

**COMPLETE CHIROPRACTIC & BODYWORK THERAPIES
PATIENT/CLIENT UPDATE FORM**

Date _____ Referral Source _____

Name _____
Last First Middle Name I prefer to be called

Address _____
City State Zip

Phone (____) _____ (____) _____ (____) _____
Home Work Cell/Pager

Email _____ Social Security# _____ Male ___ Female ___

Occupation _____ Employer _____

Date of Birth _____ Age _____ Marital Status: S M W D Partner

Emergency Contact _____
Name Phone # Relationship

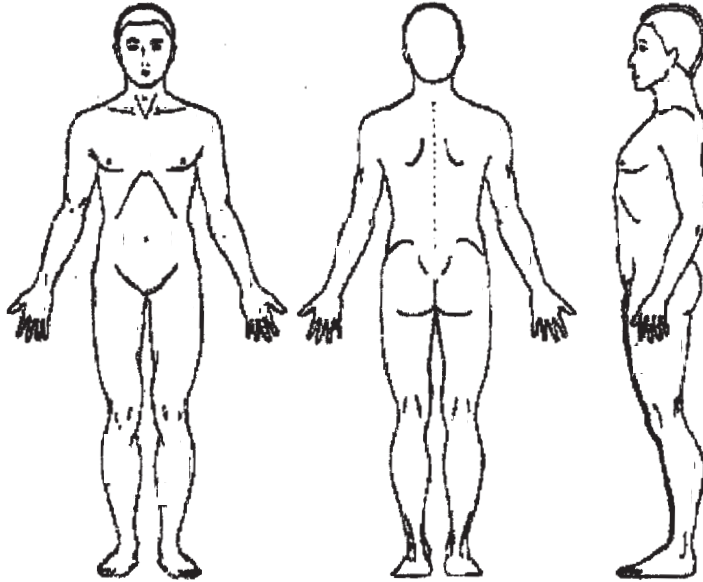
The best phone number to use to contact me or leave a message is (____) _____.

**COMPLETE CHIROPRACTIC & BODYWORK THERAPIES
PATIENT/CLIENT COMPLAINT/SYMPTOM FORM**

Date _____ Name: _____

Height _____ Weight _____

Using the symbols below, mark on the pictures where you feel pain.



- Numbness = = =
- Dull Ache O O O
- Burning X X X
- Sharp/Stabbing / / /
- Pins, Needles + + +
- Other _____ ^ ^ ^

Please state your chief complaints:

How long have you had the symptoms?

How did the condition begin?

How long did the symptoms last?

What makes it worse?

What makes it better?

How would you describe your pain on a scale of 1 to 10?

Circle one:

(0 is none - 10 severe) 1 2 3 4 5 6 7 8 9 10

Name: _____ Date: _____

Previous treatment for this complaint (include any doctors names, dates treated, test results, or home remedies: _____

(If you need more room; please write on back of sheet)

<i>X-rays, MRI's or CT's</i>	<i>Where Taken</i>	<i>Date</i>

Past Surgical History

<i>Surgery</i>	<i>Year</i>

Hospitalizations (other than surgery)

<i>Reason</i>	<i>Year</i>

Accidents/Injuries

<i>Accident/Injury</i>	<i>Year</i>

Current medications/supplements _____

Known allergies to medications/supplements _____

Exercise, type and frequency: _____

Describe your typical diet for

Breakfast: _____

Lunch: _____

Dinner: _____

How much of the following do you consume daily?

Water: _____ Milk: _____ Soda: _____ Coffee _____

Cigarettes: _____ Sweets: _____ Alcohol: _____ Tea _____

Abdominal gas frequently? _____ #of bowel movements daily? _____

List any recent travel: _____

Age of mattress: _____ Regular: _____ Waterbed _____ Fouton: _____ Sleep Position _____

Do you like your job? _____ How do you relieve stress? _____

Spiritual/Religious affiliation/Meditation/Prayer _____

List hobbies: _____

With whom do you live? _____

Estimate the stress in your life: _____ None _____ Mild _____ Moderate _____ Great

Date of last physical exam? _____

Have you ever had a professional massage, Polarity Therapy or craniosacral therapy? _____

Are you currently in psychotherapy? _____

Name _____ Date _____

Please CHECK conditions that apply and CIRCLE to specify further as necessary:

Past	Current	SPECIFY
		Abdominal
		Allergies
		Anxiety
		Arthritis, osteo or rheumatoid
		Asthma
		Bleeding Disorder
		Blood Clots
		Blood Pressure high or low
		Cancer
		Chest Pain
		Chicken Pox/Measles/Mononucleosis
		Cough
		Dental/TMJ
		Depression
		Diabetes
		Digestive Disorder
		Dizziness/Fainting spells
		Ear Disorders/Hearing loss
		Eye Disorders
		Fibromyalgia/Chronic Fatigue
		Genetic Disease
		Gout
		Headaches/Migraines
		Heart Disorder
		Hepatitis
		Hernia
		Kidney Disorder
		Leg cramps
		Low blood sugar
		Lung Disorder
		Lupus
		Malaria
		Nausea/vomiting
		Nose problems/Smell
		Polio, Rheumatic Fever, Scarlet Fever
		Seizures
		Sinus Problems
		Skin Disease
		Spinal problems
		Stroke
		Sudden weight loss/gain
		Thyroid Disease
		Ulcers
		Varicose Veins
		Venereal Disease
		Measles
		Mononucleosis
		Rheumatic Fever
		Scarlet Fever

Name _____ Date _____

Women Only

Men Only

Past	Current	Problems with Breasts	Past	Current	Prostate Problems
		Vaginal Itch/Discharge			Impotence
		Painful Intercourse			Swollen or Painful Testicle
		Take Birth Control Pills			Discharge
		Irregular Cycles/Bleeding			
		Hot Flashes			
		Difficulty Conceiving			
		Age of First Period			
		# of Pregnancies			
		# of Miscarriages			
		# of Abortions			
		Passed Menopause at Age			
		Date/Onset of last period:			
		# of Days between cycles:			

Family History:

Relationship	Age, if Living	Age, at Death	State Health Problems or Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
Sisters	_____	_____	_____
Grandfather	_____	_____	_____
Grandfather	_____	_____	_____
Grandmother	_____	_____	_____
Grandmother	_____	_____	_____

COMPLETE CHIROPRACTIC & BODYWORK THERAPIES FINANCIAL POLICY/AUTHORIZATION AND ASSIGNMENT

Thank you for choosing Complete Chiropractic & Bodywork Therapies as one of your health care providers. Please understand that payment of your bill is considered a part of your commitment here. The following is a statement of our Financial Policy, which we request you read, and sign prior to any treatment.

All New Patient paperwork must be filled out and completed prior to seeing your practitioner.

- Σ **Full payment is due at the time of services rendered, unless special arrangements have been made in advance.**
- Σ **I assign payment to be made directly to Complete Chiropractic & Bodywork Therapies for services billed to my insurance that are outstanding.**
- Σ **We accept cash, checks or Visa/MasterCard.**
- Σ **For massage therapy services not covered by your insurance, we accept cash or check only. Payment is made directly to the practitioner.**

INSURANCE:

- Σ We are **participating providers** of **BCBS Traditional** and **BCBS PPO**.
- Σ Any other insurance is **"Out of Network"** in our office. **Some insurance's do provide coverage for chiropractic services.** Our Financial Coordinator, Tonia Swinton, can call and check to see if your insurance may provide benefits for services received at our office.
- Σ We ask that all copays and deductibles be paid at time of service.
- Σ I authorize the release of any information necessary to my insurance provider, attorney or adjuster, as needed to process my claims.
- Σ Be aware that some, perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

- Σ **Adult patients are responsible for full payment at time of service.**
- Σ **When an adult accompanies a minor they are responsible for the payment.**
- Σ **An unaccompanied minor may make payment by credit card, cash or check at time of service.**

MISSED APPOINTMENTS:

A 24 hour cancellation policy is in effect for all chiropractic and massage therapy services. We reserve the right to charge for missed appointments. If you have any questions about our Financial Policy you may direct them to the Financial Coordinator, Tonia Swinton.

I have read the Financial Policy. I understand and agree to this Financial Policy. I authorize Linda Berry, DC or Kathleen Dvorak, DC to provide care for the examination and treatment of my case. I am ultimately responsible for all charges incurred, including any collection efforts or court fees. I hereby consent to any statements stated above, that apply to my situation. Copies of these statements are as legal and binding as the original.

Signature/Date: _____

Consent to Treat a Minor

I hereby authorize the doctor to treat my son or daughter.

Name of child: _____

Name of Parent/Guardian: _____