

Lowery Family Chiropractic

Please PRINT and complete all questions.

PERSONAL INFORMATION:

First, Middle, Last Name: _____ Social Security #: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Full Address: _____

Birthdate: _____ Email Address: _____

Marital Status: S M D W Referred To Our Office By: _____

Employer: _____ Work Address: _____

Circle Main Payment Type: Health Insurance Personal Payment Flex Account Workers Comp. Auto Insurance

SPOUSE INFORMATION:

Full Name: _____ Birthdate: _____

Social Security #: _____ Employer: _____

INSURANCE :

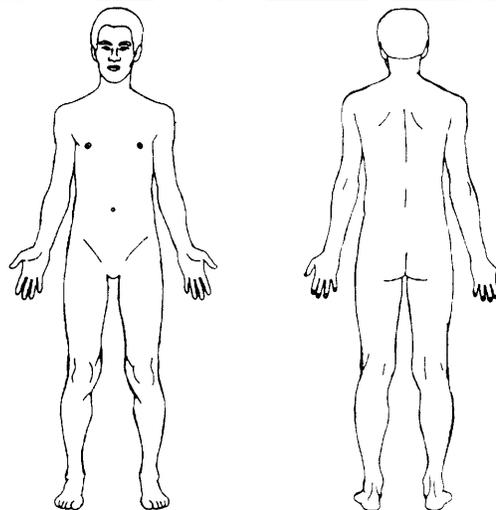
Primary Company: _____ Insured's Name: _____

Insured's Birthdate: _____ ID #: _____ Group #: _____

Secondary Company: _____ ID #: _____ Group #: _____

MAJOR COMPLAINTS:

Mark on the diagram all areas that you are having pain, if any. Describe the type and frequency of pain. For example: DULL, SHARP, CONSTANT, OCCASSIONAL, WHEN STANDING, SITTING ONLY, etc.



ACCIDENT INFORMATION:

Is your condition due to an accident? YES NO Date of Accident: _____

Type of accident that caused present symptoms: AUTO WORK AT HOME OTHER _____

PLEASE READ AND SIGN:

I/we agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered by insurance. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered to me will be immediately due and payable, regardless of any previous payment arrangements.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name _____ Date _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL
F – FREQUENT
C – CONSTANT

O F C

GENERAL

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Headache
- Loss of sleep
- Loss of weight
- Nervousness/depression
- Numbness
- Sweats
- Tremors

MUSCLE & JOINT

- Arthritis
- Bursitis
- Foot trouble
- Low back pain
- Neck pain or stiffness
- Pain between shoulders
- Pain or numbness in:
 - Shoulders/Elbows
 - Hands/Arms
 - Hips
 - Legs/Knees
 - Feet
- Painful tail bone
- Poor posture
- Sciatica
- Spinal Curvature

O F C

GASTRO-INTESTINAL

- Belching or gas
- Colitis/IBS
- Constipation
- Diarrhea
- Distension of abdomen
- Gall bladder trouble
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

EYES, EARS, NOSE & THROAT

- Asthma
- Colds
- Deafness
- Earache
- Ear discharge
- Enlarged glands
- Enlarged thyroid
- Failing vision
- Hay fever
- Nasal obstruction
- Nosebleeds
- Sinus infection
- Sore throat
- Tonsillitis

RESPIRATORY

- Chest pain
- Chronic cough
- Difficult breathing
- Wheezing

O F C

CARDIO-VASCULAR

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

SKIN

- Boils
- Bruise easily
- Hives or allergy
- Itching
- Varicose veins

GENITO-UNRRINARY

- Bed-wetting
- Blood in urine
- Frequent urination
- Inability to control kidneys
- Kidney infection or stones
- Painful urination
- Prostate trouble

FOR WOMEN ONLY

- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge
- Yes No Are you pregnant?

CHECK THE FOLLOWING CONDITION YOU HAVE HAD:

- | | | | |
|---|------------------------------------|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Polio | | | <input type="checkbox"/> Whooping cough |

PLEASE PRINT

List surgical operation and when: _____

Drugs you now take: Anti-inflammatories Pain killers Muscle relaxers Other _____
 Cholesterol pills Blood pressure pills Birth control pills

Are you wearing: Heal lifts Sole lifts Inner soles Arch supports

IN CASE OF EMERGENCY: (friend or relative) Name _____ Phone _____

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care from me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges you incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated, by contractual agreement, to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Michigan.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization and Assignment will be in continual effort until revoked by both parties.

Date

Patient/Insured Signature

TERMS OF ACCEPTANCE

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine, using the Gonstead technique.

HEALTH

A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

VERTERBAL SUBLUXATION

A misalignment of one or more of the 24 vertebra in the spinal column which causes alternation of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to be at it's maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Our only practice objective is to eliminate nerve interference, with a specific adjustment to correct vertebral subluxations.

Signature

Date