Don’t just feel better, BE BETTER.

Welcome to our clinic. We specialize in assisting our patients to achieve their highest level of health through spinal and postural corrective programs. Our approach is unique and consists of the most advanced technology out there. This allows our patients to receive the best results.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance.

Patient Signature ____________________

Today’s Date _______________________

Plaxco Chiropractic Associates, LLC

Patient Intake Application

Patient Information

Full Name: ____ Date: ______________________
Last First MI

Address: __________________________ City:____________________ State: ______ Zip: ____________

Home Phone: __________________ Work Phone: __________________ Cell/Other: __________________

I prefer to receive calls at (circle) Home/Work/Cell Email Address: ________________________________

Employer: ____ Occupation: ____________________

Business Address: __________________________ City: __________________ State: ______ Zip: ________

Who Referred You?____

Female: ______ Male: ______Social Security Number: ______________________

I am (circle) Under Age18/Single/Married/Divorced/Widowed/Separated **Birth Date:** ____________

Spouse's Name: ______________________________________ Spouse's Date of Birth: __________________

Emergency Contact: _________________________Emergency Contact Phone Number: ____________________

*Who referred you to us? ________________________________

Payment Information

Person Responsible for Payment: ____

Social Security Number: ________________ Phone: ______________________ Date of Birth: ____________

Insurance Information

Do you have health insurance? _____ Yes _____ No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Plaxco Chiropractic Associates, LLC

Health Questionnaire

Patient Information

Date: ____________________________

Patient Name: ____ Date of Birth: ____

List all prescription, non prescription medications and other supplements you take as well as the associated condition:

____

____

List any surgeries or hospitalizations you have had complete with the month and year for each:

____

____

List anything you are allergic to: ____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

____

____

Do you exercise? □ Yes □ No Hours per week _____________What activity(s)? ____

Are you dieting? □ Yes □ No Since:________ Do you smoke or dip/chew? □ Yes □ No __packs per day.

How many years have you been smoking? ________ Do you drink alcoholic beverages? □ Yes □ No ______drinks per day.

Do you wear? □ Heel lifts □ Arch supports □ Prescription Orthotics

For women: Are you pregnant or nursing? □ Yes □ No If pregnant, How many weeks? ____

Date of last menstrual period: ____

Medical History

Describe the reason(s) for your doctor visit today:

____

____

Are you here because of an accident? ______________________________What type? _______________________________________

When did your symptoms start? ____________________________ How did your symptoms begin? _________________________

____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (Circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities?____

____

____

Have you experienced these symptoms in the past?____

____

History of Treatment

Primary care physician: ______________________ Phone: ______________________

Date last seen: ______________________ May we update them on your condition? ___Yes ____ No

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: ____________

____

Experience with Chiropractic

Have you ever seen a Chiropractor before? Yes No Who? ______________ When? ______________

Reason for visits? ____

How did you respond? ____

Did your previous Chiropractor take before and after x-rays? ______________________________

Did you know that posture and structure determines your health? ______________________________

Are you aware of any of your poor posture habits? Yes No

Explain: ____

Are you aware of any poor posture habits in your spouse or children? Yes No

Explain: ____

Please check any health condition you may be experiencing, now or in the past on the next page.

Functional Rating Index

For use with Neck and/or Back Problems

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item, please **circle** the number which most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain;100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Circle a number below to indicate your **usual/average** pain intensity

0	1	2	3	4	5	6	7	8	9	10

Name: ____(Printed) Total Score: __________________

Signature: ____ Date: _______________________

CONSENT TO CARE

I do hereby authorize the doctors of Plaxco Chiropractic Associates, LLC to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Plaxco Chiropractic Associates, LLC , including those working at the clinic or office to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, ________________________, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature____ Date ________________ *(If under age 18) Parent's signature*

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle:___________

__________________ _________

Signature Date

Consent to x-ray:

I hereby grant Plaxco Chiropractic Associates, LLC. permission to perform an x-ray evaluation if needed of _____________. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

__________________ __________

Signature (parent if minor) Date

Consent to evaluate and adjust a minor child

I, ________________ being the parent of legal guardian of _________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_________________ _________

Signature Date

INSURANCE and BILLING INFORMATION

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. By signing below, I authorize Plaxco Chiropractic Associates, LLC to release medical records required by my insurance company. I authorize my insurance company to pay benefits directly to Plaxco Chiropractic Associates, LLC and I agree that a reproduced copy of this authorization will be as valid as the original. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I agree that I will be responsible for any collection agency or attorney fees incurred. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

Signature____ Date ______________________

(If under age 18) Parent's signature

Acknowledgement of Receipt of Notice of Privacy Practices

814 Second Street
Muscle Shoals, AL 35661

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- ❑ The right to review the notice prior to signing this consent,
- ❑ The right to object to the use of my health information for directory purposes, and
- ❑ The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you do not answer, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

To change an appointment, notify us 24 hours in advance via phone, message or email. If for whatever reason you miss an appointment be sure to notify us via phone, message or email to reschedule within 24 hours after your missed appointment to avoid a $25 no-show fee.

Signature____ Date ________________ *(If under age 18)* Parent's signature

If not signed by the patient, please indicate relationship.

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient
- ❑ Beneficiary or personal representative of deceased patient

Name of Patient: ____

For Office Use Only:

Signed form received by: ____

Acknowledgement refused: (Efforts to Obtain/ Reasons for refusal)

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