Welcome to Simmons Chiropractic Clinic

Patient Information:

Name: _____ Soc. Security #:_____

Address:_____ City:_____ State:____ Zip Code:_____

Sex: ☐ Female ☐ Male Birthdate:____-____-_____ E-mail: _____

Home Phone: (____)_____ Cell Phone: (____)_____ Work Phone: (____)_____

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell ☐ No Preference

Patient Employer/School: _____ Occupation:_____

Employer/School Address_____ City:_____ State:____ Zip Code:_____

Spouse or Parent's Name: _____ Employer: _____ Work Phone: (___)_____

Who may we thank for referring you to us? _____

Person to contact in case of emergency: _____ Phone: (____)_____

Primary Care Physician:_____ Phone: (____) _____

What Brings You to Our Office?

What are your most pressing health concerns? _____

_____

How long have you had these concerns? _____ Is it ☐ getting worse ☐ improving ☐ staying the same

Where is the problem? (part of your body/for how long)_____

_____

Which activities are difficult to perform? ☐ Sitting ☐Standing ☐Walking ☐ending ☐ying Down ☐her

Type of pain: ☐ Sharp ☐ll T☐obbing N☐mbness A☐hing S☐boting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

Rate the severity of your pain. (1= mild pain or discomfort, 10= severe pain) 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

Treatment you have received for your condition: ☐Medication ☐Surgery ☐Physical Therapy ☐Other

Have you received Chiropractic care before? ☐ Yes ☐ No If yes, please tell us the doctor's name_____

Were you pleased with your care? ☐ Yes ☐ No If no, please explain _____

Are you currently receiving care from other health professionals for these complaints? ☐ Yes ☐ No

Do you take any medications? ☐ Yes ☐ No If yes, for what conditions?_____

Do you take vitamins/herbs? ☐ Yes ☐ No If yes, do you take them for a specific condition?_____

Daily Habits

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What do your daily work habits include? _____

What vitamins do you currently take? _____ Nutritional supplements? _____

Do you smoke? ☐ Yes ☐ No If yes, how much per day? _____

How much liquor do you consume weekly?____ How many caffeinated beverages do you consume daily?____

What Do You Know About Chiropractic?

In your own words, what do chiropractors do? _____

Do you know what spinal nerve stress/subluxation is? ☐ Yes ☐ No If yes, please describe _____

_____

What would you like to gain from chiropractic care? _____

_____

Do you have friends/relatives who see chiropractors? ☐ Yes ☐ No

If yes, do they use chiropractic for: ☐ Health maintenance/optimization ☐ Health Problems ☐ Other

Are you seeking chiropractic for: ☐ Health maintenance/optimization ☐ Health Problems ☐ Other

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

I certify that I, and/or my dependent(s), have health insurance coverage with _____ and assign directly to Simmons Chiropractic Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance; I authorize the use of my signature on all insurance submissions.

Simmons Chiropractic Clinic may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature _____ Date _____

Print Name _____ Relationship to Patient _____

Health History

Please check all of the following that you currently and/or have suffered from within the past 6 months.

Now	Past 6 Months		Now	Past 6 Months		Now	Past 6 Months		Now	Past 6 Months	
☐	☐	Headache	☐	☐	Migraines	☐	☐	Frequent Nausea	☐	☐	Constipation
☐	☐	Neck Pain	☐	☐	Dental Problems	☐	☐	Irritable Bowel	☐	☐	Fatigue
☐	☐	Middle Back Pain	☐	☐	Jaw Pain	☐	☐	Excessive Thirst	☐	☐	Bloody Stools
☐	☐	Low Back Pain	☐	☐	Vision Problems	☐	☐	Vomiting	☐	☐	Hemorrhoids
☐	☐	Shoulder Pain	☐	☐	Difficulty Breathing	☐	☐	Prostate Problems	☐	☐	Liver Problems
☐	☐	Arm Pain or Tingling	☐	☐	Stuffy Nose	☐	☐	Breast Pain/Lumps	☐	☐	Stroke
☐	☐	Hand Pain	☐	☐	Allergies	☐	☐	Cramps	☐	☐	Paralysis
☐	☐	Leg Pain or Tingling	☐	☐	Fainting	☐	☐	Painful Urination	☐	☐	Tingling
☐	☐	Foot Pain or Tingling	☐	☐	Weight Loss or Gain	☐	☐	Bladder Problems	☐	☐	Numbness
☐	☐	Chest Pain	☐	☐	Poor Appetite	☐	☐	Excessive Urination	☐	☐	Cold Extremities
☐	☐	Infectious Disease	☐	☐	Auto or Work Injury	☐	☐	Head Injuries	☐	☐	Fights
☐	☐	Falls or Accidents	☐	☐	Dislocation	☐	☐	Spinal Tap	☐	☐	Surgery
☐	☐	Broken Bones	☐	☐	Use a Walker or Cane	☐	☐	Extensive Dental Work	☐	☐	Excessive Alcohol Use
☐	☐	Sport Injuries	☐	☐	KnockedUnconscious	☐	☐	Diabetes	☐	☐	Smoking

(Woman) Are you pregnant? ☐ Yes ☐ No

List any types of surgeries which you have had and the dates which they occurred: _____

_____

Please list all medications you are currently taking: _____

Allergies: _____

NAME:_____ DATE: _____/_____/_____

Simmons Chiropractic Clinic Financial Policy

Payment Methods: Payment is expected at the time of service unless other arrangements have been made. We accept Cash, Check, Debit, Visa, and Mastercard.

Insurance: Your insurance is a contract between you and your provider and it is your responsibility to be aware of your coverage. Upon request, we may at times be able to call on your behalf to check your benefits. We do not have any control if they do not process your treatment as quoted. Please keep your insurance information current, updating the front desk of any changes in coverage or plan. You are responsible for all annual deductibles, co-pays, and non-covered services. **Co-pays are due at the time of service to avoid a $10 administrative billing fee.**

Personal Injury: We **DO NOT** bill third party for your treatment. We will bill **your** auto insurance if you have Personal Injury Protection (PIP) or your health insurance if you do not have PIP. If you do not have either PIP, auto insurance, or health insurance, you are required to pay all costs at the time of service.

Worker's Compensation (L&I): This is provided by the employer and will normally cover 90-120 days of treatment. Any treatment for structural or postural correction that is beyond L&I coverage is the patient's responsibility.

Medicare: Simmons Chiropractic is a non-participating provider for Medicare, which means that we receive payment from the patient, not Medicare. Medicare does not cover services deemed as maintenance care or not medically necessary per their guidelines. If your care is "Medically Necessary", as deemed by Medicare (ie: injury related, accompanied by an exam and/or x-rays) and determined by your DR. to be so, you are responsible for payment and Medicare will send re-imbursement directly to you. If your Dr determines that your care will not be covered by Medicare, you are responsible for a maintenance Visit charge of $28, Medicare will not be billed and you will not be reimbursed. Medicare does not pay for chiropractic exams or x-rays. Therefore, we offer patients a 30% savings on these services.

Account Balances: Account balances MAY NOT exceed $500 individual or $750 family balance. If your account exceeds the limit, treatment will be postponed until balance is paid.

Patient Agreement: I understand that insurance policies are an arrangement between the insurance carrier and myself, and that I am financially responsible for all charges incurred that are denied or unpaid. If my account is not paid within 90 days of the date of service, and I do not have payment arrangements established, I will be responsible for legal fees, collection agency fees, account interest, and any other expenses in the collection of my account.

Signature _____ **Date:** _____

Name:_____ Date: _____

PAIN SCALE		
	0	No pain. Feeling perfectly normal
MINOR: Does not interfere with most activities. Ability to adapt to pain psychologically and with medication or devices such as cushions.	1 Very Mild	Very light or barely noticeable pain, such as a mosquito bite.
	2 Discomfort	Minor pain; such as a pinch between fingers.
	3 Tolerable	Very noticeable pain, such as an accidental cut or flu shot. A pain that is not so strong that you cannot get used to.
MODERATE: Interferes with many activities. Requires lifestyle changes but patient remains independent. Unable to adapt to pain.	4 Distressing	Strong, deep pain such as a toothache, a bee sting, or stubbing your toe. Strong enough to notice the pain all the time and cannot completely adapt.
	5 Very Distressing	Strong, deep, piercing pain such as standing incorrectly on a sprained ankle. Noticeable all the time, preoccupied with managing it that normal activities are interfered with.
	6 Intense	Strong, deep, and piercing pain so strong it seems partially dominate your senses, interrupting your thought process. Comparable to non-migraine headache.
SEVERE: Unable to engage in normal activities. You are disabled and unable to function independently.	7 Very Intense	Same as 6 except pain completely dominates senses, causing unclear thinking half the time. Comparable to an average migraine headache.
	8 Utterly Horrible	Pain so intense you can't think clearly, personality changes. Comparable to childbirth or a severe migraine
	9 Excruciating Unbearable	Pain so intense you can't tolerate and demand drugs or surgery no matter what the side effects/risks. Comparable to cancer.
	10 Unimaginable Unspeakable	Pain so intense you will go unconscious shortly. Most have never experienced this pain level. Those who have, likely passed kidney stones or suffered a crushed hand.

Please Rate Pain Levels 0-10

Neck: _____

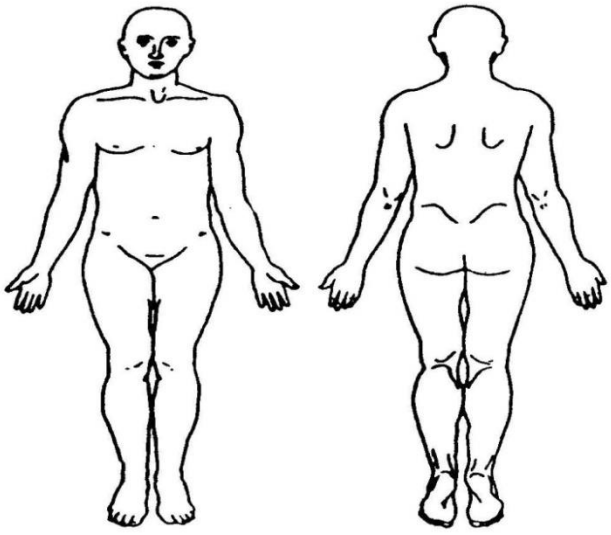
Upper Back: _____

Mid Back:_____

Lower Back:_____

Legs: _____

Arms:_____



Please label the diagram using the letters below to best describe your current pain:

(B) Burning (T) Tightness/Tension (S) Stiffness (P) Pain (N) Numbness/Tingling