Date: _____

Name (last) _____ (first) _____ (MI) _____
Address_____

City_____ State_____ Zip _____

Home Phone #_____ Cell # _____

Birth Date_____ Email _____

Marital Status: S M OTHER SS#_____

Occupation: _____

Employer: _____

Emergency Contact: _____

Phone: _____

What is your chief complaint for your visit today?

_____

What symptoms are you having?

(Check all that apply). Aching __ Numbness__ Stabbing __ Diffuse __ Radiating __ Tightness __ Dull __ Sharp __ Tingling __ Cramping__ Pulsating __ Throbbing__ Excruciating__ Shooting __ Weakness__ Burning __ Pounding __ Stabbing __

Rate the severity of your pain at its least and greatest times by checking two boxes on scale. 0 1 2 3 4 5 6 7 8 9 10

When did this happen? _____

How did this happen? _____

How often do you feel the symptoms? Less than 10% 25% 50% 75% 100%

What makes symptoms better? _____

What makes symptoms worse? _____

Have you had previous Chiropractic care? YES or NO

If YES, when was last adjustment? _____

What other treatments have you done for this symptom?

Chiropractic _____ Pain Medication_____ Exercise_____ Ice _____ Heat _____ Rest _____[2]

How is this affecting your daily life? What activities are you unable to do?

_____

Height_____Weight_____

Any previous illnesses / injuries? Please List

_____

_____

List all Surgeries:

Type_____ When_____
Type_____ When_____
Type_____ When_____

Current medications?

Name_____For what_____How Long_____
Name_____For what_____How Long_____
Name_____For what_____How Long_____
Name_____For what_____How Long_____

Please list any allergies: _____ .

Any family history of back/neck problems? _____

Do you have any vomiting, nausea, fever, chills, or any unexplained weight loss or weight gain? _____

Have you ever broken ribs or had any serious spinal injuries? _____ if yes, please explain to doctor upon examination

Past and Present Conditions Listed below are common diseases and disorders.

Please indicate whether you have had a particular disorder in the past or presently troubled by a listed disorder.
Headaches_____ Dizziness _____ Weak Immune system_____ Neck Pain ____ Pins/Needles in arms/hands ____

TMJ _____ Low Back Pain _____ Pain in legs and feet _____ Pain in joints _____ Diabetic problems _____

Heart Problems _____ High Blood Pressure _____ breathing problems _____ Asthma _____ Sinus problems _____
Allergies _____ Eye problems _____ Ear problems _____ Indigestion _____ Stomach problems _____

Skin problems _____ Gall Bladder problems _____ Thyroid problems _____ Constipation _____

Bladder problems _____ Bowel problems _____ Liver problems _____ Kidney problems _____

Menstrual problems _____ Weight problems _____ Fatigue _____ Sleeping problems _____

Whom can we thank for referring you to our office?

[3] TERMS OF ACCEPTANCE:

The goal of the chiropractor is not to diagnose/treat any disease but to locate, analyze, and correct vertebral subluxations. The purpose being to improve joint mechanics and to restore the innate healing mechanisms of the body via a nervous system free of irritation/interference. I consent to the customary examinations, tests and procedures performed at Tenniswood Chiropractic and to routine chiropractic treatment ordered or administered by my chiropractor or other Clinic staff. I recognize that the practice of chiropractic is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of services administered to me in connection with this Agreement.

I understand as with any health care procedure that certain complications may rarely occur such as fractures, disc injuries, muscle or vertebral strains, arterial dissection, or others. *_____ INITIALS

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional/chiropractic expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as original *_____ INITIALS

RELEASE OF INFORMATION I authorize this clinic to release any patient information from my case to any insurance company, adjuster, and/or attorney involved in my case; and hereby release this clinic of any consequence thereof. *_____ INITIALS

MISSED APPOINTMENT POLICY Tenniswood Chiropractic reserves the right to bill any patient $15 for a missed appointment with no advance notice of cancellation or reschedule. *_____ INITIALS

SIGNATURE_____ DATE_____.

Patient Financial Responsibility Payment is expected at Time of Service For all patients, payment of insurance co-pays and services not covered by insurance are to be paid for at the time the service is rendered. We will try to get insurance benefits as a courtesy for you. What we receive from the insurance company is a quote of benefits, not a guarantee. You are responsible for any balances not covered by your insurance, including rejected claims. While every effort will be made to submit claims in accordance with insurance requirements for payment, in the event of a dispute or rejection, you as the insured or guarantor are responsible for payment. The insurance contract is between you and your insurance provider, not between the insurance company and Tenniswood Chiropractic. Insurance claims not paid within 90 days after the original date of service will become the responsibility of the patient/insured.

X_____/ _____

Signature / Date

PAYMENT RESPONSIBILITY FOR DIVORCED/SEPARATED PARENTS The person who brought the child in for services is responsible for payment. This office cannot be responsible for collecting from any other individual. I acknowledge that I have read and understood this payment policy.

X_____/ _____ Signature / Date

[3] www.Tenniswoodchiropractic.com 4010 Page Ave. Ste. 104, Michigan Center, MI. 49254 PH: 517-764-5305 FX: 517-764-5417

HIPAA:

Consent for Purposes of Treatment and Healthcare Operations I acknowledge that Tenniswood Chiropractic's "Notice of Privacy Practices" has been provided to me. I understand that I have a right to review Tenniswood Chiropractic's Notice of Privacy prior to signing this document. Tenniswood Chiropractic's Notice of Privacy Practices has been provided to me. 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 Tenniswood Chiropractic. The Notice of Privacy Practices for Tenniswood Chiropractic is also provided on request at the main administration desk of this practice. Notice of Privacy Practices also describes my rights and Tenniswood Chiropractic's duties with respect to my protected health information. Tenniswood 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 calling the offices and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

X_____/ _____

Signature of Patient or Personal Representative / Date

Consent to email and/or text usage for appointment reminders and other healthcare communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders / information.

____ (initials) I consent to receiving emails and/or texts messages.

____ (initials) I Do NOT consent to receiving emails and/or text messages