Welcome

Patient Information

Date _____

Patient _____

Address _____

_____

Sex: ☐M ☐F Age _____ Birthdate _____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Who may we thank for referring you? _____

_____

Phone Numbers

Home _____ Work _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

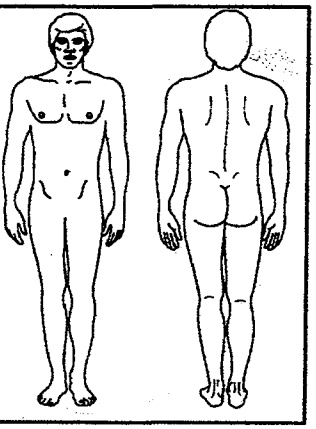
Home Phone _____

Work Phone _____ Ext _____

Payment is due on the time of services. This includes co-payments and deductibles. We accept cash, checks and credit cards.

Type of payment you are planning to make today _____

Mark an "X" on the picture where you continue to have pain, "N" where you have numbness, "T" where you feel tingling.



Reason for visit _____

What were you doing when pain occurred? _____

_____

Initial onset _____

Is the condition becoming progressively worse? Yes _____ No _____ Unknown _____

Rate the pain on a scale of 1 (least) to 10 (worst). _____

Exacerbatons (recurrent episodes). If so, how often and date of last occurrence.

_____

Does anything make it better (rest, motion, ice, heat, medication)? _____

Does anything make the condition worse (bending, driving, work, time of day)?

_____

Where does the pain start (low back, hip, neck, head, etc.)? _____

Is the pain localized in the area of complaint or does the pain travel to other parts of the body (arms, legs, buttocks, up/down spine)?

_____

Is the condition constant or does it come and go? _____

If constant, does the time of day cause increased or decreased pain? _____

Do you suffer from any other chronic illness? _____

Who is your family doctor? _____

HEALTH HISTORY

What treatment have you already received for your condition? ❑Medications ❑Surgery ❑Physical Therapy

❑Chiropractic Services ❑None ❑Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "no" to indicate if you have had any of the following:

AIDS/HIV ❑Yes ❑No	Emphysema ❑Yes ❑No	Miscarriage ❑Yes ❑No	Scarlet Fever ❑Yes ❑No
Alcoholism ❑Yes ❑No	Epilepsy ❑Yes ❑No	Mononucleosis ❑Yes ❑No	Stroke ❑Yes ❑No
Allergy Shots ❑Yes ❑No	Fractures ❑Yes ❑No	Multiple Sclerosis ❑Yes ❑No	Suicide Attempt ❑Yes ❑No
Anemia ❑Yes ❑No	Glaucoma ❑Yes ❑No	Mumps ❑Yes ❑No	Thyroid Problems ❑Yes ❑No
Anorexia ❑Yes ❑No	Goiter ❑Yes ❑No	Osteoporosis ❑Yes ❑No	Tonsillitis ❑Yes ❑No
Appendicitis ❑Yes ❑No	Gonorrhea ❑Yes ❑No	Pacemaker ❑Yes ❑No	Tuberculosis ❑Yes ❑No
Arthritis ❑Yes ❑No	Gout ❑Yes ❑No	Parkinson's Disease ❑Yes ❑No	Tumors, Growths ❑Yes ❑No
Asthma ❑Yes ❑No	Heart Disease ❑Yes ❑No	Pinched Nerve ❑Yes ❑No	Typhoid Fever ❑Yes ❑No
Bleeding Disorders ❑Yes ❑No	Hepatitis ❑Yes ❑No	Pneumonia ❑Yes ❑No	Ulcers ❑Yes ❑No
Breast Lump ❑Yes ❑No	Hernia ❑Yes ❑No	Polio ❑Yes ❑No	Vaginal Infections ❑Yes ❑No
Bronchitis ❑Yes ❑No	Herniated Disk ❑Yes ❑No	Prostate Problem ❑Yes ❑No	Vereareal Disease ❑Yes ❑No
Bulimia ❑Yes ❑No	Herpes ❑Yes ❑No	Prosthesis ❑Yes ❑No	Whooping Cough ❑Yes ❑No
Cancer ❑Yes ❑No	High Cholesteral ❑Yes ❑No	Psychiatric Care ❑Yes ❑No	Other _____
Chemical Dependency ❑Yes ❑No	Kidney Disease ❑Yes ❑No	Rheumatoid Arthritis ❑Yes ❑No	_____
Chicken Pox ❑Yes ❑No	Liver Disease ❑Yes ❑No	Rheumatic Fever ❑Yes ❑No	_____
Diabetes ❑Yes ❑No	Measles ❑Yes ❑No		
	Migraine Headaches ❑Yes ❑No		

EXERCISE

- ❑None
- ❑Moderate
- ❑Daily
- ❑Heavy

WORK ACTIVITY

- ❑Sitting
- ❑Standing
- ❑Light labor
- ❑Heavy Labor

HABITS

- ❑Smoking Packs/Day _____
- ❑Alcohol Drinks/Week _____
- ❑Coffee/Caffeine Drinks Cups/Day _____
- ❑High Stress Level Reason _____

Are you pregnant? ❑Yes ❑No Due Date _____

Injuries/Surgeries you have had: Description Date

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name _____		

Employment, ADL, and Recreation Information

Patient name _____ File # _____ Date _____
Initial Exam _____ Re-activation _____ Re-evaluation Exam _____
Vitals: Height _____ Weight _____ Blood Pressure _____ Pulse _____

Outcomes Assessment Tool Used _____ **Score** _____

Description of Work: _____

Condition's Effect On Job Performance: ☐ **No Effect** ☐ **Mild** (painful can do) ☐ **Mod** (painful limited ability)
☐ **Mod/Sev** (limited duty) ☐ **Sev** (no limited duty) ☐ **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Care –Infirm Family:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Carrying Groceries:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Change Posn–Sit-Stand:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Climb Stairs:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Driving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Extended Computer Use:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Feeding:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Household Chores:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Kneeling:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lift Children:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Pet Care:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Reading (Concentration):	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Bathing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Dressing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Shaving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sexual Activities:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sleep:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Sitting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Standing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Walking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Yard Work:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
_____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
_____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform

Attending Doctor's Signature _____ Date _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

Jones Family Chiropractic Clinic

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

I consent to the use or disclosure of my protected health information by Dr. James Jones 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 Dr. Jones. I understand that analysis, diagnosis or treatment of me by Dr. Jones 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. Dr. Jones is not required to agree to the restrictions that I may request. However, if Dr. Jones agrees to a restriction that I request, the restriction is binding on Dr. Jones.
I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Jones 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 or 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 Dr. Jones and understand that I have a right that Notice's 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 Dr. Jones. The Notice of Privacy Practices for Dr. Jones is also posted in the waiting room at 100 Century Plaza 4D, Seneca SC. This Notice of Privacy Practices also describes my rights and duties of the Dr. Jones with respect to my protected health information.

Dr. Jones 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 calling the office of Dr. Jones and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____ _____

Date of Signing | Description of Personal Representative's Authority

Jones Family Chiropractic
100 Century Plaza Suite 4D
Seneca, SC 29678
Tel:864-888-4122 Fax: 864-888-4630

Financial Policy

Co-Pays & Deductibles

All Co-Pays and deductibles are due when services are rendered. It is the patient's responsibility to be aware of his/her co-pay and/or deductible at the time of services. Some insurance companies do not cover chiropractic care. You will be responsible for the charges that your insurance does not cover.

Self-Pay/ High-deductibles

Payments is expected when services are rendered. First initial visit is $65 plus the cost of x-rays 75 min. Each office visit following will be 45.00.

Medicare

Patient is responsible for all non-covered services, deductibles and co-pays. X-rays are not covered by Medicare. Adjustments are the only procedure covered by Medicare. Therapies such as muscle stimulate, traction, etc. are not a covered service. If modalities utilized for treatment a $20 per visit fee per visit is changed. Wellness visits are not a covered service.

Health Insurances Plans

If you participate in a plan which we accept we will file your insurance as a courtesy; otherwise payment in full is expected at the time of service. Please note that insurance companies do not guarantee payment for procedures that are covered by them.

I have read and accept these policies and would like to proceed with care at this time.

Name_____ **Signature**_____ **Date**_____