Thank you for choosing our clinic for your chiropractic care. Please complete this form **in ink**.

We are happy to help you---just ask! **Date:** ____________________

Last Name: ________________________________ First Name: _________________________ M.I_________

Date of Birth (D.O.B.) _____/______/_________ Age: __________ Gender: **M F**

Home Address: ____ Apt. #____________

City: _______________________ State: ____ Zip: __________ Height: ___ft. ___in. Weight: _____lbs.

Email: __________________________________ ***Who may we thank for referring you**? _______________

Home phone: _________________ Cell phone: __________________ Work phone: ____________________

Preferred places for messages? **Home Cell Work Email** (Circle all that apply)

Marital Status: □ Married □ Single □ Divorced □Widowed Spouse's name: ____________________

Women: Is there a chance you are pregnant? _____________ Due date? _________________________

Children's names and ages: ____

____

Your employer: ______________________________________ Job title: ________________________

Emergency contact: _____________________________ Relationship to you: ___________________

Phone: _____________________ Address: ____

City____ State________________ Zip____________

Primary Doctor (PCP)_________________________________ Phone: _________________________

Have you had previous chiropractic care? No Yes Date of last care: ______________________

Is this an accident case? Yes No Date of accident: _______________________________

Circumstances: Auto collision On the job Other_____________________________________

Details: ____

____

Staff only: *BP* ____________/___________ *Pulse:* ________ *Date:* ____________ *Initials:* _______

Staff only: *BP* ____________/___________ *Pulse:* ________ *Date:* ____________ *Initials:* _______

Staff only: *BP* ____________/___________ *Pulse:* ________ *Date:* ____________ *Initials:* _______

Action Chiropractic Clinic & Therapy, PLC

Patient Name____Date of Birth___________________

Insurance Company Name__________________________Subscriber's Employer______________________

Subscriber's Name____Date of Birth___________________

Group #_______________________Contract #___________________

Patient's Relationship to subscriber (Circle one): Self Spouse Child Dependent

_____I authorize BCC to copy my driver's license/personal I.D. --and insurance cards, if applicable--for my records

Financial Responsibility With/Without Insurance: All services rendered to me are charged directly to me; I am personally and financially responsible for payment of all charges incurred at Action Chiropractic Clinic & Therapy, PLC ("ACC" or, "ACC, PLC"), including insurance deductibles, copayments, and any & all services rejected/not covered by insurance. All charges are due at the time of service unless I have signed a payment plan agreement. I instruct and direct my insurance company to pay, by check made out to and mailed directly to ACC, PLC, the professional or medical expenses benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward charges for professional services rendered by ACC, PLC; a photocopy of this assignment shall be considered as valid as the original. I authorize ACC, PLC to release any pertinent Protected Health Information (PHI) to any insurance company, adjustor, and/or attorney involved in my case, and I hereby release ACC, PLC of any consequence thereof.

Health and accident insurance policies are an arrangement between the insurance carrier and me; I am responsible for knowing my carrier's rules, regulations, and payment policies. For specific questions regarding my insurance coverage, I must contact my carrier directly. **As a courtesy**, ACC will submit insurance bills within 4 weeks of date of service; ACC has no control over insurance carriers' response time(s). As ACC will collect approximated amounts from me, I may end up with a bill or credit on my account. For any automobile accident claim(s), I am responsible for any charges rejected, deemed unreasonable or unnecessary by my automobile insurance company and/or an independent medical examination, and ACC may require another form of payment guaranty. If workman's compensation is deemed unrelated to work, I will be responsible for all services.

Delinquent accounts (over 60 days of non-payment by patient and/or insurance) will be assessed a $25 billing charge. An additional $75.00 minimum amount will be charged if outside collection agency and/or small claims court are required to collect the balance on an account. I agree to resolve all financial matters with ACC on my own, without legal representation.

Chiropractic, like medicine, is an applied science as well as an art; absolute guarantees are not possible. I understand that regardless of individual results, I am responsible for payment for services received at ACC. If I suspend or terminate my recommended treatment of care, any fees for professional services will be immediately due and payable.

There is a 0.0399% surcharge for using credit/debit cards.

Health Insurance Portability and Accountability Act (HIPAA): ACC's current Notice of Privacy Practices (NOPP) has been made available to me. The NOPP explains my rights and ACC's duties regarding my PHI, including ways in which my PHI may be used or disclosed by ACC. ACC reserves the right to amend its NOPP. A printed copy of ACC's current NOPP is provided upon request at ACC's main administrative desk, or by calling ACC and asking that a copy be mailed to me.

These people are authorized to receive my health and financial information:

Name: ____________________________Relationship: _________________Phone: ____________________

Name: ____________________________Relationship: _________________Phone: ____________________

I understand and agree to all the above financial responsibility/HIPAA terms and conditions:

Patient/Guardian Signature: ______________________________Date: __________Witness: _____________

Patient/Guardian Signature: ______________________________Date: __________Witness______________

Patient/Guardian Signature: ______________________________Date: ________Witness: ______________

Pediatric Health History Form (Age 10 & under)

It is a pleasure to welcome you to our family of healthy chiropractic patients. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: ____ Date of Birth: ____/____/_____

Phone: ___________________________ Height: _________ Weight: ___________ Gender: M F

Names of Parents/Guardians: ____

Purpose for visit: ____

Other Doctors seen for this condition: _____No ______Yes

Name of Pediatrician: ____

Other Health Problems: ____

Previous Chiropractor: ____

Date of Last Visit: _____/_____/______ Reason: ____

Check any of the following conditions your child has suffered during the past six months:

___ Ear Infections ___ Scoliosis ___Seizure ___ Chronic Colds ___Temper Tantrums
___Asthma/Allergies ___ Digestive Problems ___Colic ___ Headaches ___ Car accident
___Recurring Fevers ___ Growing back pains ___ADHD ___ Bed Wetting
___ Others: ____

Family Health History:
____

# of doses of antibiotics child has taken in the past six months: ________ Total during lifetime: _______

# of doses of other prescription medications your child has taken in the past six months: ______________

List of medications: _____________________________ Total during lifetime: ___________________________

Did you choose to have your child vaccinated? ___No ___Yes

History: ____

Have you noticed any side effects of changes post-vaccination? _____________________________________

CHILDHOOD DISEASES

Chicken pox: ___ No ___ Yes Age: _____ Mumps ___ No ___ Yes Age: _____

Rubella: ___No ___Yes Age: _____ Whooping Cough ___ No ___ Yes Age: _____

Rubeola: ___ No ___Yes Age: _____ Other ______________ ___ No ___ Yes Age: _____

Menarche (first menstrual period) ____ No ____ Yes Age: _______

Patient Name: ____ Date of Birth: ____/____/_____

PRENATAL HISTORY

Name of Obstetrician/Midwife: ____

Complications during pregnancy? ___ No ___ Yes List: ____

Ultrasound during pregnancy? ___No ___Yes Number: ____

Medications during pregnancy? ___ No ___ Yes List: ____

Cigarette/Alcohol use during pregnancy: ___ No ___ Yes

Location of birth: ___ Hospital ___ Birthing Center ___Home

Birth Intervention: Forceps, Vacuum Extraction, Caesarean Section, Emergency or Planned? __________

Complications during delivery: ___ No ___ Yes List: ____

Genetic Disorders or Disabilities: ___ No ___ Yes List: ____

Birth Weight: _______________Birth Length: _________ APGAR Scores: ______________________________

FEEDING HISTORY

Breast Fed: ___ No ___ Yes How Long: ____

Formula Fed: ___ No ___ Yes How Long: __________________Type: _________________________________

Introduced Solids at ________ Months Cow's Milk at ______________ ___ months

Food/Juice allergies or Intolerances: ____ No ____ Yes List: ____

DEVELOPMENTAL HISTORY

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spine & interference).

At what age was your child able to:

Respond to Sound __________ Respond to Visual Stimuli ________ Hold Head Up __________
Sit Up ___________ Cross Crawl __________ Stand Alone ____________ Walk Alone_________

According to the National Safety Council, approximately 50% of children fall head first from a high place their first year of life (i.e. a bed, changing table, down stairs, etc). Was this the case with your child? ____ No ____ Yes
List: ____

Is/has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, Wrestling, etc.)? ____ No ____ Yes

List: ____

Has your child ever been involved in a car accident? ___ No ___ Yes List: ____
Has your child been seen on an emergency basis? ____ No ____ Yes List: ____
Other traumas not described above? ____ No ____ Yes List: ____
Prior Surgery? ____ No ____Yes List: ____

Patient Name: ____ Date of Birth: ____/____/_____

Major Complaint____

The major complaint came on gradually (how long) _____________ suddenly (date of onset) ____________
What makes the condition worse? Cough Laugh Sneeze Bend/Lift Stand Sit Walk

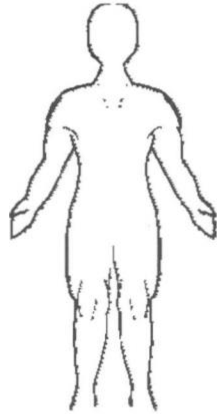
What makes the pain better? Sit Stand Lie Down Meds Heat Ice Other_____________

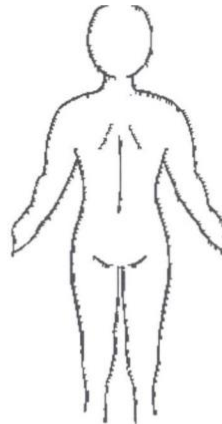
When is the pain worse? Morning Afternoon Evening Night All the time Varies

When is the pain better? Morning Afternoon Evening Night All the time Varies

Description of pain: Burning Dull Ache Sharp Throbbing Spasm Radiating Numbness
Tight/Stiff Tingling Other____

Please draw where you are experiencing symptoms.





Has this condition happened before? Yes NO If yes, when _________________________________

What diagnostic tests have you had for this condition? ____

Is this condition interfering with your: Work Sleep School Daily Routine Other ______________

How long has it been since you really felt good? ____

What do you believe is wrong with you? ____

CONSENT TO TREAT MINOR:

We are here to serve you, and encourage you to ask questions. Your participation is vital and will help determine your results!

I hereby authorize this office and its doctors to administer care to my son/daughter, as they deem necessary, even if I am not present.

Signed: _______________________________________Print Name: ____

Relationship to Patient: ____Date: _____________________

Witness: ____ Date: _____________________