Chiropractic Plus, P.C.

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Valparaiso, IN 46383
(219) 464-1100
FAX (219) 464-1101

Confidential Patient Information Date_______________

Name ____________________________Birth Date ___________Age ____Sex M F
Address____ Apt.#________
City__________________________ State ____ Zip Code(+4 if known)____________
Home Phone(____)__________________ Cell Phone(____)_____________________
**E-mail address ____
Social Security Number ____________________Occupation_____________________
Employer ____________________ Employer's Address________________________
Employer's Phone Number (___)_____________________ Marital Status S M D W
Spouse's Name _______________________ Occupation ______________________

Emergency Contact Information
Emergency contact person (*other than your spouse*)___________________________
Telephone number at Home (___)_________________Work(___)________________

Guarantor Information
Guarantor's Name____
Birth Date________________ Social Security Number_________________________
Guarantor's Occupation _________________ Employer_________________________
Employer's Address ______________________Work Phone (___)________________

Insurance Information
Name of Insured Party _____________________________Birth Date______________
Insured Party's Social Security Number______________________________________
Insurance Carrier_______________________ Telephone Number_________________
Policy Number____________________________ Group Number__________________
Claims Address____
Coverage Information____
____

PLEASE READ CAREFULLY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Chiropractic Plus will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Chiropractic Plus will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that all past, present, and future bills incurred at Chiropractic Plus are my responsibility for payment. In the event that my bill must be turned over to an attorney for collection, I understand that I am liable for the balance due plus interest at the current rate, reasonable attorney's fees, and court costs. I authorize the release of any medical information necessary to process my claims.

PAYMENT IS DUE AT THE TIME OF THE VISIT

Patient's Signature____________________________________ Date_________________
Driver's License Number__________________________________ Expires______________
Guarantor's Signature ___________________________________ Date________________
Guarantor's Driver's License Number________________________ Expires_____________

CHIROPRACTIC PLUS

Current Health Condition

Please briefly describe the reason for this appointment:
____
____
____
____

When did this problem begin? ____________________
Have you had this problem before? **Yes No**
When was the last episode?______________________
Is the condition related to (circle one):
Job Accident, Auto, Home Injury, F all, Other
____

Have you been evaluated or treated for this condition by any other doctor/provider? **Yes No** If "yes", please list each provider and the treatment received:______________________________________
____
____

Are you still under the care of any of these providers?
Yes No If "yes" whom?________________________
____
____

During the course of your <u>current condition</u>, have you experienced or are you experiencing any of the following: (please check all that apply)

- ☐ Headache
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Stiffness
- ☐ Tension
- ☐ Trouble sleeping
- ☐ Pins/Needles in arms
- ☐ Pins/Needles in legs
- ☐ Numbness
- ☐ Cold hands or feet
- ☐ Dizziness
- ☐ Ringing in ears
- ☐ Pressure in head/neck
- ☐ "Head feels too heavy"
- ☐ Loss of bowel control
- ☐ Loss of bladder control
- ☐ Loss of smell or taste
- ☐ Memory loss
- ☐ Loss of balance
- ☐ Irritability
- ☐ Nervousness
- ☐ Depression
- ☐ Fatigue/Tiredness
- ☐ Flushing of face
- ☐ Lights bother eyes
- ☐ Spots in front of eyes
- ☐ Fever/chills
- ☐ Night sweats
- ☐ Difficulty swallowing
- ☐ Unexplained weight loss
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Heart Palpitations
- ☐ Burning on urination
- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Stomach problems
- ☐ Nosebleeds
- ☐ Frequent sore throats
- ☐ Hot/cold flashes
- ☐ Cramps
- ☐ Female problems
- ☐ Swelling anywhere

Past Medical History

If you have had any of the following, please check the box and give a brief description:

☐ Surgery ________________________________
____
☐ Broken Bones ____________________________
____
☐ Hospitalization ___________________________
____
☐ Serious Diseases __________________________
____
☐ Prior Accidents/Injuries (include dates)________
____

Please provide us any other information you feel is related to your **present** condition:
____
____
____

Please list all current medications, vitamins, supplements, or herbs you are currently using:
1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
5. ____________________________________

Please list **<u>any</u>** allergies:
1.____
2.____
3.____

Family History

Please list any members of your immediate family who have or had any of the following:
Musculoskeletal Disease_______________________
Heart Disease______________________________
Lung Disease______________________________
Cancer___________________________________
Nervous Disorder___________________________
Metabolic Disorder (thyroid, diabetes, etc.)________
____
Other____________________________________

Pain Rating Scale

Please rate your pain on a **<u>scale from 1 to 10</u>** in each of the following categories:
Current level of pain:_______ out of 10
Average level of pain: _______ out of 10
Worst level of pain: _______ out of 10

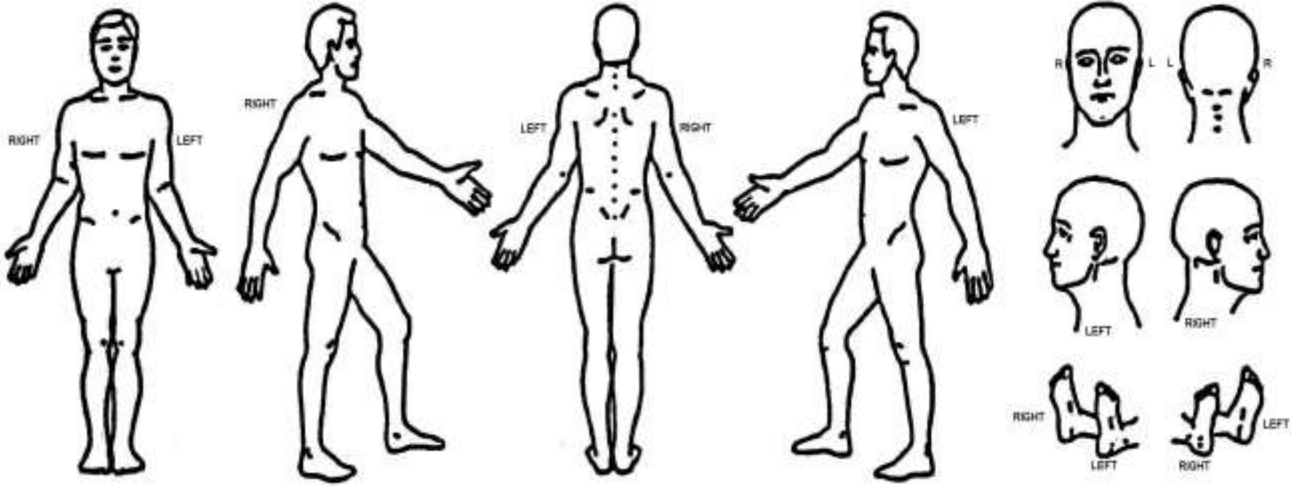
Name:___________________________________ File #________________ Date _____________

CHIROPRACTIC PLUS

Pain Assessment Tool

1. Location

Please mark the area(s) you are currently experiencing pain on the drawings below:



2. Quality

Using your own words, please describe the pain (i.e. ache, burn, sharp, dull, pulling, etc.)

____

____

____

3. Onset, Duration, Variations, Rhythms

Describe how the pain begins, how long it lasts, whether it varies, and if it increases at certain times:

____

____

____

4. What relieves the pain?

____

____

____

____

5. What aggravates the pain?

____

____

____

6. Describe any other factors associated with your pain:

____

____

____

____

I certify that the information on all the forms is true and accurate to the best of my knowledge.

Patient Name ____________________________________Date_________________