CONFIDENTIAL PATIENT 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.

Date: _____ E-mail Address:_____

Name: _____ Social Security #_____

Address:_____ City:_____

State:_____ Zip:_____ H/Phone:_____ Cell phone_____

Work Phone:_____ Age:_____ Date of Birth:_____

Children:_____ Marital Status: M S W D Occupation:_____

Spouse's Name:_____ Spouse's Office Phone:_____

Referred by:_____ Nearest Relative & Phone:_____

HEALTH INFORMATION: **Have you had previous chiropractic care?** _____

Reason for today's visit: □ Emergency □ New Injury □ Chronic Pain □ Wellness Visit

Are you in pain: □ Yes □ No Rate your pain with the following scale

Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

What is your major complaint?_____

Doctors Notes: _____
_____
_____
_____
_____
_____
_____

Other complaints:_____

Has this or something similar happened in the past? □ Yes □ No If yes, please explain:_____

Onset of complaints/condition/accident/injury, etc: _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? □ Yes □ No □ Constant □ Comes and go

Is this condition interfering with your: □ Work □ Sleep □ Daily Routine Other:_____

Other doctors who have treated this condition: _____

Drugs you now take: □ Nerve pills □ Pain killers □ Muscle relaxers □ "Pep" pills
□ Insulin □ Others: _____

_____

Do you take Supplements or Vitamins? □ No □ Yes _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke
Y N Pacemaker
Y N Heart Murmur
Y N Mitral Valve Prolapse
Y N Alcohol/Drug Abuse
Y N Hepatitis
Y N Diabetes
Y N Shingles
Y N Frequent Neck Pain
Y N Kidney Problems
Y N Psychiatric problems
Y N Severe/Frequent Headaches
Y N Ulcers/ Colitis
Y N Sinus problems
Y N Arthritis
Y N Artificial Bones/Joints/Implants

Y N Heart/ Surg.
Y N High Blood Pressure
Y N Congenital Heart Defect
Y N Artificial Valves
Y N Venereal Disease
Y N Anemia
Y N Chemotherapy
Y N Cancer
Y N Glaucoma
Y N Low Blood Pressure
Y N Rheumatic Fever
Y N Tuberculosis
Y N Fainting/Seizures/Epilepsy
Y N Emphysema/Asthma
Y N Difficulty Breathing
Y N Lower back problems

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:

_____

_____

List any past serious accidents with dates: _____

_____

Please list anything that you may be allergic to: _____

_____

Family Health History: _____

Do you exercise? □ No □ Yes _____ hours per week

Do you smoke? □ No □ Yes How much?_____ How long?_____

Are you wearing: □ Shoe lifts □ Inner soles □ Arch supports
Are you dieting: □ No □ Yes Since ___/___/___

For Women: Are you taking birth control? □ No □ Yes

Are you nursing? □ Yes □ No Are you pregnant? □ No □ Yes how many weeks? _____

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Payment is due at the time services are rendered. Cash, check, or credit cards are acceptable forms of payment.
- For all HMO/PPO insurance groups that we are contracted with, co-pays, co-insurance, deductibles, and non-covered services are due at the time services are rendered. If an overpayment results based on an explanation of benefits, refunds will be issued. Any balance which is determined to be the patient responsibility on the explanation of benefits will be due immediately.
- For all insurance groups that we are not under contract with, assignment acceptance will be determined at the time the benefits are verified. If assignment is accepted, all co-pays, co-insurance, deductibles and non covered services will be due at the time the service is rendered. If we do not accept assignment, payment is due at the time services are rendered.
- For all discount plans that we participate in, payment is due at the time services are rendered.
- We allow a reasonable amount of time for claim processing. If claims are not processed within the state mandated time allowance, the account balance will be the patient's financial responsibility.
- Any and all account balances which are 90 days overdue will be sent to collections, and a surcharge will be applied to the account balance.
- Personal and business checks that are returned from the bank will incur a $25 check return charge and will no longer be a valid form of payment.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment.
- I authorize the release of any medical or other information necessary to process claims. I also request payment of benefits either to myself or to the party who accepts assignment.
- I authorize payments of medical benefits to David L. Frerking, D.C., D.A.B.C.I.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was 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 placed in my patient chart and maintained for six years.

DISCLOSURE & CONSENT FOR CHIROPRACTIC ADJUSTMENT AND CARE

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: *"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."*

A vitamin is not a drug, NEITHER is a Mineral, Enzyme, Probiotic, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:	To be completed by the patients' representative, if Necessary, e.g, if the patient is a minor or Physically or legally incapacitated:
_____ Print name	_____ Print name of patient
_____ Signature of patient	_____ Print name of patient's representative
_____ Date signed	_____ Signature of patient's representative & Relationship: _____
	_____ Signature Date signed

To be completed by doctor or staff

_____ Witness to patient's signature	_____ date	_____ translated by	_____ date