BACK IN ACTION CHIROPRACTIC CLINIC

Dr. Cameron J. Mitchell D.C.
520 Pointer Trail Suite B, Van Buren, AR 72956

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill this form out completely. If you have any questions we will be glad to help you. We look forward to working with you in maintaining your health.

PATIENT INFORMATION **DATE** ____________________

Name____ Social Sec. # ____________________
Address_________________________________ City_______________ State________ Zip____________
Phone______________________ Mobile # _______________________ Date of Birth ________________
Age________ yrs. Sex _____Male ____ Female Marital Status______________
Who may we thank for referring you?____
Employer____________________________________ Occupation ______________________________
Business Phone _______________________ Are we allowed to phone you at work __________________
Spouse's Name________________________________ Employer ________________________________
Occupation___________________________ Is your spouse the insured?___________________________
Number of Children_____________ Name of Children ____
E-Mail Address ____

INSURANCE INFORMATION

Insurance Company___________________________________ Insured's Date of Birth _______________
Insured's ID# / Group #_____________________________________/ ____________________________
Primary Care Physician Name___________________________________ Phone _____________________

REASON FOR VISIT

Have you ever been to a chiropractor for treatment? ____Yes ____ No If yes, when ___________________
and why? ____
Your reason for this visit ____
Date symptom began for this visit?_______________ Have you had similar conditions? ___Yes ___No
If yes, please explain ____
____
Is your pain getting _______Worse _______Better _______Same _______Comes and Goes
Have you been treated by a medical physician for this condition? ______Yes ______No
If yes, when and where?____

HEALTH

Please list any medication (including painkillers and any over-the-counter drugs you are taking. (Please list date started and dosage): ____
____

Please list any serious injuries, such as falls, head in juries, broken bones, dislocations, surgeries and any other serious medical conditions you have had in the past. Go back as far as you can remember and give dates as well. ____
____
____
____

PERSONAL

Please check any of the following that apply to you.

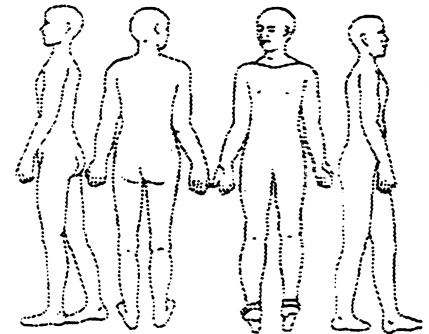
	Heavy	Moderate	Light	None
Alcohol	______	______	_____	______
Coffee	______	______	_____	______
Drugs	______	______	_____	______

	Heavy	Moderate	Light	None
Exercise	_______	_____	____	______
Sleep	_______	_____	____	______
Appetite	_______	_____	____	______

Are you pregnant? _______Yes _______No
If so, how far along are you? ____ Months ____Weeks
Are you currently nursing? _______Yes _______No

Please fill out the illustration to the right. Be sure to indicate with a **P** where you are having pain, **N** for numbness, **S** for muscle spasms, **T** for tenderness and H for Hypoesthesia (which is decreased feeling or sensation in the hands or feet). Also, rate the pain that you are feeling at this present time from **1 to 10** on the pain scale located a the bottom of the illustration.

SYMPTOM LOCALIZATION



P ___ **Pain** **T** ___ **Tender**
N ___ **Numb** **H** ___ **Hypoesthesia**
S ___ **Spasm**

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Please mark any of the following medical conditions.
(Please write in the date of the condition).

_____ Heart Attack/Stroke
_____ Congenital Heart Defect
_____ Alcohol/Drug Abuse
_____ Fainting/Seizures/Epilepsy
_____ Shingles
_____ Psychiatric Problems
_____ Difficulty Breathing
_____ Hepatitis
_____ Anemia
_____ Ulcer/Colitis

_____Arthritis
_____ Frequent Neck Pain
_____ Jaw Pain
_____ Wrist Pain
_____ Shoulder Pain
_____ Arm Pain
_____ Leg Pain
_____ Lower Back Problems
_____ Frequent Earaches
_____ Gout

_____ Ringing in Ears
_____ Severe/Frequent Headaches
_____ Diabetes/Tuberculosis
_____ Dizziness
_____ Emphysema/Glaucoma
_____ Kidney Problems
_____ Artificial Bones/Joints
_____ Cancer
_____ HIV Positive/AIDS

AUTHORIZATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Back In Action Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me at charged directly to me and that I am personally responsible for payment. I also understand that is I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize the use of this signature on all insurance submissions. I authorize this Chiropractic office to release all information necessary to secure payment of benefits. I hereby authorize and release the doctor and whom ever he may designate as his assistants to administer treatment of chiropractic care or any clinic services that he deems necessary in my case. I have reviewed the information in this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the Chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the Chiropractor.

Printed Name: ____ Date ______________________

Signature: ____

Patient Health Questionnaire

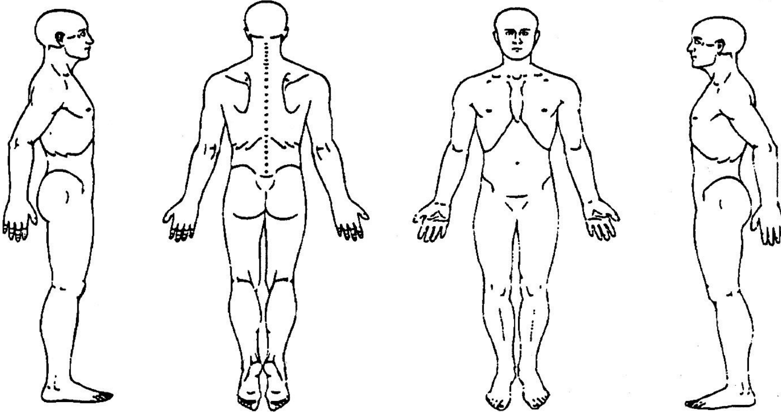
Patient Name ______________________ **Date** ____________

When did your symptoms start? ______________ **Describe your symptoms and how they began:**

____

____

Indicate on the pictures below where you have pain or other symptoms



How often do you experience your symptoms?
- ○ 1-Constantly (76-100% of day)
- ○ 2-Frequently (51-75% of day)
- ○ 3-Occasionally (26-50% of day)
- ○ 4-Intermittently (0-25% of day)

What describes the nature of your symptoms?
- ○ Sharp ○ Shooting
- ○ Dull ache ○ Burning
- ○ Numb ○ Tingling

How are your symptoms changing?
- ○ 1-Getting Better
- ○ 2-Not Changing
- ○ 3-Getting Worse

What is the intensity of your symptoms at their:

	None									Unbearable
worst	1	2	3	4	5	6	7	8	9	0
best	1	2	3	4	5	6	7	8	9	0

Who have you seen for this episode of your symptoms? ○ No one ○ Medical Doctor ○ Other ○ Other Chiropractor ○ Physical Therapist

When and what treatment? ______________________________

Have you had the same or similar symptoms in the past? ○ Yes ○ No

If you have received treatment in the past for the same or similar symptoms, who did you see? ○ This office ○ Medical Doctor ○ Other ○ Other Chiropractor ○ Physical Therapist

What tests have you had for your symptoms? ○ Xrays ○ CT Scan ○ MRI Scan ○ Other

What is your occupation?
- ○ 1-Professional/Executive ○ 4-Laborer ○ 7-Retired
- ○ 2-White Collar/Secretarial ○ 5-Homemaker ○ 8-Other
- ○ 3-Tradesperson ○ 6-FT Student

____

If you are not retired, a homemaker or a student, what is your current work status?
- ○ 1-Full-time ○ 4-Unemployed
- ○ 2-Part-time ○ 5-Employed, off work due to restrictions
- ○ 3-Self-employed ○ 6-Other

As a result of your symptoms are you restricted in your ability to perform work and/or daily activities? ○ Yes ○ No

Describe your restrictions ______________________________

What type of regular exercise do you perform? ○ 1-None ○ 2-Light ○ 3-Moderate ○ 4-Strenuous

What is your height and weight? Height [ ][ ][ ] (Feet, Inches) Weight [ ][ ][ ] lbs.

Patient Signature ______________________ **Date** ____________

OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.
2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file you insurance but require full payment per visit
3. We accept assignment as a courtesy to you; you are responsible for you entire bill should your insurance company not pay any of the anticipated charges for any reason. Weare not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.
4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine if proper payment has been made. If you should receive a check from our insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check :...it will not come from you insurance company. All insurance payments, regardless of which company issues a check *first,* are applied to you account as long as any balance is due.
5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.
6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjustor, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
7. If the patient is referred to another specialist of discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full immediately; regardless of any claims submitted.
8. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

____ ________________________

Patient's Signature Date

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ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I, ____ acknowledge that I was
(Please Print)
provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. **I understand that this form will be place in my patient chart and maintained for six years.**

______________________________________ ____________________
Patient's Signature Date

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CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

Date:______________________________ Time:____________________ AM / PM

I have been informed by Dr. that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness). I authorize Dr. Mitchell to perform such radiographic examination necessary to diagnose and to administer whatever treatment is deemed necessary to treat my present problem (or illness).

____ ________________________
Patient's Signature Date

____ ________________________
Witness Signature Date

To the best of my knowledge I am **NOT pregnant** and Dr. Mitchell has my permission to x-ray me for diagnostic interpretation.

____ ________________________
Patient's Signature Date