

Jennings Chiropractic Clinics

New Patient Information Form

Name _____ Date _____
Street Address _____
City, State, Zip _____
Home Phone _____ Work Phone _____ Cell _____
Date of Birth _____ SS#: _____ Driver's Lic: _____
Sex: M/F Marital Status: Single Married Divorced Widowed

Referred by: _____

Employer _____ Occupation: _____
Employer Address _____

Auto Accident Work/ Industrial Injury Wellness Other

People chose Chiropractors for various reasons. Some go for symptomatic relief of pain. (Relief Care). Some people are interested in treating the cause of the problem and preventing future occurrences. (Corrective Care). Other individuals seek their symptoms addressed but seek the highest state of health possible in order to feel optimal physical and emotional well-being (Comprehensive Care). Our clinics offer some of the latest approaches for optimal well-being.

Health care is a choice of the individual. We respect your choice to choose any type of health care that benefits your needs. Please check the type of health care you wish.

Relief Care Corrective Care Comprehensive Care Would like to discuss options with the doctor

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal visit. Please help us serve you better by keeping your scheduled appointments.

I understand and agree that health insurance is an arrangement between myself and the insurance carrier even if this office is a network provider. Jennings Chiropractic Clinics do not participate in any HMO/PPO organizations. I understand that this clinic will prepare any necessary forms to assist me in making collection from the insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, covered charges, secondary insurance, "usual and customary" charges, other than to provide factual information. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time of service. This agreement may be waived if payment arrangements have been made in advance, i.e. automobile accident coverage or signed attorney lien.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

IN CASE OF EMERGENCY; (name of relative or close friend not living in your home):

Name _____ Hm. Phone _____ Wk: _____

Please list your major complaints in order of severity:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Complaint # 1: When did you first notice this condition? _____

Did it begin Immediate or Gradually? (please describe briefly) _____

What is the exact location of your symptoms? _____

Do your symptoms spread? No Yes Where? _____

How often do you experience these symptoms? Constant Frequent (75% of day) Often (50%)

Seldom (25%) Rarely (less than 25%) _____

Is this condition progressively Worsening Improving or Unchanged

What is the intensity of your symptoms? Severe Moderate Mild

Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain) _____

Is your pain Deep or Superficial

Please indicate the character of your pain: Dull Sharp Burning Aching Knife-like Throbbing

Are you experiencing any of the following associated symptoms? Pins & Needles Tingling Numbness

Twitching of muscles If yes, please describe: _____

Please indicate what activities provoke (P) or aggravate (A) your condition:

Sitting _____ min Lying Lifting _____ lbs. Bowel Movements Hot or Cold

Standing Pushing Gripping Mental Activities _____

Walking Pulling Coughing/Sneezing Bright Lights _____

Please indicate what helps you to relieve the pain.

Lying Walking Rest Medications _____ _____

Sitting Standing Heat or Cold _____

Please list what doctors you have seen for this condition. (Including diagnoses, treatment received, and any changes in your condition) _____

Please include any other relevant history in regards to this complaint. _____

Complaint # 2: _____ When did you first notice this condition? _____

Did it begin Immediate or Gradually? (please describe briefly) _____

What is the exact location of your symptoms? _____

Do your symptoms spread? No Yes Where? _____

How often do you experience these symptoms? Constant Frequent (75% of day) Often (50%)
 Seldom (25%) Rarely (less than 25%)

Is this condition progressively Worsening Improving or Unchanged

What is the intensity of your symptoms? Severe Moderate Mild

Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain) _____

Please indicate the character of your pain: Dull Sharp Burning Aching Knife-like Throbbing

Is your pain Deep or Superficial

Are you experiencing any of the following associated symptoms? Pins & Needles Tingling Numbness
 Twitching of muscles If yes, please describe: _____

Please indicate what activities provoke (P) or aggravate (A) your condition:

Sitting ___ min Lying Lifting ___ lbs. Bowel Movements Hot or Cold

Standing Pushing Gripping Mental Activities _____

Walking Pulling Coughing/Sneezing Bright Lights _____

Please indicate what helps you to relieve the pain.

Lying Walking Rest Medications _____ _____

Sitting Standing Heat or Cold _____

Please list what doctors you have seen for this condition. (Including diagnoses, treatment received, and any changes in your condition) _____

Complaint # 3 _____ When did you first notice this condition? _____

Did it begin Immediate or Gradually? (please describe briefly) _____

What is the exact location of your symptoms? _____

Do your symptoms spread? No Yes Where? _____

How often do you experience these symptoms? Constant Frequent (75% of day) Often (50%)
 Seldom (25%) Rarely (less than 25%)

Is this condition progressively Worsening Improving or Unchanged

What is the intensity of your symptoms? Severe Moderate Mild

Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain) _____

Please indicate the character of your pain: Dull Sharp Burning Aching Knife-like Throbbing

Is your pain Deep or Superficial

Are you experiencing any of the following associated symptoms? Pins & Needles Tingling Numbness
 Twitching of muscles If yes, please describe: _____

Please indicate what activities provoke (P) or aggravate (A) your condition:

Sitting ___ min Lying Lifting ___ lbs. Bowel Movements Hot or Cold

Standing Pushing Gripping Mental Activities _____

Walking Pulling Coughing/Sneezing Bright Lights _____

Please indicate what helps you to relieve the pain.

Lying Walking Rest Medications _____ _____

Sitting Standing Heat or Cold _____

Please list what doctors you have seen for this condition. (Including diagnoses, treatment received, and any changes in your condition) _____

Family History

Mother Alive & Well, age ___ Deceased age ___ from what? _____
Any health conditions _____

Father Alive & Well, age ___ Deceased age ___ from what? _____
Any health conditions _____

Brother Alive & Well, age ___ Deceased age ___ from what? _____
Any health conditions _____

Brother Alive & Well, age ___ Deceased age ___ from what? _____
Any health conditions _____

Sister Alive & Well, age ___ Deceased age ___ from what? _____
Any health conditions _____

Sister Alive & Well, age ___ Deceased age ___ from what? _____
Any health conditions _____

Children: Ages _____ Any health conditions? _____

Maternal Grandmother A&W Deceased age ___ from what? _____
Any health conditions _____

Maternal Grandfather A&W Deceased age ___ from what? _____
Any health conditions _____

Paternal Grandmother A&W Deceased age ___ from what? _____
Any health conditions _____

Paternal Grandfather A&W Deceased age ___ from what? _____
Any health conditions _____

Have any of your family members have ever suffered from any of the following conditions?

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Disorders _____ | <input type="checkbox"/> Depression/Mental Illness _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Autoimmune Diseases _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> _____ |

Medications Please list your current medications and what taken for.

Vitamins and Minerals Please list your current supplements and by whom prescribed.

Habits

Cigarettes none How much per week? _____ Cigars none How many per week? _____

Alcohol none How many drinks per week? _____ Type of alcohol _____

Coffee none How many cups per week? _____

Recreational Drugs none Types _____ Frequency _____ Years of Usage _____

Exercise none Hours/Days per week _____ Types _____

Water none Glasses per day _____

Soft Drinks none Amount per week _____ Types _____

Sleep Average per night _____ Do you have difficulty falling asleep or staying asleep? Hours desired per night?

Meals per days _____ What type of foods do you eat? _____

Do you consider your diet healthy? Yes No _____

DATE OF LAST:

Physical Examination: _____ By Whom? _____ Results _____
 Blood Work: _____ By Whom? _____ Results _____
 Bone Density Study _____ results _____ Mammogram _____ results _____
 Pelvic Exam _____ results _____ Self Breast Exam _____ Regularity _____
 PSA level _____ results _____ Digital Prostate Examination _____ results _____
 Chest X-rays _____ results _____ EKG _____ results _____ Echocardiogram _____ results _____
 Spinal X-rays _____ By Whom? _____ Where are they located? _____
 MRI / CAT Scan _____ results _____ Where are they located? _____
 Other tests: _____

CHECK any of the following conditions you have HAD and CIRCLE anything you HAVE.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Infective Diseases _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anemia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Fungal Infection _____ |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Herpes _____ |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Parasites | <input type="checkbox"/> Autoimmune Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Venereal Infection | <input type="checkbox"/> _____ |

NERVOUS SYSTEM

- Depression
- Memory loss/Confusion
- Dizziness
- Fainting
- Convulsions
- Numbness
- Weakness
- Poor Balance/Coordination
- Twitches/Tremor
- Cold/Tingling Extremities
- Sleeping Difficulties
- Headaches

C-V

- Chest Pain
- Irregular Heartbeat
- High Blood Pressure
- Shortness of Breath
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling

GU

- Bladder Trouble
- Painful Urination
- Excessive Urination
- Incontinence
- Discolored Urination

MUSCULOSKELETAL

- Jaw Pain
- Difficulty Chewing
- Face Pain
- Neck Pain
- Arm/Elbow Pain
- Wrist/Hand Pain
- Mid Back Pain
- Lower Back Pain
- Thigh/Knee Pain
- Ankle/Foot Pain
- Difficulty Walking
- Leg/Arm Fatigue

GI

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Frequent Diarrhea
- Frequent Constipation
- Hemorrhoids
- Black/Bloody Stools
- Digestive Problems
- Abdominal Cramping
- Gas/Bloating After Meals
- Heartburn
- Weight Problems
- Gall Bladder Problems
- Liver Problems

REPRODUCTIVE

- Erectile Difficulties
- Sexual Dysfunction
- Menstrual Irregularity
- Menstrual Cramping

How often do you have a bowel movement? _____ Are your movements consistent? Yes No
 Do your stools float or sink

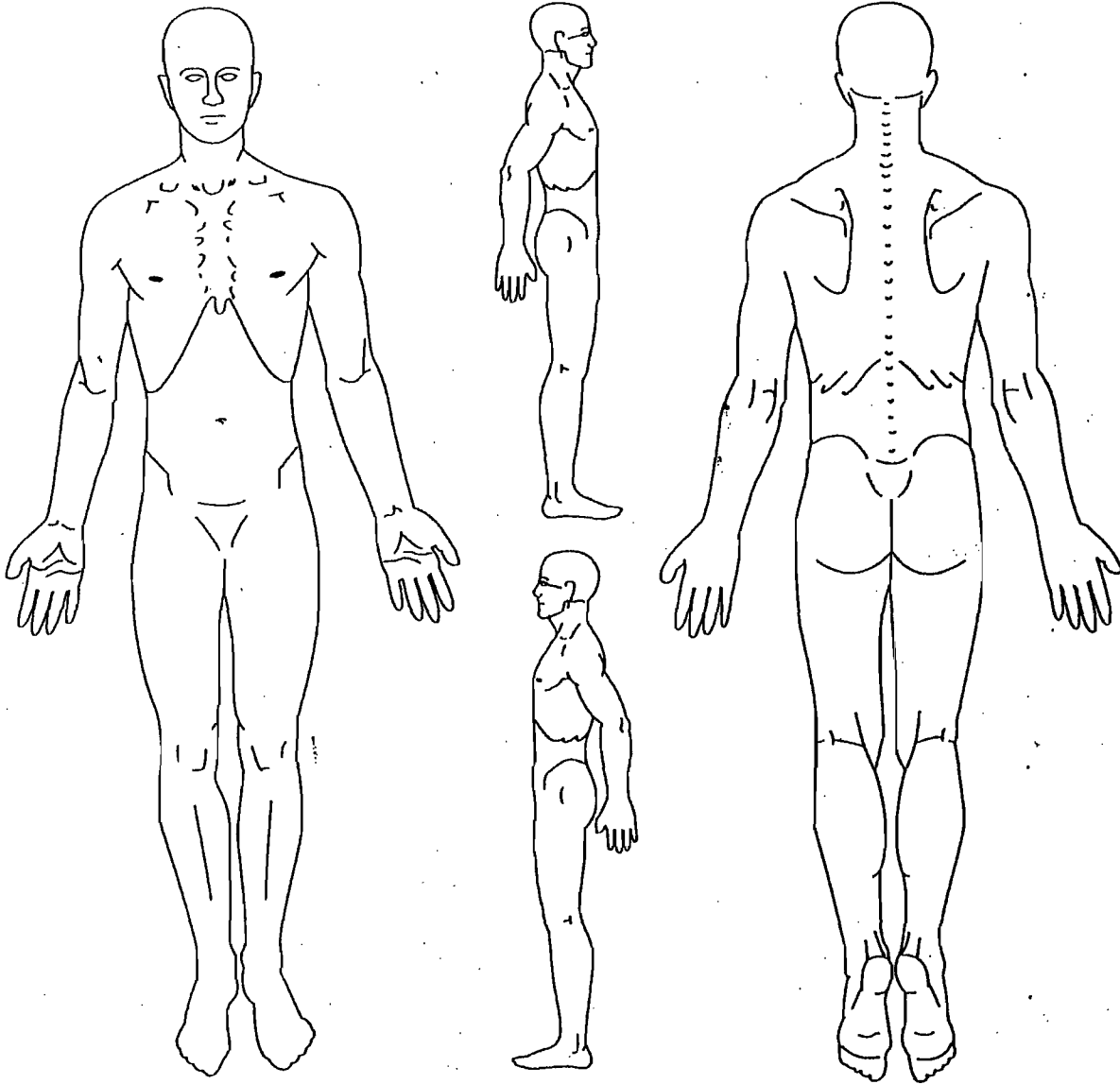
How many times a day do you urinate? _____ Is this consistent? Yes No _____
 Do you experience any urgency, dribbling, incontinence? _____

Patient Name(Print) _____ Date _____

Patient ID # _____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

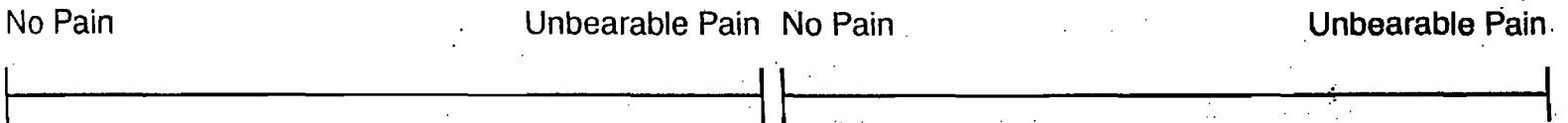
- D = Dull
- B = Burning
- N = Numb
- S = Stabbing/Cutting
- T = Tingling (Pins & Needles)
- C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

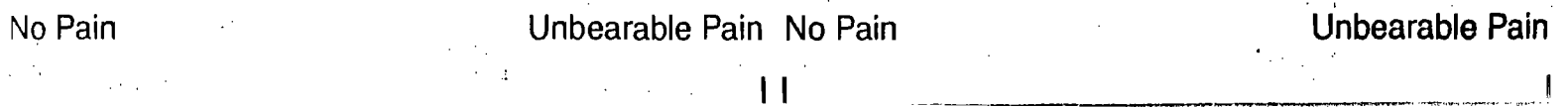
Rate the pain you have right **now**:

Rate your pain at its **best** in the past week:



Rate your **average** pain in the past week:

Rate your **worst** pain in the past week:



Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient

Date

JENNINGS CHIROPRACTIC CLINICS

FINANCIAL POLICY

We are committed to providing you with the best possible health care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask, if you have any questions about our fees, financial policy, or your responsibility.

- All patients must complete our "Patient Information" forms before seeing the doctor.
- Payment is due at the time of service, unless other arrangements have been made.
- We accept cash, checks, and VISA/MASTERCARD.

REGARDING INSURANCE

We do not participate in any insurance plans. We will not become involved in disputes between you and your insurance company regarding deductibles, covered charges, secondary insurance, "usual and customary" charges, etc. other than to provide factual information. You are responsible for providing all necessary insurance for proper billing.

MEDICARE

We do not participate with Medicare. You will be responsible for payment of services at the time service is rendered unless other arrangements have been made. Medicare only covers spinal manipulation. You will be responsible for examination, x-rays, physical therapy, and any other non-covered services. We will bill Medicare for you as a courtesy.

WORKER'S COMPENSATION

Injuries related to your job are usually covered at 100%. There are several regulations governing where an injured worker can seek treatment. We will need to speak directly with the claims adjustor before we continue treatments past today's visit. Your help in providing us with all the necessary information regarding the injury and the insurance will speed this process.

PERSONAL INJURY

If you are involved in a car accident and have medical payment coverage (MED PAY) through your own car insurance, we will bill your carrier regardless of who is at fault. This is an added benefit on your policy that you are already paying for and it will not make your rates increase. When your care is finished, your insurance carrier will seek reimbursement from the party at fault.

When there is not any medical payment coverage through your car insurance, and there is a high probability that you were not at fault, we may choose to offer our services on a lien basis. This means that we will provide our services to you in good faith without requiring you to pay in advance. You will be required to sign several papers guaranteeing to pay us in full at the close of your case and also directing the third party insurance.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us to serve you better by keeping your scheduled appointments.

Date _____

Responsible Party Signature