AMERIHEALTH
CHIROPRACTIC & WELLNESS

Patient Information

Date_____ Patient ID#_____

Patient Name_____
Last Name

_____
First Name Middle Initial

Address _____

City_____

State_____ Zip_____

E-mail_____

Sex ☐ M ☐ F Age_____ Birthdate_____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for ___years

Preferred Language: ☐ English ☐ German ☐ Spanish
Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Unreported
Race: ☐Am.Indian/Alaska Native ☐Asian ☐Black/Afr.American
☐>1 Race ☐Natv.Hawaiian ☐Pac.Islander ☐White ☐Unreported

Occupation _____

Patient Employer_____

Do you have kids living at home? List Names & Ages

_____

_____

Spouse's Name _____

Whom my we thank for referring you?_____

_____

Phone Numbers

Cell Phone (____)_____

Home Phone (____)_____

Work Phone (____)_____

Best time & place to reach you_____

_____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (____)_____

Cell Phone (____)_____

Insurance

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____ Subscriber Id #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birthdate _____ ss#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and my disclose such information to the above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Accident Information

Is condition due to an accident? ☐ Yes ☐ No

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

Date of accident_____

_____

Attorney Name (if applicable) _____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting ☐ Worse ☐ Better ☐ About the same

Rate the severity of your pain on a scale from 1(least pain) to 10 (severe pain) _____

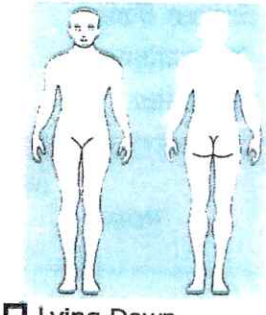
Type of pain ☐ Sharp ☐ Dull/Aching ☐ Throbbing ☐ Numbness/Tingling ☐ Shooting ☐ Burning

How often do you have this pain? (constant, come & go, etc.) _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Mark an X on the picture everywhere you experience pain or symptoms.



Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name of your primary care doctor _____ Practice Name _____

Phone _____

Name/Practice of other doctor(s) who have treated you for your condition _____

Phone _____

Date of Last: Physical Exam_____ Spinal Exam _____ Spinal X-Ray _____

MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV ☐Yes ☐No	Chicken Pox ☐Yes ☐No	Liver Disease ☐Yes ☐No	Rheumatoid Arthritis ☐Yes ☐No
Alcoholism ☐Yes ☐No	Depression ☐Yes ☐No	Measles ☐Yes ☐No	Rheumatic Fever ☐Yes ☐No
Allergy Shots ☐Yes ☐No	Diabetes ☐Yes ☐No	Migraine Headache ☐Yes ☐No	Scarlet Fever ☐Yes ☐No
Anemia ☐Yes ☐No	Emphysema ☐Yes ☐No	Miscarriage ☐Yes ☐No	Stroke ☐Yes ☐No
Anorexia ☐Yes ☐No	Epilepsy ☐Yes ☐No	Mononucleosis ☐Yes ☐No	Suicide Attempt ☐Yes ☐No
Appendicitis ☐Yes ☐No	Fractures ☐Yes ☐No	Multiple Sclerosis ☐Yes ☐No	Thyroid Problems ☐Yes ☐No
Arthritis ☐Yes ☐No	Glaucoma ☐Yes ☐No	Mumps ☐Yes ☐No	Tonsillitis ☐Yes ☐No
Asthma ☐Yes ☐No	Goiter ☐Yes ☐No	Osteoporosis ☐Yes ☐No	Tuberculosis ☐Yes ☐No
Bleeding Disorders ☐Yes ☐No	Gout ☐Yes ☐No	Pacemaker ☐Yes ☐No	Tumors, Growths ☐Yes ☐No
	Heart Disease ☐Yes ☐No	Parkinson's Disease ☐Yes ☐No	Typhoid Fever ☐Yes ☐No
Breast Lump ☐Yes ☐No	Hepatitis ☐Yes ☐No	Pinched Nerve ☐Yes ☐No	Ulcers ☐Yes ☐No
Bronchitis ☐Yes ☐No	Hernia ☐Yes ☐No	Pneumonia ☐Yes ☐No	Vaginal Infections ☐Yes ☐No
Bulimia ☐Yes ☐No	Herniated Disk ☐Yes ☐No	Polio ☐Yes ☐No	Venereal Disease ☐Yes ☐No
Cancer ☐Yes ☐No	High Blood Pressure ☐Yes ☐No	Prostate Problem ☐Yes ☐No	Whooping Cough ☐Yes ☐No
Cataracts ☐Yes ☐No		Prosthesis ☐Yes ☐No	Other _____
Chemical Dependency ☐Yes ☐No	High Cholesterol ☐Yes ☐No	Psychiatric Care ☐Yes ☐No	_____
	Kidney Disease ☐Yes ☐No		

Exercise

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Habits

- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week_____
- ☐ Coffee/Caffeine Drinks — Cups/Day_____
- ☐ High Stress Level — Reason_____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Back/Neck Injuries		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications

Name	For What Condition(s)

Allergies

Vitamins/Herbs/Minerals

Consultation History

Patient Name _____ Date _____

What have you heard about chiropractic? ❑ Positive ❑Negative? _____
Have you had care? ❑Y ❑N How was your experience? ❑ Good ❑ Bad?
How long ago was your last adjustment? _____

Major complaint that brought you in to our office: _____

How often do you experience it? ❑ Seldom ❑ occasional ❑ often ❑ always ❑ comes and goes
How did it happen: _____

Other physical complaint that you experience: _____

How often do you experience it? ❑ Seldom ❑ occasional ❑ often ❑ always ❑ comes and goes
Doctor Notes: _____

Other physical complaint that you experience: _____

How often do you experience it? ❑ Seldom ❑ occasional ❑ often ❑ always ❑ comes and goes
Doctor Notes: _____

Are there any other health problems that you wish you could get rid of, *even if you never considered a chiropractor could help you with them*? ❑ Hormone problems ❑ Sinus problems ❑ Allergies ❑ Asthma ❑ Digestive ❑ Sports injuries ❑ Fatigue ❑ Arthritis ❑ Weight problem ❑ Diabetes ❑ Blood Pressure

Doctor Notes: _____

Trauma and Stress History

Before you began to suffer from these problems, were there any earlier accidents, or physical stressors that may have injured your spine or nervous system? **Please include the approximate year of the trauma.**

Total number of Auto Accidents in your lifetime _____
List all Auto Accidents (minor and major)

List all Sports you played and any Injuries _____

List any Lifting Injuries/Falls (work injuries, missed steps, moving, etc) _____

Childhood Injuries (difficult birth, playground falls, rough play with siblings) _____

List any Stress you have experienced (contributing factors)? ❑ Job ❑ Family ❑ Time ❑ Recent move ❑ Other (Explain) _____

Since the time you have been suffering from these problems, what have you attempted to use to get rid of your problem(s)? ___Ice ___Heat ___Rest ___Medications ___Massage ___ Exercise/PT

Most drugs provide FAST TEMPORARY RELIEF" have you ever heard that? They often fail to fix the problem. Muscles problems usually heal within a few days, ligaments, joints, and nerves do not.

Do these problems cause you to become frustrated? ❑Y ❑N

(If not frustrated then) how does it make you feel? _____

Can you think of a time when these problems were at their worst? In your own words, how did it affect you or make you feel? (Ex: irritable, can't function, severe pain, locked up, tired?)

_____

Does this problem make you feel older when it is at its worst? ❑Y ❑N _____

I am now going to ask you some questions about how these problems might be affecting your life so we can better measure your progress.

Does it affect your job or housework? ❑Y ❑N Have you lost time from work? ❑Y ❑N

Would you say you are less productive? ❑Y ❑N Do you have to take more breaks? ❑Y ❑N

What hobbies or interests do you have outside of work? _____

When your problem is at its worst has it ever affected these activities? ❑Y ❑N When? _____

Is there anything else you would do more of or just enjoy more if it wasn't for these problems?

_____

When your problems are at their worst how could it affect your relationships with family & friends?
❑Less fun to be around ❑Irritable/Cranky ❑Left Alone/Antisocial ❑Depressed ❑Tired/worn out
❑Other _____

Did you know that most healing occurs when we sleep? Since sleep is also essential for a proper immune system function, please answer the following questions related to your sleep.

	Yes	No	Explain:
1. Trouble falling asleep due to being uncomfortable	❑	❑	_____
2. Not enough restful sleep	❑	❑	_____
3. Awaking in the middle of the night	❑	❑	_____
4. Waking earlier than you normally would	❑	❑	_____

With Sleep problems this would complicate the case because you must sleep in order to fully heal.

Your primary complaint(s) have been going on for _____ days ___weeks _____months _____ years

What do you think will happen if you let your symptoms go? ❑Same ❑Better ❑Worse

Taking into consideration what we have discussed so far, do you see there is a real need for change in the way you have been dealing with these problems? ❑Y ❑N

On a scale from 1-10, ten being the highest, rate your commitment to getting rid of these problems?

_____

Assuming we can help you, is there anything preventing you from getting these problems taken care of?
❑ money ❑ insurance coverage ❑ commitment to health ❑ time _____

_____

_____

_____

_____

Informed Consent

- **The nature of the chiropractic adjustment (manual manipulation)**
  We will use our hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel or sense movement. You may also have adjustments that may not produce a cracking or popping sound.
- **The material risk inherent in chiropractic adjustment**
  As with any health care procedures, there are certain complications which may arise during a chiropractic adjustment. Those complications include fractures, disc injuries, dislocations, and muscle strain, Horner's syndrome, cauda equina syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of adjustments of the neck have been associated with injuries to the arteries in the neck leading to complications, including strokes. Some patients will feel some stiffness and soreness following the first few days of treatment.
- **The probability of those risks occurring**
  Fractures are rare occurrences and generally result form some underlying weakness of the bone, which we check for during the taking of your history and during examination and x-ray. Strokes have been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in - a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ test sin our examination which are designed to identify if you may be prone to that kind of injury. The other complications are also generally described as "rare".
- **Ancillary Treatment**
  In addition to chiropractic adjustments, I intend to use some of the following treatments as I feel is medically necessary: electrical stimulation, cold laser therapy, cold packs, hot packs, traction, de-compression therapy, rapid release, massage, and r exercise rehab programs.
- **The risk and dangers attendant to remaining untreated**
  Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read the above explanation of the chiropractic adjustment and related ancillary treatments. By signing I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest, or interest of my child, to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

_____ _____

Patient's Name Date

_____

Signature/Guardian

Patient HIPAA Acknowledgement

This office has made me aware of HIPAA Notice of Privacy Practices and I acknowledge I may receive a copy of this notice for my review upon request. By signing this acknowledgement for I agree to its terms.

_____ _____

Patient Signature Date

AMERIHEALTH
CHIROPRACTIC & WELLNESS

Patient Name: _____ DOB: _____

Agreement of Financial Responsibility

Thank you for choosing Amerihealth Chiropractic & Wellness (Amerihealth) as your health provider. The following is a statement of Amerihealth's financial policy, which we require that you read and agree to prior to receiving any treatment from Amerihealth Chiropractic & Wellness.

Payment of your bill is considered part of your treatment. Fees are due and payable when services are rendered. Amerihealth accepts cash, check, credit cards, and pre-approved insurance for which Amerihealth is a contracted provider.

Proof of photo ID is required for all patients. If you don't have insurance, or we are not billing your insurance, then you are responsible for payment in full at time of service, unless other arrangements are made by the doctor/Amerihealth staff.

Insurance Patients
It is your responsibility to know your own insurance benefits, including:

- Whether or not Amerihealth Chiropractic is a contracted provider with your insurance company
- Your covered benefits and any exclusions in your policy; and
- Any pre-authorization requirements of your insurance company

Amerihealth will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide us with your current and accurate insurance information, including any updates or changes in your insurance coverage. Should you fail to provide this information, you will be financially responsible for the costs of the services rendered by Amerihealth.

If Amerihealth has a contract with your insurance company, Amerihealth will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility.

Amerihealth will ask to make a copy of your ID & insurance cards for our records. Providing a copy of your insurance card does not confirm that your coverage is effective, or that the services rendered will be covered by your insurance company.

Some insurance coverage has out-of-network benefits that have higher co-insurance charges, higher co-payments, and limited annual benefits. If you receive services that are part of an out-of-network benefit, your portion of financial responsibility may be higher than the in-network rate. I acknowledge that if my insurance company denies coverage and/or payment for services provided, I understand that I will be responsible for and will pay all charges due and in full.

Delinquent accounts
For accounts with a balance not collected after 180 days, they are subject to being sent to collections at which time there will be a $30 fee charged for an attorney letter, and then the collections agency will charge 1.5% interest per month until collected. I consent to communications from Amerihealth's staff or third parties working on behalf of Amerihealth.I know that none of my Protected Health Information will be sent to the collection agency. I understand that data usage and other charges from my mobile service provider may apply. I may stop all text messages by replying STOP.

I have read the financial policy stated above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Name of Patient/Responsible Party Relationship to Patient