WELCOME TO THE CHIROPRACTOR WHITEFISH

NAME_____DATE_____

ADDRESS_____CITY_____

STATE_____ZIP_____PHONE#_____

EMAIL_____SS#_____

CELL#_____CELL PROVIDER_____

BEST WAY TO REACH YOU? TEXT EMAIL PHONE CALL

MALE/FEMALE BIRTHDATE_____AGE_____

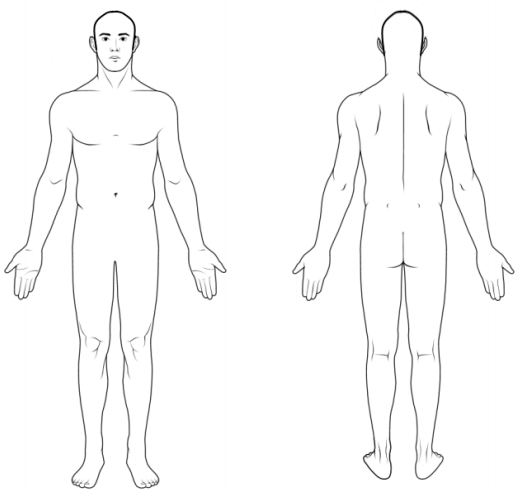
WHO CAN WE THANK FOR THE REFERRAL?_____

EMERGENCY CONTACT_____PHONE#_____

1ST COMPLAINT OR CONCERN_____

HOW LONG HAS THIS BEEN GOING ON?_____

RATE DISCOMFORT ON SCALE OF 1 (MILD) TO 10 (SEVERE)_____



TYPE OF PAIN:

SHARP	DULL	THROBBING
SHOOTING	TIGHTNESS	
BURNING	TINGLING	NUMBNESS
SWELLING	OTHER	

ON THE DIAGRAM, PLEASE PUT AN X ON AREAS THAT ARE BOTHERING YOU

SECONDARY CONCERNS_____

_____

_____

HEALTH HISTORY HAVE YOU EXPERIENCED THE FOLLOWING:

- ○Allergies
- ○Bowel/Bladder issues
- ○Constipation
- ○Dizziness
- ○Fever
- ○Hernia
- ○Jaw Problems
- ○Light sensitivity
- ○Mood Swings
- ○Numbness
- ○Sinus problems
- ○Ulcers
- ○Arthritis
- ○Buzzing/Ringing in ears
- ○Depression
- ○Fatigue
- ○Fractures
- ○Hot flashes
- ○Kidney Disease
- ○Miscarriage
- ○Neck Pain
- ○Pins & Needles
- ○Stomach Upset
- ○Asthma
- ○Bronchitis
- ○Diabetes
- ○Fainting
- ○Herniated Disk
- ○High Blood Pressure
- ○Loss of Balance
- ○Menstrual Pain
- ○Neck Stiffness
- ○Seizures
- ○Stroke
- ○Back Pain
- ○Cancer
- ○Digestive issues
- ○Fertility problems
- ○Headache
- ○Irritability
- ○Loss of smell/taste
- ○Menstrual irregularity
- ○Nervousness
- ○Shoulder Pain
- ○Thyroid problem

OTHER

_____

HAVE YOU HAD X-RAYS OR AN MRI IN THE LAST YEAR? YES/NO

WHERE?_____FOR WHAT?_____

DOES YOUR HEALTH INTERFERE WITH YOUR LIFE IN ANY OF THESE AREAS?

WORK	SLEEP	ENERGY	PRODUCTIVITY
EXERCISE	SELFCARE	ATTITUDE	CREATIVITY
RECREATION	RELATIONSHIPS	PATIENCE	OTHER_____

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING:_____

_____

_____

HAVE YOU EXPERIENCED THE FOLLOWING IN RECENT MONTHS/YEARS?

BROKEN BONES AUTO ACCIDENT HEAD INJURY STROKE HOSPITALIZED

DESCRIBE ANY THAT APPLY:_____

Terms of Acceptance of Care

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is important that both parties be working towards the same objective. Chiropractic has one goal: to facilitate the body's correction of vertebral subluxation. Chiropractors do this by specific adjustments of the spine. Health is a state of optimum function physically, mentally, socially, and emotionally, not merely an absence of disease. Vertebral subluxation is a misalignment of 1 or more of the 24 vertebrae which causes an alteration in nerve function, interference of mental impulses and lessens the body's ability to achieve maximum health.

We do not diagnose, or treat any disease besides vertebral subluxation. If during care, we encounter unusual non-chiropractic findings, we will advise you. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom, by adjusting to correct vertebral subluxation. My signature certifies that I have read and fully understand the above statements and agree to chiropractic care on this basis.

Signature _____Date_____

Financial Agreement

The Chiropractor will work with you to provide the necessary information to determine the type of care you require and also the financial information you may need to determine how you wish to handle your financial obligation for care. These policies apply to services performed, and in no way obligates the patient to continue the course of care recommended. Payment is due at the time service is rendered. We accept cash, credit card, local checks.

____ CASH / CREDIT CARD

____ MEDICARE – Payment is due at time of service. The Chiropractor will bill Medicare, but does not accept assignment from Medicare.

____INSURANCE – The Chiropractor is a provider for some insurance companies. We will bill your insurance and check on benefits. If insurance fails to pay, you will be responsible for the balance of your care. By signing you agree to assign insurance benefits to The Chiropractor and authorize the use of your signature on insurance submissions. Dr. Dudley may use health information and release such information to insurance company, adjustors, and attorneys for the purpose of obtaining payment for services rendered by the Chiropractor and I hereby release Dr. Dudley of any consequences thereof.

My signature below signifies agreement to the financial agreement and also certifies that I have been given the opportunity to review The Chiropractor Whitefish's HIPPA Privacy Practices and accept its terms.

PATIENT'S NAME (please print) _____

SIGNED_____ DATE_____