1st care Chiropractic

1st Care
CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

This information is needed so we may better serve you. Please fill in ALL portions of this form. If you need assistance, please inquire at the front desk and we will be happy to have our Patient Services Representative assist you.

First Name: _____ Last Name: _____

Today's Date: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Age: _____ Date of Birth: _____ E-mail: _____ @ _____ • _____

(PLEASE CIRCLE) Sex: Female / Male Marital Status: M S D W SS#: _____

Drivers License #: _____ State: _____

You're Occupation: _____ Employed by: _____

Phone #: _____ Address: _____

(PLEASE CIRCLE) Is your visit due to a Motor Vehicle Accident? ***Yes / No*** A Work Accident? ***Yes / No***

Your Spouse's Name: _____

Spouse's Employer: _____ Spouse's Work Phone #: _____

Name of person to contact in case of emergency: _____

Their home phone number: _____ and work phone number: _____

Who is your doctor? _____ Phone: _____

Were you referred by a physician? ***Yes / No*** Name: _____

Are you a Medicare Patient? ***Yes / No*** Medicare #: _____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURES TO THE RIGHT.
Use the following symbols:

Aches ^^^^ **Numbness** oooo **Stabbing** //// **Pins & Needles** XXXX **Burning** WWWW

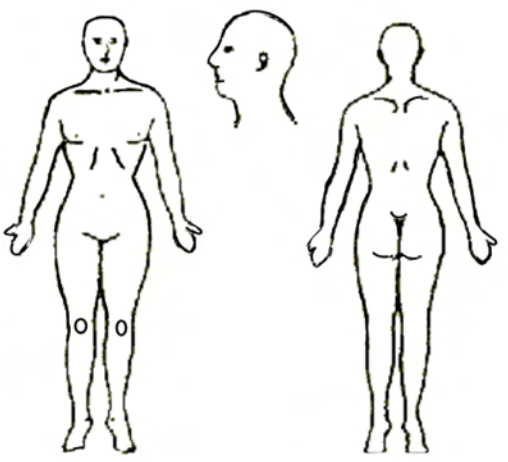
MARK AN "X" ON THE LINES BELOW:

How bad are your symptoms now?

_____
None Most Severe

How bad have they been in the past?

_____
None Most Severe



Insurance Coverage Information **Page 2**

Medical Insurance

Insurance Carrier: _____ Phone: _____
Policy Holder Name: _____ Policy Number: _____
Group Number: _____

For Motor Vehicle Accidents:
Passenger name(s):_____
_____

Were you: **Driver / Passenger / Pedestrian / Other**

Do you have *"Med Pay"* or *"PIP"* on your Auto Policy: ***(PLEASE CIRCLE)*** ***Yes / No / Not Sure***

Auto Insurance Carrier Name:_____ Phone: _____

Policy #: _____

Adjuster: _____ Claim Number: _____

Date of Accident: _____

Did you receive emergency medical treatment from a hospital or medical center?
(PLEASE CIRCLE) ***Yes / No*** If **"yes"** please provide the name of the hospital or medical center that you treated at:_____

(PLEASE CIRCLE) Were you transported from the accident by ambulance? ***Yes / No***

(PLEASE CIRCLE) Have you retained an attorney? ***Yes / No***

Attorney's Name:_____

Please Describe Accident: _____

_____

_____

_____

_____

_____

_____

Date of injury _____ Approx. time of injury _____ ☐ am ☐ pm

Company/Business name where injury occurred _____

Company/Business address where injury occurred _____

City _____ State _____ Phone # _____

Date you last worked at your place of injury _____

To the best of your knowledge please describe the accident as it occurred: _____

_____

_____

_____

_____

Was accident reported to your employer? *YES* ☐ *NO* ☐ Name of person reported to: _____

Their job title/position _____ Phone # _____

(I.e. Supervisor, Manager, co-worker, friend)

Were you treated for this injury? *YES* ☐ *NO* ☐ If *YES*, doctor's name _____

Type of treatment you received: _____

How many times were you treated by the above mentioned doctor? _____ Are you: ☐ Improved ☐ Unchanged ☐ Getting worse

Did you ever have any previous accidents or injuries? *YES* ☐ *NO* ☐ If *YES,* list date, type of injury and doctor who treated you or hospital:

_____

_____

Are you currently out of work? *YES* ☐ *NO* ☐ Have you returned to work? *YES* ☐ *NO* ☐ If *YES*, date in which you returned: _____

Name of compensation carrier: _____

Address of carrier: _____ Claim# _____

AUTHORIZATION OF PAYMENT

I hereby authorize direct payment to 1st Care benefits due me for his services. I also authorize release of information to all my insurance carriers. I understand I am financially obligated and responsible for all charges for services rendered to me that are not covered by my insurance.

Print name _____ Signature _____ Date _____

Present Complaints (please circle the appropriate ones) **Page 4**

Headache	Feet / Hands cold	Head seems heavy	Pins and needles in arms
Mental dullness	Depression	Confusion	*Right / Left*
Loss of memory	Pins and needles in arms	Constipation	Pins and needles in hands
Dizzy	Rib pain	Unbalanced	*Right / Left*
Neck Pain	Neck stiffness	Chest pain	Pins and needles in legs
Fainting	Shortness of breath	Ears ringing/buzzing	*Right / Left*
Upper back pain	Upper back stiffness	Midback pain	Midback stiffness
Lower back pain	Lower back stiffness	Blurred vision	Double vision
Neck restriction	Eye strain / pain	Loss of taste	Loss of smell
Nervousness	Fear	Irritability	Tension

(PLEASE CIRCLE) Difficulty in: *Standing, Sitting, Bending, Walking*

(PLEASE CIRCLE) Pain radiation to the: *Right arm, Left arm,* Right *leg, and Left leg*

(PLEASE CIRCLE) Cannot lift: Light, Moderate*, and Heavy, Repetitively*

(PLEASE CIRCLE) Pain radiating to: *Neck, Base of skull, Ribs, Shoulders, Arms*

(PLEASE CIRCLE) Pain in the: *Foot, Ankle, Knee, Hip, Heel spurs*

OTHER: _____

Since the time this (these) complaint(s) began, what, if anything, have you tried that ***did not*** work? _____

(PLEASE CIRCLE) Have you missed *work as a result of this problem*? ***Yes / No*** if you answered ***"yes"*** What date did you stop working? _____

List any doctors or therapists that you have seen for this complaint:

1. _____ Specialty _____
2. _____ Specialty _____
3. _____ Specialty _____

Relevant medical history: (Please circle the conditions you **have** or **had previously**)

Arthritis	Epilepsy	Muscular Dystrophy
Asthma	Fibromyalgia	Neck pain or spasms
Anemia	Hand or wrist pain	Neuritis
Back pain or spasm	Headaches	Numbness
Cancer	Heart problems	Polio
Concussion	Hepatitis	Rheumatic Fever
Convulsion	High blood pressure	Sinus trouble
Diabetes	HIV	Sciatica
Digestion problems	Measles	TB
Dizziness	Multiple sclerosis	Venereal disease

List any operations, illnesses, or accidents that you've had, approximate dates, and treating doctor:

1. _____ Date: _____ Dr: _____
2. _____ Date: _____ Dr: _____
3. _____ Date: _____ Dr: _____
4. _____ Date: _____ Dr: _____

Are you taking any medications? Please list: _____

_____

Are you allergic to any medication? Please list: _____

_____

(PLEASE CIRCLE) Are you pregnant? ***Yes / No*** Due date: _____

(PLEASE CIRCLE) Do you smoke? ***Yes / No*** Amount per day: _____

(PLEASE CIRCLE) Do you drink? ***Yes / No*** What type of drinker are you? ***Light Medium Heavy***

(PLEASE CIRCLE) How often do you Exercise: ***Never Sometimes Frequently Regularly***

I attest that the above information is true and correct to the best of my knowledge. I understand that because of specialized procedures, testing, and reporting, 1st Care does not participate with managed care health insurance plans. I authorize and direct 1st Care to file a UCC lien to secure payment for services provided. I authorize and instruct my attorney to pay bills incurred by me to 1st Care out of proceeds of any settlement or judgment. I instruct all insurance companies to pay bills submitted by 1st Care directly to 1st Care unless expressly stated in my insurance policy, in which case I instruct my insurance company to make checks payable to myself and 1st Care, and to mail such payment directly to 1st Care. In the event of any dispute arising from bills incurred by me, I direct my attorney to hold proceeds of any settlement or judgment in escrow until said dispute is resolved. I agree that this agreement will act as a lien against any settlement or judgment, and this agreement may be rescinded only by mutual consent of myself and the management of 1st Care. Any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement. I have read and understand the HIPPA privacy policy posted in the office. All disputes arising from this agreement or professional relationship will be resolved by arbitration in accordance with American Arbitration Association rules. Any questions regarding this agreement should be addressed to a Patient Services Representative or the Office Manager and clarified, before signing it. I understand that copies of this and all documents in my medical record are available to me upon request, in accordance with HIPPA guidelines.

Patient's Signature: _____ Date: _____

Consent to Treat Minor Child

I hereby authorize the doctors and staff of 1st Care to treat my minor child with care or diagnostic procedures deemed necessary. I agree to all terms and conditions outlined in this form.

Name: _____ Date: _____

Signature: _____