zip

Phone # (H) _____ (W) _____ (Other) _____

Can we call you at work? Yes No

Date of Birth: _____ Sex: Male Female SS#: _____

Marital Status: Single Married Divorced Widowed Separated Minor

Race Caucasian African American Asian Native American Latin American Other _____

Ethnicity Hispanic Latino Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to an accident? Yes No If yes, what type? Auto Work Other _____

Has it been reported? Yes No If yes, to whom? _____

Insurance Information

Policy Holder Name: _____ D.O.B. : _____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? Yes No Name of Carrier: _____

Do you have secondary insurance? Yes No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ DATE _____

Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

- | | | | | |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Bowel/Bladder Changes | |

Please check to indicate if you have ever had any of the following:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | |
| | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other _____ | |

Are you currently under drug and/or medical care? Yes No If yes, explain _____

Please list any medications you are currently taking (**Be sure to include dosage and frequency**) _____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ | |

Do you exercise: Never Daily Weekly Walks Runs Swims

Do your work activities mostly involve: Sitting Standing Light Labor Heavy Labor

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

ALCAT Food Tolerance Survey

Patient Name _____ Date _____

Please complete the following food and chemical sensitivity questionnaire. Mark each symptom based upon your experiences over the last 60 days. Some of these symptoms may have been repeated previously in this paperwork.

Symptom Scoring System:

- = No Symptoms
- = Experience Mild Symptoms ○○●○ = Experience Moderate Symptoms ○○○● = Severe Symptoms

Digestive Symptoms

- 0000 Stomach Pains or Cramping
- 0000 Constipation
- 0000 Diarrhea
- 000 Reflux of Heartburn
- 0000 Bloating
- 0000 Gas
- 0000 Nausea or Vomiting

Weight

- 0000 Inability to Lose Weight
- 0000 Food Cravings
- 0000 Binge Eating
- 0000 Water Retention

Sinus Respiratory

- 0000 Stuffy or Runny Nose
- 0000 Asthma
- 0000 Chest Congestion
- 0000 Chronic Cough
- 0000 Wheezing
- 0000 Frequent Sneezing

Head/Ears

- 0000 Migraines
- 0000 Headaches
- 0000 Earaches
- 0000 Ear Infections
- 0000 Ringing in Ears

Eyes & Throat

- 0000 Itchy eyes
- 0000 Watery Eyes
- 00○ Sore Throat
- 0000 Persistent Canker Soar

Emotional/Mental

- 0000 Depression
- 0000 Anxiety
- 0000 Mood Swings
- 0000 Irritability
- 0000 Poor Concentration

Energy

- 0000 Fatigue
- 000○ Hyperactivity
- 0000 Lethargy
- 0000 Restlessness
- 0000 Insomnia

Skin Disorders

- 0000 Eczema
- 0000 Dermatitis
- 0000 Excessive Sweating
- 0000 Rashes
- 0000 Hives

Other Symptoms

- 00○0 Joint Pain
- 0000 Arthritis
- 0000 Irregular Heartbeat
- 000○ Chest Pains
- 0000 Muscle Aches

Please list any symptoms not mentioned above: _____

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME _____ DATE _____

For any YES answer, please include details.

- | | | |
|---|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 3. Do your hands or arms fall asleep regularly?
Comment: _____ | NO | YES |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms?
Comment: _____ | NO | YES |
| 5. Do you suffer from a loss of handgrip strength?
Comment: _____ | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 8. Do our legs or feet fall asleep regularly?
Comment: _____ | NO | YES |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet?
Comment: _____ | NO | YES |
| 10. Do you suffer from cold hands or feet?
Comment: _____ | NO | YES |
| 11. Do have frequent falls or find that you trip over your feet while walking?
Comment: _____ | NO | YES |
| 12. Have you tried any medications such as anti-inflammatory?
If yes, what kind of medication? | NO | YES |
| 13. Have you tried any Physical Therapy or Chiropractic treatments before?
If yes: When? For how long? What kind?
_____ | NO | YES |
| 14. Have you had an MRI?
If yes: When? Who ordered it? What was it ordered for?
_____ | NO | YES |
| 15. Have you used any splint or braces or other prescribed treatment by an MD?
If yes: When? What kind? Who ordered it?
_____ | NO | YES |
| 16. If you have tried any treatment or medications, did this make your problem better?
Comment: _____ | NO | YES |

For any yes answer, rule in/out the diagnosis with these two tests:

A) NCU/EMG tests Upper Lower Indicated Not Indicated (circle one)

B) Vascular Test Indicated Not Indicated (circle one)

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care 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. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Patient's Signature

Date

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

This notice is effective as of the date it is signed and will expire seven years after the date on which you last received services from us.

Patient Signature

Date

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

There is a possibility that I a may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because: _____

Date of last menstrual period: _____

Patient's Signature

Date

PATIENT

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Superior HealthCare.
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of Superior HealthCare to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Olivia Byess, about my concerns.

Signature of Patient/Guardian

Date

Witness (Office Staff)

Date