

JASSY CHIROPRACTIC CENTER

Confidential Health Concern History

Personal Information:

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ May we send you office newsletters? Yes No

Sex: M F Marital Status: _____ Birth Date: _____ Social Security #: _____

Who may we thank for your referral to our office? _____

Names/ages of children: _____

Empl Status: Employed Full-time Student Part-time Student Other

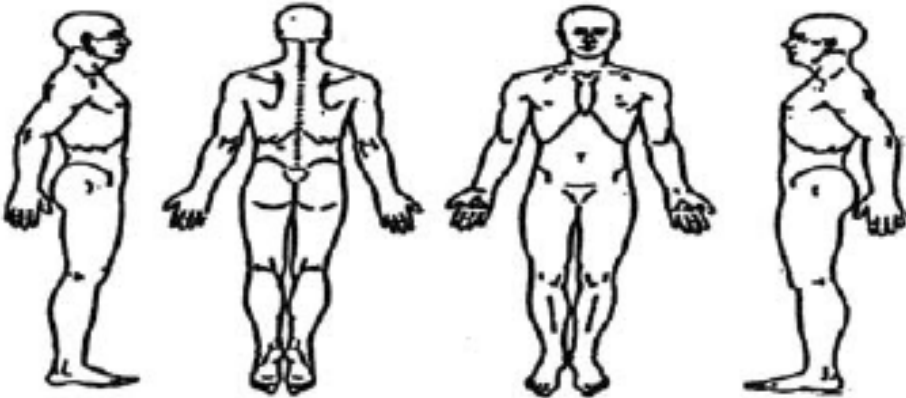
Employer: _____ Address: _____

Work telephone #: _____

Health and Wellness Information:

Is today's problem caused by: Auto Accident? Workman's Compensation?

Indicate in the figures below where you have pain/symptoms:



Please list your symptoms in order of importance to you:

1. _____
2. _____
3. _____
4. _____
5. _____

How often do you experience your symptoms?

- Constantly (76-100% of the time)
- Frequently (51-75% of the time)
- Occasionally (26-50% of the time)
- Intermittently (1-25% of the time)

How would you describe the type of pain?

- Sharp
- Dull
- Diffuse
- Achy
- Burning
- Shooting
- Stiff
- Numb
- Tingly
- Sharp with motion
- Shooting with motion
- Stabbing with motion
- Electric like with motion
- Other _____

How are your symptoms changing with time?

- Getting worse
- Staying the same
- Getting better

Using a scale from 0-10 (10 being the worst), how would you rate your problem? (Circle one) 0 1 2 3 4 5 6 7 8 9 10

How much has the problem interfered with your work?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

How much has the problem interfered with your social activities?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

Who else have you seen for your problem?

- Chiropractor
- ER physician
- Massage Therapist
- Neurologist
- Orthopedist
- Physical Therapist
- Primary Care Physician
- Other _____
- No one

How long have you had this problem? _____

How do you think your problem began? _____

Do you consider this problem to be severe? Yes Yes, at times No

What aggravates your problem? _____

What concerns you most about your problem? What does it prevent you from doing? _____

What is your: Height _____ Weight _____ lbs

Occupation: _____

How would you rate your overall health?

- Excellent
- Very good
- Good
- Fair
- Poor

What type of exercise do you do?

- Strenuous
- Moderate
- Light
- None

Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis
- Heart problems
- Diabetes
- Cancer
- Lupus
- ALS

For each of these conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

- | Past | Present | | |
|--------------------------|---|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Headaches | <input type="checkbox"/> | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> | <input type="checkbox"/> Neck pain | <input type="checkbox"/> | <input type="checkbox"/> Bladder Infection |
| <input type="checkbox"/> | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> | <input type="checkbox"/> Painful/Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> | <input type="checkbox"/> Loss of bladder control |
| <input type="checkbox"/> | <input type="checkbox"/> Low back pain | <input type="checkbox"/> | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> | <input type="checkbox"/> Abnormal weight gain/loss |
| <input type="checkbox"/> | <input type="checkbox"/> Elbow/Upper arm pain | <input type="checkbox"/> | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> | <input type="checkbox"/> Wrist pain | <input type="checkbox"/> | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> Hand pain | <input type="checkbox"/> | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> Hip pain | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> Upper leg pain | <input type="checkbox"/> | <input type="checkbox"/> Liver/Gall Bladder Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> Knee pain | <input type="checkbox"/> | <input type="checkbox"/> General Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> Ankle/Foot pain | <input type="checkbox"/> | <input type="checkbox"/> Muscular Incoordination |
| <input type="checkbox"/> | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> Joint pain/stiffness | <input type="checkbox"/> | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer | <input type="checkbox"/> | <input type="checkbox"/> Smoking/Tobacco Use |
| <input type="checkbox"/> | <input type="checkbox"/> Tumor | <input type="checkbox"/> | <input type="checkbox"/> Drug/Alcohol Dependence |
| <input type="checkbox"/> | <input type="checkbox"/> Asthma | <input type="checkbox"/> | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> | <input type="checkbox"/> Depression |
| <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> Systemic Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> Chest pains | <input type="checkbox"/> | <input type="checkbox"/> Dermatitis/Eczema/Rash |
| <input type="checkbox"/> | <input type="checkbox"/> Stroke | <input type="checkbox"/> | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> Angina | <input type="checkbox"/> | <input type="checkbox"/> Hormonal Replacement (females only) |

Are you currently taking any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Pain medications | <input type="checkbox"/> Cholesterol medications |
| <input type="checkbox"/> Birth control | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart medications | |

List all surgical procedures you have had: _____

What activities do you do at work?

- Sit ___ Most of the day ___ Half the day ___ A little of the day
- Stand ___ Most of the day ___ Half the day ___ A little of the day
- Computer work ___ Most of the day ___ Half the day ___ A little of the day
- On the phone ___ Most of the day ___ Half the day ___ A little of the day

What activities do you do outside of work? _____

Have you ever been hospitalized? No Yes, why? _____

Have you had significant past trauma? _____

What are your objectives in consulting our office? _____

What are your health goals once these objectives have been met? _____

Who was the last doctor who created a health development plan for you? _____

Did you follow all the doctor's recommendations? Yes No

How long were you able to stay on the health development plan? _____

What were your results? _____

Are you healthier today than you were 5 years ago? Yes No

Will you be healthier 5 years from now than you are today? Yes No

If not, have you thought about what could you do to improve your health rather than to have it continue to decline? _____

Have you had previous chiropractic care? Yes No **This year?** Yes No

Is there a possibility that you are pregnant? Yes No



I clearly understand that I am personally responsible for payment of all balances incurred for services rendered to me at Jassy Chiropractic Center, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. I authorize Jassy Chiropractic Center to prepare any necessary forms and to assist in making collection from my insurance company, and that any amount authorized to be paid directly to Jassy Chiropractic Center will be credited to my account upon receipt.

Patient/Guardian Signature: _____ **Date:** _____

JASSY CHIROPRACTIC CENTER

WORKING WITH A HEALTHCARE PROVIDER IS A PARTNERSHIP OF SHARED RESPONSIBILITY

OUR RESPONSIBILITY:

1. We will provide friendly, helpful, and courteous staff.
2. You will be seen within minutes of arriving for your appointment—no long waiting times.
3. We will provide a clear explanation of any health problems and the strategies to solve them.
4. We will submit your insurance claims using the appropriate codes and notes the same week of your visit; given that you have provided us with your most up-to-date insurance information.
5. After 30 days, if your insurance has not responded, we will resubmit the entire claim.
6. If your insurance has still not responded or not paid the entire bill after 60 days, we will then bill you. We will expect this bill to be paid within 30 days.

YOUR RESPONSIBILITY:

1. We realize that life is hectic and unpredictable. I understand that my body and spine heal with a rhythm and pattern. I understand that if I am going to get the most benefit from my treatments, I need to keep all of my appointments. If I have to miss an appointment, I will make it up the same day or at latest within 24 hours.
2. The Doctor will recommend specific exercises, stretches, nutrients, and activities. If you should choose not to follow the recommendations, which is your prerogative, you may find that your results are less than optimal. *Remember: The Chinese define insanity as doing the same behavior and expecting different results.*
3. If your insurance does not pay for your visit for any reason, you will be sent a bill which you need to pay within 30 days.
4. We recommend that you verify your insurance coverage (if possible, prior to your visit) to avoid any confusion.
5. Please notify us with any changes in your insurance or address information so we can keep your file current.

JASSY CHIROPRACTIC CENTER

PAYMENT POLICY

As a courtesy to our patients, we offer the following billing choices. Please read the terms and initial the payment plan that applies to you. Then sign at the bottom of the page.

_____ **SELF PAY:** I will pay for all services as they are rendered on the date of my visit. I understand that I may contact Jassy Chiropractic Center for required documentation if I choose to submit my own insurance claims.

_____ **INSURANCE SUBMITTAL:** I would like to assign my insurance benefits to Jassy Chiropractic Center and have you submit my insurance claims for me. I understand that I will be responsible for paying my estimated share at each office visit. If applicable, I understand that I am responsible for obtaining any necessary pre-authorization from my primary care physician. I understand that I am responsible for any balance as billed to me by Jassy Chiropractic Center that results from co-payments, deductibles, or non-covered services. I will also sign over to Jassy Chiropractic Center within 5 business days any insurance checks mailed to me that are owed for services received at Jassy Chiropractic Center. In the event that my insurance company requests a refund of payments made, I will be responsible for the amount of money refunded to the insurance company.

_____ **AUTO ACCIDENT/PERSONAL INJURY CLAIM:** I was involved in an accident and would like to assign benefits to Jassy Chiropractic Center and have you submit all charges to my insurance/lawyer for me. I will sign all liens necessary to protect your office. I also understand that regardless of the settlement, I am personally responsible for the entire balance. If Jassy Chiropractic Center is not paid within 30 days of the case settlement, I will personally pay the entire balance.

_____ **WORKMAN'S COMPENSATION CLAIM:** I was involved in an injury at work. I will ensure that my employer files the appropriate paperwork as needed for Jassy Chiropractic Center to receive compensation. I understand that it is in my rights to have any bills paid that are incurred as a result of a work related injury. If after 60 days of my visit to Jassy Chiropractic Center my claim is not paid, I understand that I am responsible for the balance.

*I understand that I am financially responsible for all charges arising from the treatment of myself. I understand that payment in full is due at the time services are rendered; however, I agree to pay a **finance charge** of 1.5% per month on balances over 30 days past due, which is an **annual percentage rate** of 18%. If my account is referred to an attorney for collection, I agree to pay all collection and court costs, including attorney fees in the amount of 33 1/3% of the total outstanding indebtedness. A photocopy of this contract shall be considered as valid as the original. I hereby authorize the release of my medical records to third-party insurers or others to whom disclosure is necessary to establish or collect a fee for the services rendered.*

Name (please print): _____

Signature: _____ **Date:** _____