FILE # _____
DATE: _____

NAME: _____
ADDRESS: _____
CITY: _____
STATE: _____ ZIP: _____
HOME PHONE: _____
CELL PHONE: _____
EMPLOYER: _____
CO. ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

SEX: (circle one) MALE FEMALE
AGE: _____
DATE OF BIRTH: _____
SOCIAL SECURITY: _____
E-MAIL ADDRESS: _____
BUSINESS PHONE: _____
OCCUPATION: _____
STUDENT STATUS: (circle one) HS COLLEGE FT/PT
MARITAL STATUS: _____

HOW WERE YOU REFERRED TO THIS OFFICE?

FRIEND: _____
PHYSICIAN: _____
OTHER: _____

TV RADIO PHONE BOOK MAILER
ATTY: _____
NEWSPAPER: _____

HEALTH INSURANCE

INS. CO: _____
INSURED'S NAME: _____
RELATIONSHIP TO INSURED: _____
POLICY #: _____
GROUP #: _____

SPOUSE'S INSURANCE

INS. CO: _____
INSURED'S NAME: _____
POLICY #: _____
SPOUSE'S SS#: _____
D.O.B. _____

Is your injury due to an accident? _____

Did it occur at work? _____
If yes have you reported it to your employer?
_____

Are you eligible for Medicare? _____

AUTHORIZATION TO RELEASE INFORMATIONS:
I herby authorize this clinic to release any information acquired in the courses of my examination or treatment

AUTHORIZATION OF BENEFITS:
I herby assign and grant the benefits that I am eligible to receive for professional services rendered in this office to this office. I understand that I am financially responsible for these charges not paid by my insurance.

PATIENTS SIGNATURE: _____ (PARENT IF MINOR)

**** PLEASE PRESENT YOU INSURANCE CARD WHEN RETURNING THIS FORM**
**** PAYMENT IS EXPECTED IN FULL UPON FIRST VISIT**

Ratio Wellness & Chiropractic
FINANCIAL POLICY REGARDING FEES

PLEASE NOTE THAT REGARDLESS OF INSURANCE BENEFITS AVAILABLE TO YOU, ANY FEES THAT ARE DENIED WILL BE YOUR RESPONSIBILTY TO PAY.

PLEASE CHECK ONE AND SIGN BELOW

_____ **I will pay for services as they are rendered.**

Treatment may be paid by cash, personal check or credit card. An insurance receipt will be issued upon request when the balance is paid in full

_____ **Group Health/Medical Insurance. Please bill my group health insurance directly.**

Please present you insurance ID card to the front desk personnel. Specific information is required for us to bill your insurance directly. Please sign our Office Policy form.

ALSO: If it is determined that we cannot bill your insurance directly, you will be advised that payment is required at time of service.

_____ **Workmen's Compensation Claim. Please bill my employer directly.**

Please advise the front desk personnel that your services are work-related. Specific information is required in order for us to bill this type of claim. Please complete the Workmen's Compensation Information Sheets.

_____ **Automatic Accident Injury Claim. Please bill my auto insurance directly.**

Please advise the front des personnel that your services are related to an auto accident. Specific information is required in order for us to bell this type of claim. Please complete the Auto Accident Information sheets.

_____ **Medicare Patient**

Our office will file your claim with Medicare for you. Your 20% co-pay will be due at the end of each visit after your $150 deductible has been met.

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 if I suspend or terminate my care and treatment, any fees for professional services tendered to me will be immediately due and payable.

Patient Signature _____

PAST HISTORY:

MARK "**X**" IF YOU EVER HAD OR NOW HAVE THE FOLLOWING CONDITIONS.

CIRCLE ALL CURRENT PROBLEMS.

_____ ALLERGIES
_____ ANEMIA
_____ ARTHRITIS
_____COLITIS
_____ DIABETES
_____ HYPOGLYCEMIA
_____ EPILEPSY
_____ POLIO
_____ ULCERS
_____ INJURIES
_____ DIZZINESS
_____ FAINTING
_____ HEADACHES
_____ TREMORS
_____ WEAKNESS/ FATIGUE
_____ GALLBLADDER TROUBLE
_____ LIVER TROUBLE
_____ THYROID TROUBLE
_____ VENEREAL DISEASE
_____ PNEUMONIA
_____ NERVOUSNESS
_____ SKIN PROBLEMS
_____ SMOKING
_____ HOSPITALIZAION
_____ OTHER

_____ WEIGHT GAIN OR LOSS
_____ HEARING DIFFICULT
_____ EYE TROUBLE/ GLASSES
_____ PERSISTENT COUGH
_____ CHEST PAIN
_____ BREATHING DIFFICULTY
_____ HEART TROUBLE
_____ RAPID HEARTBEAT
_____ HYPERTENSION
_____ CHOLESTEROL
_____ ABDOMINAL PAIN
_____ SWOLLEN JOINTS
_____ POOR APPETITE
_____ CONSTIPATION/ DIARRHEA
_____ NAUSEA/ VOMITING
_____ DIFFICULTY URINATING
_____ PARALYSIS
_____ TUMOR OR LUMPS
_____ CANCER
_____ JOINT PAINS
_____RHEUMATIC FEVER
_____ BREAST SORENESS
_____ VAGINAL PROBLEMS
_____ OPERATIONS (**LIST THEM**)

Please describe your current problem

_____

_____

How long have you had this condition? _____

HAVE YOU EVER HAD CHIRPORACTIC CARE? _____ DOCTOR'S NAME_____

NAME OF YOUR MEDICAL PHYSICIAN: _____

DATE OF LAST PHYSICAL EXAM: _____

DATE OF LAST LABORATORY TESTS: _____ LIST THEM: _____

LIST MEDICATIONS: -

_____

_____

Please answer the following questions:

1) Why did you choose to come to this clinic?

_____

_____

_____

2) For you to feel your treatment successful, what do you want to take place over the course of your care here?

_____

_____

_____

3) How long do you feel this will take?

_____

_____

4) What are the areas of your lifestyle that you would like to improve: (Circle, than prioritize #1, 2, 3 etc.)

My level of anxiety	My pace of living
Not enough quiet time and rest	My diet and nutrition program
My exercise program	My energy level

5) What is you present level of commitment to address any underlying causes of your signs and symptoms that related to your lifestyle? (Rate from 1 to 10 being with 10 being 100% committed)

_____

_____

6) How confident are you that you will follow through on the healthy lifestyle changes (e.g. nutrition and exercise) that it will take to achieve your wellness goals? (Rate 1 to 10, where 1 is "not at all" and 10 is "100%" certainty").

_____

_____

_____

Patient: _____ Date: _____

Patient History

1. What is your **main complaint**? _____

2. On the scale below, please **circle** the **severity** of your **main complaint** (at its worst)

None		Slight		Mild		Moderate			Severe
1	2	3	4	5	6	7	8	9	10

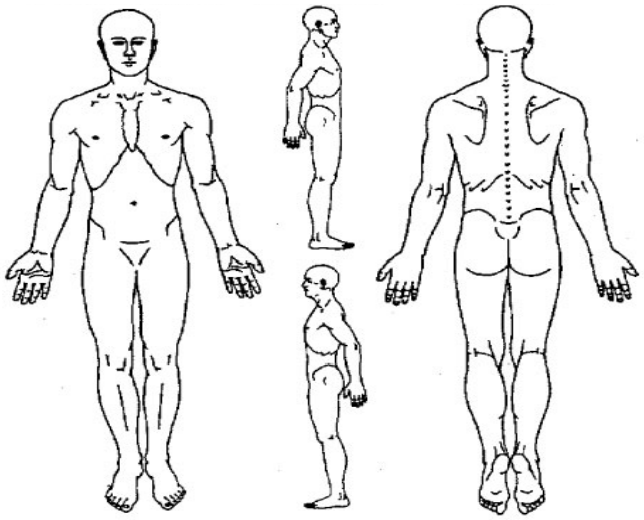
3. On the scale below please **circle** the **percentage of time** you experience your **main complaint**

		Intermittent		Occasional			Frequent			Constant	
0	10	20	30	40	50	60	70	80	90	100	%

4. How **long** have you been experiencing your **main complaint?** _____Onset date:_____

5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **N:** numbness **R:** throbbing pain **S:** sharp **T:** tingling



6. When do you notice it most? □ AM □ PM How long does it last? _____ Mins _____Hrs
7. What makes it feel better? _____
8. What makes it feel worse? _____
9. Have you ever had this problem in the past? □ Yes □ No
10. I have: □ been hospitalized □ been treated by another Chiropractor:
    □ been treated by another specialty provider □ never received care for this problem
11. Is your sleep disturbed due to pain? □ Yes □ No
12. Have you lost time from work because of it? □ Yes □ No Dates: _____ to _____
13. How much have your symptoms interfered with your usual daily activities? (*including both work outside the home and housework*) □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely
14. How is your condition changing, since care began at *this* facility?
    □ N/A – This is the initial visit □ Much worse □ Worse □ A little worse □ No change □ A little better □ Better □ Much better
15. How has this condition affected/changed your lifestyle?

_____

_____