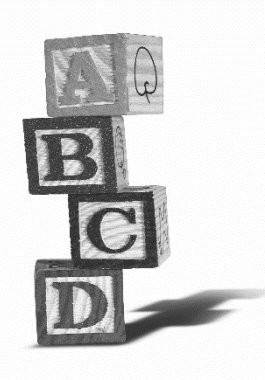
*Stevens Chiropractic Center* Dr. Matthew Stevens

*903 Williams Street ● Angola, Indiana 46703 ● (260) 665-9479*




Patient ID#_____

## CONFIDENTIAL PATIENT INFORMATION

Date_____ SS# _____

Name_____ Email Address_____

(First) (MI) (Last)

Phone#: Cell/Home_____ ❑ Verizon ❑ AT&T ❑ Sprint ❑ Boost Mobile ❑ Other _____

Local Address_____ City/State/Zip _____

Age_____ DOB_____/_____/_____ Marital Status: S M W D Number of Children_____

Occupation_____ Employer_____ Work Phone #_____

Work Address_____ City/State/Zip_____

Name of Spouse_____ Occupation_____ Employer_____

Work Address_____ City/State/Zip_____ Phone #_____

Emergency Contact _____ Relation_____ Phone #_____

Who may we thank for referring you to our office? _____

Have you had an X-ray or MRI of your spine in the last year? ❑ Yes ❑ No

Have you ever had Chiropractic care before? _____ If so, when? _____

**List your primary complaints in order of severity:**

(1) _____ For how long? _____

(2) _____ For how long? _____

(3) _____ For how long? _____

**List any other doctors you have consulted for these conditions:**

(1) _____ Location _____

(2) _____ Location _____

Did this injury occur while at work? _____ Have you reported it to your employer? _____

Is this an injury related to an auto accident? _____ If yes, name of:

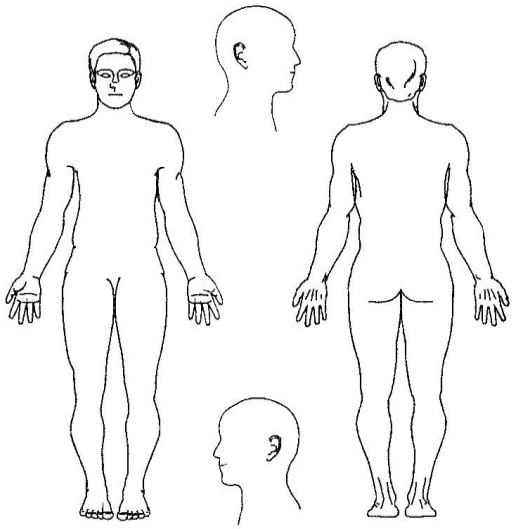
Your Auto Ins Company _____ Policy # _____ Claim # _____

**List major surgeries:**

(1) _____ When _____

(2) _____ When _____

Please mark your areas of pain on the figure below.



0----------5----------10
Circle how bad your pain is: 0 = no pain, 10 = unbearable

**HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING:**

**Check Current and Circle Past Health Issues**

□ Stroke
□ Fatigue
□ Nervousness
□ Numbness in arms or legs
□ Weakness in arms or legs
□ Spinal Curvature
□ Heart Disease
□ High Blood Pressure
□ Heart Attack
□ Headaches / Migraines
□ HIV/AIDS
□ Dizziness
□ Cancer
□ Diabetes
□ Neck Pain
□ Low Back Pain
□ Depression
□ Anxiety

**LIST** any of the above conditions that run in your family: _____

**LIST all other known health issues:**

Gastrointestinal complaints: □ None List: _____

Ear, Nose, Throat complaints: □ None List: _____

Muscle, Joint, Bone complaints: □ None List: _____

Genital, Urinary complaints: □ None List: _____

Cardiovascular complaints: □ None List: _____

Male Related complaints: □ None List: _____

Female Related complaints: □ None List: _____

Other Related complaints: □ None List: _____

**Are your symptoms:** ☐ getting worse ☐ getting better ☐ staying the same

Method of payment you plan to use to take care of today's charges:

□ Cash □ Check □ MasterCard □ Visa □ Care Credit

Major Medical Insurance Co. _____

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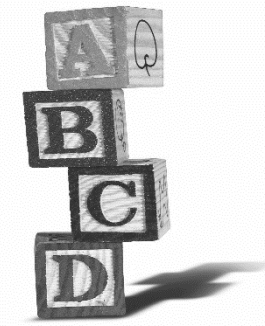


**Demographic and Medical Information**

**Name** _____

**Race** *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑ Samoan ❑ Guamanian or Chamorro ❑Other_____ ❑ I choose not to specify

**Multi-Racial** *(check one)* ❑Yes ❑No ❑ Unknown

**Ethnicity** *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

**Preferred Language** *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi

**Verification Question** *(choose only one question by checking the question, then give the answer)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?

Verification Answer to the Chosen question: _____

*Answers must be at least 6 characters.*

**Do you currently smoke tobacco of any kind?** ❑ Yes ❑ Former smoker ❑ Never been a smoker

*If yes, how often do you smoke:* ❑ Current every day smoker ❑ Current sometimes smoker

*If yes, what is your level of interest in quitting smoking?*

□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

*No interest* *Very Interested*

**Current medications, including *frequency*, *dosage*, and *start date*; if known.**
**If there are no current medications, check here: ❑**

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

**List any known allergies you have had to any medications. <u>If no allergies are known, check here</u>: ❑**

1) _____ 2) _____ 3) _____

**Has any doctor diagnosed you with High Blood Pressure presently?** ❑ Yes ❑ No

**Has any doctor diagnosed you with Diabetes presently?** ❑ Yes ❑ No What kind? ❑ Type I ❑ Type II

*If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0*

❑ Yes ❑ No ❑ Not Sure

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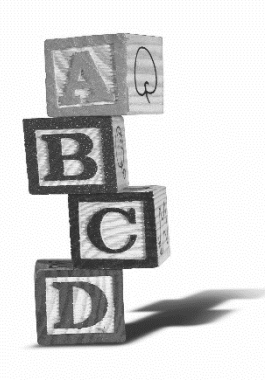


## X-RAY Confirmation:

This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic imaging.

## Notice to Insurance Company of Assignment:

You are instructed to pay directly to Stevens Chiropractic Center, P.C., for all professional services rendered to me. This instruction to you is an assignment of my rights under medical coverage to the extent credited to my account and I shall be personally liable for any unpaid balance to the doctor. I am also personally liable for any unpaid accounts for hospital, diagnostic, and consultation services at Stevens Chiropractic Center, P.C., Located at 903 Williams St., Angola, IN 46703

I hereby authorize the chiropractic office listed above to furnish you the information and evidence in the doctor's possession regarding my history and physical condition.

## Informed Consent to Treatment:

I hereby request and consent to the performance of chiropractic adjustments, via manual techniques or instrument assisted techniques, and other chiropractic procedures, including various modes of physical therapy and diagnostic radiology, on me (or on the patient for whom I am legally responsible) by Matthew T. Stevens, D.C. and/or other licensed doctors of chiropractic who now or in the future work at Stevens Chiropractic Center, P.C.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and I agree to the above-named procedures. 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.

**I fully understand the X-Ray Confirmation, Assignment to Insurance, and Informed Consent.**

Signature _____ Date _____

Printed Name _____

Signatures required on reverse →

## Insurance and Payment Coordination

I understand that Stevens Chiropractic Center, P.C. will file my claims with my insurance carrier if requested, however, it is no guarantee of coverage. I understand that I am ultimately responsible for my account. If my account is past due, and I am not on an approved payment agreement or I am not making payments as promised in an agreement, I understand that I may be turned over to a collection agency or law firm and any associated collection costs, including but not limited to reasonable attorney fees, may be added to my account balance.

Signature _____ Date _____

Printed Name _____

## Privacy Policy

I acknowledge that I have been provided with a copy of the Privacy Policy for Stevens Chiropractic Center, P.C., and fully understand its contents.

Signature _____ Date _____

Printed Name _____

## Authorization To Treat A Minor

**(Parents or Guardians Only)**

**I authorize this office to administer chiropractic care as deemed necessary to my child or ward.**

Name of Patient _____ Date _____

Signature of Guardian _____ (Parent / Legal Guardian)

Printed Name _____