HealthSource®
America's Chiropractor

WELCOME TO OUR OFFICE

Included you will find the forms required for your first visit at our office.

Please complete the forms in their entirety, prior to your appointment, using a BLACK ink pen. DO NOT DATE any forms. We will complete the date when you arrive for your appointment. If the appointment is for a minor, all forms must be completed by a parent or guardian and must include the patient's name and the parent's or guardian's signature on each from. If you are a guardian, it is important that you bring the court ordered paperwork with you for the minor's first visit.

We have included specific instructions for each form in your packet to assist you in completing this necessary information.

REMEMBER to bring your completed forms, driver's license and insurance card(s) with you to your appointment. We look forward to your visit in our office and helping you with your health concerns.

If you have any questions regarding the completion of these forms, please contact our office and we will be happy to assist you.

ENTRANCE APPLICATION

This form provides us with your personal information required to complete your registration as a new patient in our office. Please be sure to fill out the form as complete as possible.

FINANCIAL AGREEMENT

This form informs you of your financial responsibility for your treatment in our office and gives us permission to file your insurance and receive benefit payments directly from your insurance company. Please sign this form in all three places. DO NOT DATE.

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Entrance Application

We are honored you chose us to evaluate your health. To better serve you, please fill out the personal information below. If you need assistance, please inform our front desk team member.
Thank you and welcome to HealthSource!

Patient Information

First Name: _____ Middle _____ Last _____ Gender: __M __ F

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Social Security Number: _____

Email Address: _____ Birthdate: _____ Age: _____

Marital Status: __ S __ M __ W __ D Job Title: _____ Work Phone: _____

Spouse Name: _____ Birthdate: _____ Social Security Number: _____

Children: Names and Ages: _____

Insurance Information

Name of person on the insurance card: _____ DOB: _____

Name of employer: _____

Employer phone number: _____ City: _____

Person responsible for this account: _____

Additional Information

In case of emergency, whom should we contact? _____

Relation to patient: _____ Phone Number: _____

Family Physician: _____

May we send your Family Physician updates on your progress? _____Yes _____ No

What is your primary complaint? _____

_____

Is this worker's compensation? _____ Is this personal injury? _____

Office use only **Account Number** **Date**

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Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, HealthSource shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

PATIENT'S / GUARDIAN'S SIGNATURE

INSURED'S SIGNATURE

DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to HealthSource all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

PATIENT'S / GUARDIAN'S SIGNATURE

DATE

HealthSource®

NAME_____ DATE_____

What is your main complaint or injury? _____

Date of Onset_____ How did it Occur?_____

Date of Surgery_____ Type_____

Occupation_____

Working:	Full-time	Part-time	Light duty	Not working		
Job Requires:	Sitting	Standing	Bending	Walking	Lifting	Sitting
Physical Requirements:	Sedentary	Light	Moderate	Heavy	Very Heavy	

Please circle how you would best describe your pain or symptoms:

Constant Intermittent Sharp Dull/ Ache Burning Throbbing Stabbing Pins/ Needles Shooting Tingling/ Numb Tight Pulling Other_____

Pain Level: SEVERITY On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

Pain at LOWEST

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

Pain CURRENTLY:

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

Pain at WORST:

0 1 2 3 4 5 6 7 8 9 10

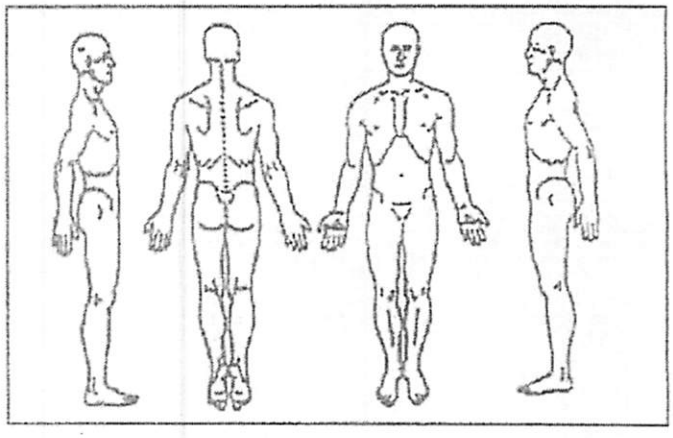
No pain Worst pain

BODY CHART:

X Sharp stabbing pain ..... Numb/ Tingling

O Dull achy pain //// Throbbing

==== Burning



What aggravates the pain/symptom?

_____Sneezing	_____Lifting	_____Exercising	_____Looking up/down	_____Walking
_____Coughing	_____Sitting	_____Stooping	_____Looking side/side	_____Standing
_____Stress	_____Driving	_____Getting out of bed	_____ Repetitive movement	_____Pulling
_____Pushing	_____Carrying	_____Straining at BM	_____ Getting in/out of car	_____ Stairs

Other:_____

What relieves this pain/symptom? _____Resting _____Sleeping _____Lifting _____Exercising _____Looking up/down _____Shower _____Advil _____Stooping _____Looking side/side _____Mineral Ice _____Other: _____

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

List 1 (one) important activity you are unable to perform as a result of your pain or symptoms:

_____.

What is your goal for physical therapy?_____.

Patient Signature:_____ Date:_____

(office use only) PT initials_____ Date_____

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NAME:_____ DATE:_____ PHYSICIAN: _____

Have you RECENTLY noted any of the following (check all that apply)?

- □changes in appetite
- □ changes in bowel or bladder function
- □ difficulty maintaining balance while walking
- □ difficulty swallowing
- □ dizziness/lightheadedness
- □fever/chills/sweats
- □ headaches
- □ nausea/vomiting
- □ pain at night
- □ shortness of breath
- □ weakness/fatigue
- □ weight loss/gain

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- □ anemia
- □ asthma
- □ cancer (type)_____
- □ chemical dependency (i.e., alcoholism)
- □ depression
- □ diabetes
- □ pacemaker inserted
- □ other_____
- □ heart disease
- □ high blood pressure
- □kidney/liver problems
- □ lung problems
- □ multiple sclerosis
- □ osteoporosis
- □HIV
- □ Parkinson's disease
- □ rheumatoid arthritis
- □stomach ulcers
- □ stroke
- □ thyroid problems
- □ epilepsy
- □arthritis

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Do you smoke? YES NO _____ pack/day

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Please list current medications (QUATINITY& FREQUENCY):

1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

Are you currently taking blood thinning or anticoagulant medications for any medical conditions? YES NO

ALLERGIES: _____

Are you latex sensitive? YES NO

PLEASE LIST PAST SURGERIES:

1. _____ Year_____ 2. _____ Year_____
3. _____ Year_____ 4. _____ Year_____
5. _____ Year_____ 6. _____ Year_____

HEIGHT_____ WEIGHT_____

FOR DIABETIC PATIENTS only: **SHOE SIZE AND WIDTH**_____

□*Hammer toes* □Blister/ callus □Bunions □Corns

□Xerosis (dry, rough, cracking) □Ingrown Nails

Patient Signature:_____ Date:_____

(office use only) PT Initials_____ Date_____