

Welcome!

Red-Rose Chiropractic Clinic



Date: _____

Patient Name: _____

Address: _____

Email: _____

Home Ph.#: _____

Work Ph. #: _____

Cell Ph.#: _____

Patient SSN: _____

Sex: () Male () Female

Age: _____ Birthdate: _____

() Single () Married () Other: _____

Any children (ages)?: _____

Occupation: _____

Whom may we thank for referring you?

In Case of an Emergency, Contact:

Name: _____

Phone #: _____

Relationship: _____

Primary Insurance

Insurance Name: _____

Subscriber's Name: _____

Insurance ID#: _____

Group or Plan #: _____

Subscriber () Male () Female Birthdate: _____

Relationship to Patient: _____

Insurance Address: _____

Insurance Ph.#: _____

Who is responsible for this account?

Name: _____

Address: _____

Phone#: _____

SSN: _____

Employer: _____

Accident Information

Type of accident: () Auto () Work () Home

To whom have you made a report of your accident?

Attorney Name (if applicable): _____

Assignment

I, the undersigned, certify that I (or my dependent) have insurance with _____.
I authorize direct payment to Red-Rose Chiropractic Clinic for any insurance benefits otherwise payable to me for the services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure benefits. I authorize the use of this signature on all insurance claims.

X _____

Patient Signature

Secondary Insurance

Insurance Name: _____

Subscriber's Name: _____

Insurance ID#: _____

Group or Plan #: _____

Subscriber () Male () Female Birthdate: _____

Relationship to Patient: _____

Insurance Address: _____

Insurance Ph.#: _____

Health History

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

() Chiropractic Care () None () Other: _____

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

Date of last: Physical Exam: _____ Spinal Adjustment: _____ Spinal X-ray: _____

Check below to indicate if you have had any of the following:

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Infertility | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fever (prolonged) | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Lowback Pain | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Measles | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Midback Pain | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Migraines | <input type="checkbox"/> Rheumatoid Arthritis | Women Only |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mumps | <input type="checkbox"/> Sinus Infections | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Numbness | <input type="checkbox"/> STD's | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Irregular Menses |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Cramps |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tiredness | <input type="checkbox"/> Breast Problems |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> TMJ (jaw) | <input type="checkbox"/> Currently Pregnant? |

Exercise	Work Activity	Stress Level	Habits
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking - #Packs per day _____
<input type="checkbox"/> 1-2 x week	<input type="checkbox"/> Standing	<input type="checkbox"/> Moderate	<input type="checkbox"/> Alcohol - #Drinks per week _____
<input type="checkbox"/> 3-4 x week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda - #Cups per week _____
<input type="checkbox"/> 5+ x week	<input type="checkbox"/> Heavy Labor	Causes: _____	
Type of Exercise: _____			

Injuries & Surgeries

- Falls/Head Injuries: _____ Date _____
- Broken Bones/Dislocations: _____ Date _____
- Surgeries: _____ Date _____
- Work Injuries: _____ Date _____
- Auto Accidents: _____ Date _____

Medications, Allergies, & Vitamins/Herbs/Minerals

- List medications currently taking: _____
- List vitamins/herbs/minerals currently taking: _____
- List any allergies you have: _____

X _____ Date: _____
 Patient Signature

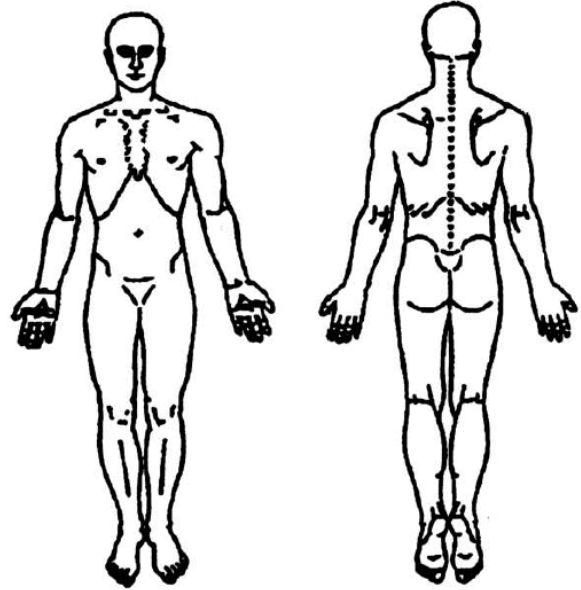
Pain Location and Rating Scales

My chief complaint is: _____

Second complaint: _____

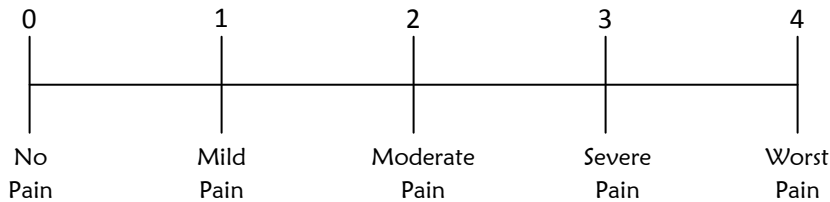
Third complaint: _____

Please use the illustrations and lines below to explain your complaints:

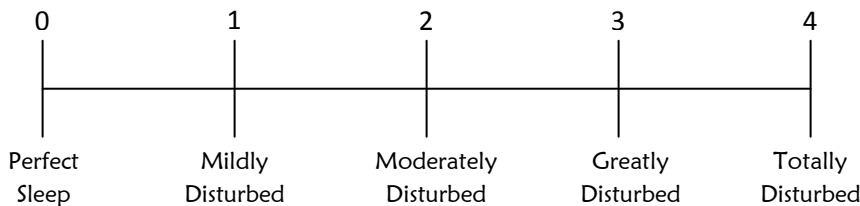


In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now:

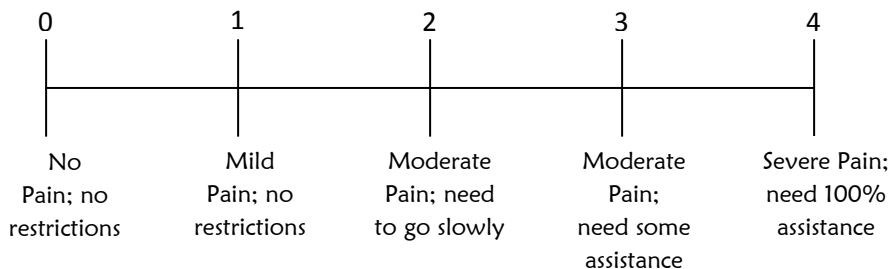
1. Pain Intensity



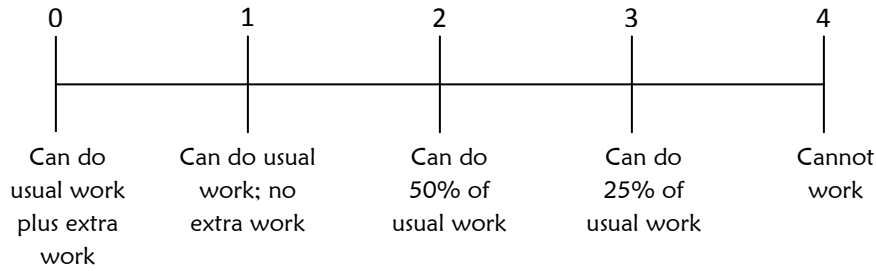
2. Sleeping



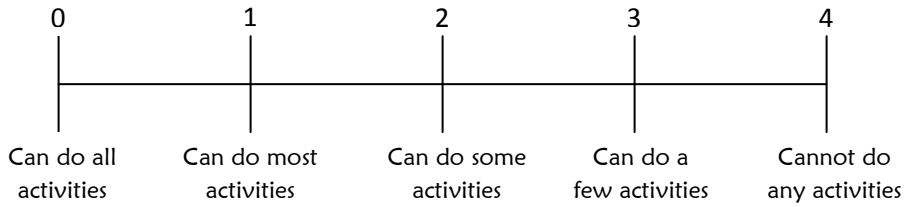
3. Personal Care (washing, dressing, etc.)



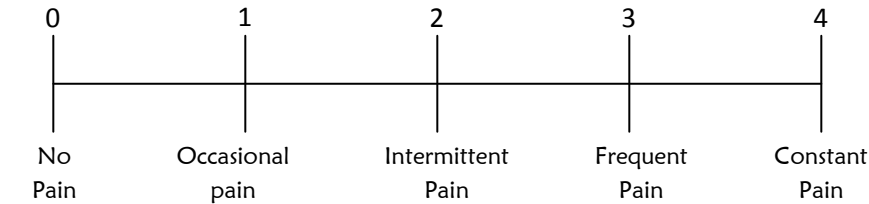
4. Work



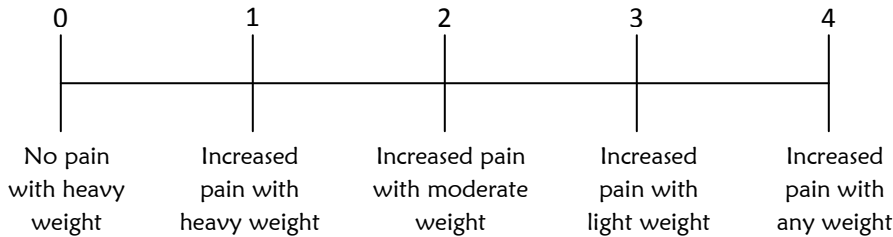
5. Recreation



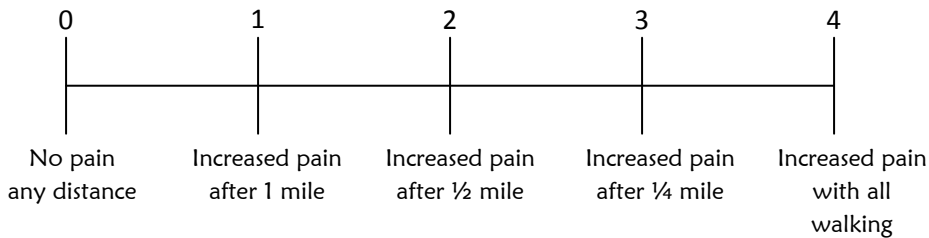
6. Frequency of pain



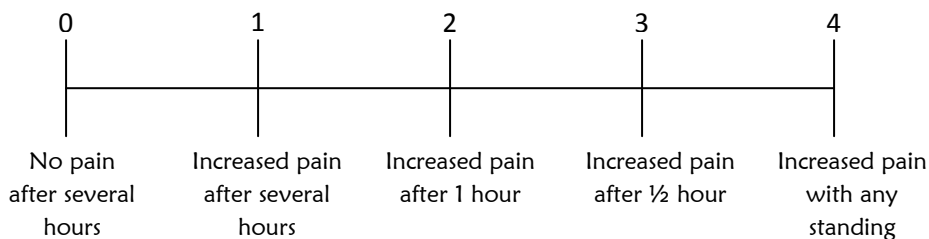
7. Lifting



8. Walking



9. Standing



Patient Signature: _____ Date: _____

Red-Rose Chiropractic Consent to Use or Disclose Health Information

I authorize Red-Rose Chiropractic Clinic to use and disclose the health and medical information of _____ for the purposes of Treatment, Payment, and Health Care Operations.

*Treatment (includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers our practice by telephone as the on-call physician).

*Payment (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification, and pre-authorization).

*Health Care Operations (includes the necessary administrative and business functions of our office).

You may review Red-Rose Chiropractic Clinic's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this consent prior to signing this Consent. Please verify that you have received a copy of our Notice by placing your initials here: _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Red-Rose Chiropractic has already used or disclosed the information in reliance on this Consent.

Signature of Patient: _____

Signature of Person Authorized by Law: _____

Date: _____