COASTAL CHIROPRACTIC

Dr. Lee Smith, DC

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HEALTH QUESTIONNAIRE

TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU PLEASE COMPLETE ALL QUESTIONS

LAST NAME	FIRST NAME	M.I.	E-MAIL ADDRESS	DATE
ADDRESS		CITY	STATE	ZIP

HOME PHONE	WORK PHONE	ALT. PHONE	DATE OF BIRTH	AGE

EMPLOYER	OCCUPATION	SOCIAL SECURITY NUMBER

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED | NO. OF CHILDREN | REFERRED BY:

Have YOU had CHIROPRACTIC CARE BEFORE? YES or NO *(Please Circle)*
If So: WHERE? HOW LONG AGO?

Do YOU have HEALTH INSURANCE? YES or NO *(Please Circle)*
Company: Policy # Group#

PLEASE INDICATE IF YOU ARE HERE BECAUSE OF AN:
☐ Auto Accident ☐ On the Job Injury
IF SO: Date of Injury

WHAT IS YOUR MAJOR COMPLAINT?

HOW LONG HAS IT BEEN BOTHERING YOU?	HAS IT BOTHERED YOU BEFORE?	HOW LONG AGO?

(1-6) PAST HISTORY	MONTH/YEAR INJURY OR SURGERY	TYPE OF INJURY/SURGERY	DESCRIBE INJURY
HAVE YOU HAD ANY FALLS, AUTO ACCIDENTS, INJURIES, OR SURGERIES?			
IF YES, PLEASE DESCRIBE IN BOXES TO THE RIGHT			

DO YOU TAKE ANY?	TYPE AND DOSES
(7) PRESCRIBED MEDICATIONS?	
(8) VITAMINS?	
(9) HERBS?	

Please indicate if you have of have had any of the following: ***Write "C" for current problem, "P" for past problem***:

10. __ Headaches
11. __ Sinus trouble
12. __ Loss of smell
13. __ Allergies
14. __ Hay fever
15. __ Loss of taste
16. __ Inflammation of throat
17. __ Twitching of face
18. __ Loss of memory
19. __ Dizziness
20. __ Fatigue
21. __ Depression
22. __ Fainting
23. __ Ringing in ears
24. __ Loss of balance
25. __ Visual disturbances
26. __ Lights bother eyes
27. __ Cold sweats
28. __ Sleeping problems
29. __ Diarrhea
30. __ Constipation
31. __ Incontinence
32. __ Neck pain
33. __ Muscle spasms in neck
34. __ Grinding/Grating sounds in neck
35. __ Shoulder pain/tightness
36. __ Arm pain/tightness
37. __ Pins/needles and/or numbness in shoulders and arms
38. __ Cold hands
39. __ Shortness of breath
40. __ Mid-back pain
41. __ Stomach trouble
42. __ Anxiety
43. __ Inner tension
44. __ Irritability
45. __ Indigestion/reflux
46. __ Intestinal gas
47. __ Ulcers
48. __ Low back pain
49. __ Leg pain
50. __ Hip pain
51. __ Pins/needles and/or numbness in legs
52. __ Painful joints
53. __ Swollen joints
54. __ Swollen ankles
55. __ Foot pain
56. __ Cold feet
57. __ Menstrual irregularity/cramps
58. __ Other____________________
59. __ Other____________________
60. __ Other____________________

61. Do you smoke? No or Yes (amount) _______________

62. Alcohol Intake: _________beer(s) /Liquor / wine **PER** day / week / month / year. ***(Please circle)***

63. Females: Are you pregnant? Yes No Not sure ***(Please circle)***

Please indicate if you or a family member has had any of the following: ***Write "S" for self, "F" for family member:***

64. __ Heart Disease
65. __ Cancer
66. __ Gastrointestinal Disease
67. __ Diabetes
68. __ High/Low blood pressure
69. __ Osteoporosis/Osteopenia
70. __ Stroke
71. __ Asthma
72. __ Thyroid problem

I fully understand that I am directly responsible to said doctors for all chiropractic bills for services rendered.

I hereby authorize my insurance company to pay directly to **Coastal Chiropractic** the benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebted-ness to the above mentioned assignee, and I have agreed to pay in a current manner any balance if said professional service charges are over and above this insurance payment. It is understood and agreed that the amount paid for x-rays is for examination only and the x-ray negatives will remain property of this office, being on file where they may be seen at any time while a patient of this office.

______________________________ ______________________

Patient's/Guardian's Signature Date

______________________________ ______________________

Signature Authorizing Care Date

NAME:

DATE: / / Account#:

Please check all symptoms you, **HAVE** or have **EVER HAD**, even if they do not seem related to your current problem

	Fatigue		Irritability		Joint Stiffness/Swelling		Seizures/Tremors
	Chronic Fever		Depression		Spinal Curvature		Dizziness
	Chills		Memory Loss		Back Pain		Tremors
	Night Sweats		Headache		Constipation/Diarrhea		Loss of Sensation
	Fainting		Muscle Pain		Digestive Issues		Loss of Coordination
	Nervousness		Muscle Weakness		Stiff Neck		Paralysis
	Concentration Loss		Muscle Cramps		Lumps / Masses		Difficulty of Speech

Do you have a pacemaker? ____YES ____NO

Are you Pregnant? _____YES _____NO

Do you think you may be pregnant? _____YES _____NO

List any surgeries, key slips, falls or accidents you've had from childhood to present:

	Date
1)	
2)	
3)	
4)	
5)	
6)	

What medications are you currently taking?	What medications (if any) are you allergic to?
1)	1)
2)	2)
3)	3)

HAVE YOU EVER TAKEN:	Yes	No	Year
Insulin			
Cortisone			
Thyroid Medicine			
Male/Female Hormones			
Blood Pressure			
Tranquilizers/Sedatives			
Birth Control			

Hospitalizations: ____________________

Height: ____ft. _____in. Weight: _________

Frequency of Exercise: ____Never ____Rarely ____Occasionally ____Moderately ____Regularly

Intensity of Exercise: ____Low Level ____Medium Level ____High Level ____Competition Level

Sufficient Rest: ____Never ____Rarely ____Occasionally ____Moderately

Hours of Sleep: ____6 ____8 ____10 ____More than 10

Well balanced diet: ____Never ____Rarely ____Occasionally ____Moderately

Do you smoke? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 packs/day

Do you drink caffeinated beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Do you drink alcoholic beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Have you ever used street drugs? ____No ____Yes

Hobbies: ____________________

Patient history was obtained from: _____Patient _____Father _____Mother _____Son _____Daughter

Notes / Comments: ____________________

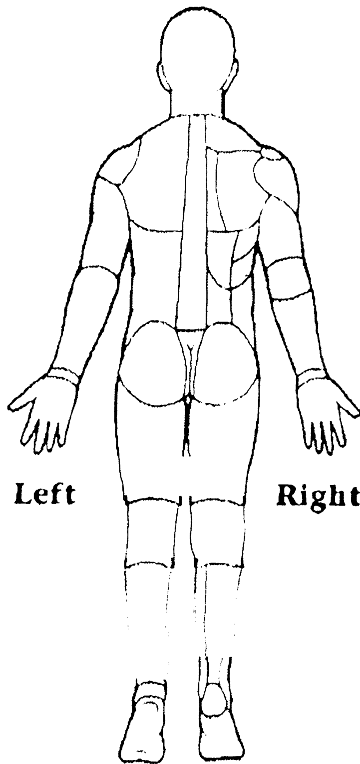
Coastal Chiropractic

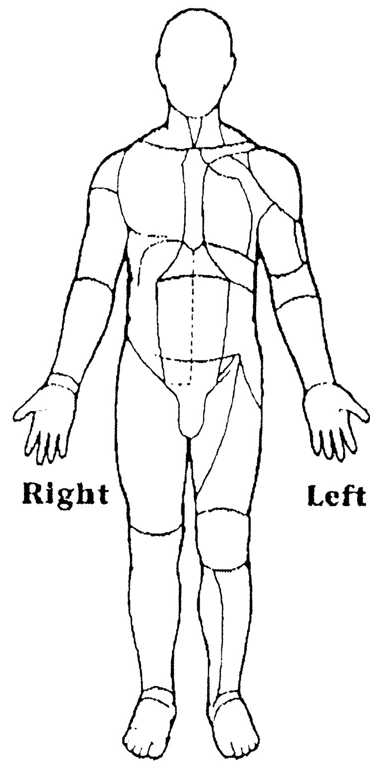
Pain Representation
Ache V V V V V V V V V V V V V
Burning
Numbness O O O O O ● O O O O O O O O O O
Pins & Needles ● ● ● ● ● ● ● ● ● ● ● ● ●
Stabbing / / / / / / / / / / / / / / / / /
Other X X X X X X X X X X X X X

Pain Chart (full body)

Patient's Name

Draw location and type of pain on the body outline and mark the degree on the pain line at the bottom of the page.





Back

No Pain **Worst Pain Possible**

Please make a slash through this line to indicate the level of your pain.

Patient's /Guardian's Signature

Date

Coastal Chiropractic's
Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Coastal Chiropractic** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of I understand that diagnosis or treatment of me by the doctors and practitioners of the **Coastal Chiropractic** may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Coastal Chiropractic** is not required to agree to the restrictions that I may request. However, if **Coastal Chiropractic** agrees to a restriction that I request, the restriction is binding on **Coastal Chiropractic** and its doctors and practitioners. I have the right to revoke this consent, in writing, at any time, except to the extent that the doctors and practitioners of the **Coastal Chiropractic** have taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review **Coastal Chiropractic** Notice of Privacy Practices prior to signing this document. The **Coastal Chiropractic** Notice of Privacy Practices is available at the front desk. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of the **Coastal Chiropractic**. This Notice of Privacy Practices also describes my rights and the **Coastal Chiropractic's** duty with respect to my protected health information. **Coastal Chiropractic** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the **Coastal Chiropractic** website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____
Signature of Patient or Personal Representative

____
Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, Boca Chiropractic shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

PATIENT SIGNATURE   INSURED'S SIGNATURE

DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred. I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned. and hereby assign and convey directly to Coastal Chiropractic all medical benefits and/or insurance reimbursement. if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents. insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medic al expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits. insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation. I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including. if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing A photocopy of this assignment is to be considered as valid as the original I have read and fully understand this agreement

Signature of Insured/Guardian   Date