Tooele Chiropractic

Full Name:_____ Date:_____

Address:_____
Residence and mailing City State Zip

Home Telephone: ( )_____ Cell Phone: ( )_____

Name of Spouse or Guardian:_____ E-mail _____

Marital Status: M S W D Age: _____ DOB: _____ Number of Children: _____

Male:____ Female:____ Pregnant?____ Height:_____ Weight:_____ Occupation:_____

Employer's Name and Address: _____

Spouse's Occupation/Employer:_____

Name of person responsible for payment:_____

Do you have insurance that covers Chiropractic care? Yes_____ No_____

Name of insurance company: _____ Group/Policy #: _____

Address: _____ Phone: ( )_____

WHO MAY WE THANK FOR REFERRING YOU: _____

List your problems or complaints according to <u>severity of pain</u>	Date started, or for how long	If you had the condition before, when?	Did problem begin with an injury?
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____

Is this condition interfering with: work _____ sleep _____ daily routine _____ sports/exercise _____ other _____

What aggravates your condition? _____

Other Doctor's seen for this condition? Medical Dr_____ Chiropractor_____ Dentist_____ Other_____

1. Name_____ Address_____

When?_____ What did he/she say was wrong? _____

2. Name _____ Address_____

When?_____ What did he/she say was wrong? _____

3. Name_____ Address_____

When?_____ What did he/she say was wrong?_____

Are you taking any medications (drugs)? _____ What kind?_____

_____

Have you had x-rays taken? _____ When? _____ Where?_____ Area of body_____

When? _____ Where?_____ Area of body_____

Do you wear orthotics or heel lifts? Yes _____ No _____

Accidents and /or injuries: auto, work related, or other (Especially those related to your present problems).

1. Type _____ When _____ Hospitalized: yes _____ no _____

2. Type _____ When _____ Hospitalized: yes _____ no _____

3. Type _____ When _____ Hospitalized: yes _____ no _____

NOTE: If you have RECENTLY been involved in an accident or injury, **please inform a staff member so they may bring you our accident report form.**

Have you had any surgery (please include all surgery)

1. Type _____ When _____ Doctor _____

2. Type _____ When _____ Doctor _____

3. Type _____ When _____ Doctor _____

4. Type _____ When _____ Doctor _____

Have you ever been to a chiropractor?

What are your expectations with regard to today's visit?

What are your goals for care in this office?

CHECK any conditions you may have had in the **past**, and **CIRCLE** any **current** conditions

___Allergy	___ Anxiety	___Asthma	___Arthritis
___Cancer	___ Chest Pain	___Cold hands/feet	___Concentration Loss
___Constipation	___ Depression	___Diabetes	___Dizziness
___Eyes Sensitive to light	___ Fainting	___ Fatigue	___ Headache
___ Heart Disease	___ Heavy Feeling of Head	___ High Blood Pressure	___ Insomnia
___ Irritable	___ Jaw Pain	___ Leg Pain R/L	___Loss of Balance
___ Loss of Consciousness	___ Low Back Pain/Stiff	___ Irregular Periods	___ Menstrual Cramps
___Migraines	___ Memory Loss	___ Mid Back Pain	___ Neck Pain/Stiff
___ Nervousness	___ Numbness	___Pins/Needles Arms	___ Pins/Needles Legs
___Ringing In Ears	___ Short of Breath	___ Shoulder/Arm Pain R/L	___Sinus Problems
___ Ulcers	___ Vision Problems		

___ Radiation of Pain Into ___ Rt. Arm ___Lt. Arm ___ Both ___ Rt. Leg ___Lt. Leg ___ Both

___Aggravation of Pain Upon ___ Walking ___ Sitting ___ Standing ___ Bending ___ Riding

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Matthew Peterson, D.C. may prepare any necessary reports to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Matthew Peterson, D.C. will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and I am personally responsible for payment. I understand that not all examination procedures are covered by all insurance carries and agree to pay for these services in full if my insurance denies payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be due and payable within 30 days.

Patient Signature _____ Date _____

If minor, Guardian's Signature _____ Date _____

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc.on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) named above and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____
Printed Name of Patient

X_____ _____
Signature of Patient Date

X_____ _____
Signature of Representative (if patient is minor or handicapped) Date

X_____ _____
Witness to Patients' Signature Date

Doctor:_____

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Tooele Chiropractic as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

The patient (or patient's guardian, if minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance. Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered or approved by their insurance plan. Copays are due at the time of service. Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.

PRINT PATIENT NAME:_____

PATIENT SIGNATURE:_____ DATE:_____

PARENT OR GUARDIAN must sign if patient is under 18 years of age

SIGNATURE:_____ DATE:_____