PATIENT INFORMATION

Today's Date________________________________

Last Name________________________________ First Name________________________________ MI_____

Street Address ____

Mailing Address (if different from above) ________________________________

City____________________ State____ Zip__________ Sex: (Please Circle One) Male Female

Home Phone (_____)____________________ Birthdate ___/___/___ Age __________

Work Phone (_____)____________________ Soc. Sec. # _____-_____-_____

Cell Phone (_____)____________________ Employer____________________

E-mail Address____________________ Occupation____________________

Who may we thank for referring you? ____________________ or Phonebook__ Newspaper__ Flyer/Brochure__ Radio Ad__ Internet__ Drove By___ None of These __

EMERGENCY INFORMATION

IN CASE OF EMERGENCY, CONTACT:

Name________________________________ Relationship to Patient____________________

Address____

Home Phone (_____)______________ Cell Phone (_____)______________ Work Phone (_____)______________ Ext._____

FINANCIAL INFORMATION

Person Responsible for Payment ____________________ Payment By: (circle one) **Cash** **Credit Card** **Check** **Insurance**

If paying by insurance, please take your insurance card to the front desk.
If you do not have your card, please fill out the insurance information on the back of this form.

____

Signature of Patient or Parent/Legal Guardian **Date**

Tea Chiropractic & Rehab

A SPORTS AND FAMILY CHIROPRACTIC CLINIC

PATIENT NAME: ______________________________ **DATE:** ____________

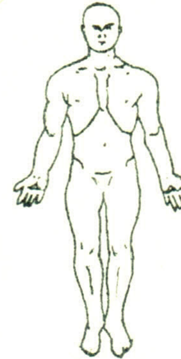
1. What brings you into our office today? ______________________________

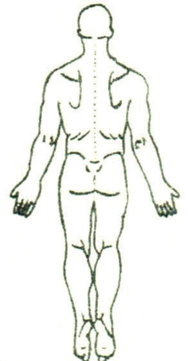
2. What started the pain? Injury /unknown (Please circle) If injury, please describe. ______________________________

____

3. When did the pain begin? (Approx date)____________________

Circle on the diagram the location of pain and / or dysfunction





4. How bad is the pain? NO PAIN — UNBEARABLE

At Worst	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
At Best	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Currently	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

5. Describe the pain: ☐ Sharp ☐ Shooting ☐ Dull Ache

6. Does the pain travel away from specific location? ☐ No ☐ Yes

If yes, describe where and how: ____________ ☐ Burning ☐ Numb ☐ Tingling

7. How bad is the referral pain? ☐ Mild ☐ Moderate ☐ Intense

8. HOW OFTEN DOES THE PAIN OCCUR?

☐ 1- CONSTANTLY (76-100% OF THE DAY)

☐ 2- FREQUENTLY (51-75% OF THE DAY)

☐ 3- OCCASIONALLY (26-50% OF THE DAY)

☐ 4- INTERMITTENTLY (0-25% OF THE DAY)

9. ARE YOUR SYMPTOMS CHANGING?

☐ GETTING BETTER ☐ COMES AND GOES

☐ NOT CHANGING ☐ GETTING WORSE

10. Have you had any injuries in the past? _____ (If yes, when and describe) ______________________________

____

11. Have you experienced any associated signs/symptoms such as:

Are there any bowel or bladder changes? ☐ Y ☐ N If Y How? ______________________________

Do you have breathing difficulties or chest pain? ☐ Y ☐ N If Y how?______________________________

Are there any visual or auditory changes? ☐ Y ☐ N If Y, how? ______________________________

12. Have you seen any other physician for this episode? ☐ Y ☐ N If Y, who?______________________________

13. What was the diagnosis & Treatment? ______________________________

14. Have you had these symptoms in the Past? ☐ Y ☐ N If yes, please describe when and with whom: ______________________________

____

15. What test(s) have you had for your symptoms? ☐ X-rays ☐ CT Scan ☐ MRI ☐ Other ☐ None

Results?______________________________

16. As a result of your symptoms, are you restricted in your ability to perform ☐ work ☐ exercise ☐ Sleep ☐ Normal daily activities ☐ No

If so, describe ______________________________

(More On Back)

How often do you regularly exercise? ☐ None ☐ 1-2 times per week ☐ 3-4 times per week ☐ 5 + times per week

How many alcoholic beverages do you consume in a week? Beer ____ Liquor ____ Wine____

How many cigarettes do you smoke in a week? ________________

What is your height and weight? Height ____‘____“ Weight __________lbs.

Are you Right or Left handed?________ Right or Left footed? ______

FOR EACH OF THE CONDITIONS LISTED BELOW, PLEASE 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		PAST	PRESENT		PAST	PRESENT	
☐	☐	HEADACHES	☐	☐	HIGH BLOOD PRESURE	☐	☐	EMPHYSEMA
☐	☐	NECK PAIN	☐	☐	HEART ATTACK	☐	☐	ASTHMA
☐	☐	UPPER BACK PAIN	☐	☐	CHEST PAINS	☐	☐	CHRONIC COUGH
☐	☐	MID BACK PAIN	☐	☐	STROKE	☐	☐	CHRONIC SINUSITIS
☐	☐	LOW BACK PAIN	☐	☐	RAPID HEART BEAT	☐	☐	DIABETES
☐	☐	SHOULDER PAIN	☐	☐	ANGINA	☐	☐	EXCESSIVE THIRST
☐	☐	ELBOW/UPPER ARM PAIN	☐	☐	AORTIC ANEURYSM	☐	☐	FREQUENT URINATION
☐	☐	WRIST PAIN	☐	☐	BLOOD DISORDER	☐	☐	DEPRESSION
☐	☐	HAND PAIN	☐	☐	KIDNEY STONES	☐	☐	DRUG/ALCOHOL DEPENDANCE
☐	☐	HIP/UPPER LEG PAIN	☐	☐	KIDNEY DISORDERS	☐	☐	SYSTEMIC LUPUS
☐	☐	ANKLE/FOOT PAIN	☐	☐	PAINFUL URINATION	☐	☐	HIV
☐	☐	JAW PAIN	☐	☐	BOWEL/BLADDER CHANGES	☐	☐	HYPO/HYPER THYROID
☐	☐	KNEE PAIN	☐	☐	ABNORMAL WEIGHT GAIN			
☐	☐	JOINT SWELLING/STIFFNESS	☐	☐	ABNORMAL WEIGHT LOSS			
☐	☐	ARTHRITS	☐	☐	ANOREXIA	**FEMALES ONLY**		
☐	☐	RHEUMATIOD ARTHRITIS	☐	☐	LOSS OF APPETITE	☐	☐	IRREGULAR MENSES
☐	☐	MUSCULAR INCOORDINATION	☐	☐	DIFFICULTY SWOLLOWING	☐	☐	BREAST LUMPS/SORNESS
☐	☐	FAINTING	☐	☐	ULCER	☐	☐	ENDOMETRIOSIS
☐	☐	VISUAL DISTURBANCES	☐	☐	IRRITABLE COLON	☐	☐	BIRTH CONTROL
☐	☐	DIZZYNESS	☐	☐	HEPATITIS	☐	☐	HORMON REPLACE THERAPY
☐	☐	TINNITUS (EAR NOISES)	☐	☐	LIVER/GALL BLADDER DISORDER			
☐	☐	CANCER	☐					

INDICATE IF AN IMMEDIATE FAMILY MEMBER HAS HAD ANY OF THE FOLLOWING

☐	☐	CHRONIC BACK PROBLEMS	☐	☐	RHEUMATIOD ARTHRITIS	☐	☐	CANCER
☐	☐	CHRONIC HEADACHES	☐	☐	HEART PROBLEMS	☐	☐	DIABETES
☐	☐	HIGH BLOOD PRESSURE	☐	☐	SYSTEMIC LUPUS	☐	☐	OTHER

Do you have a disability rating? ☐ YES ☐ NO RATING % ______ DATE RECEIVED RATING? ______________________

List all prescription and over the counter medications you are taking

____

List all surgical procedures you have had and times you have been hospitalized including pregnancies.

____

List any head injuries or concussions and date

____

List all fractures: Location and date

____

Patient Signature:____ **Date:**______________________

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

____

Signature of Patient or Legal Guardian Date

FINANCIAL POLICY

Tea Chiropractic & Rehab
725 E. Figzel Ct. #104, Tea, SD 57064

Dear Patient,

Thank you for choosing us as your chiropractic & rehab care provider. The following is our financial policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to direct them to our Office Manager.

We require that all patients read and sign our Financial Policy, as well as complete our Patient Information and HIPAA Acknowledgement of Receipt of Notice of Privacy Practices forms prior to receiving treatment.

We accept most health insurance plans, however you must understand that:

1. Your Co-Payment is due at the time that services are rendered. The patient's responsibility portion of the bill is due in full within 10 business days of receipt of the monthly statement [unless prior payment plans have been previously set forth and agreed upon with our office].

2. Your health benefits policy is a contract between You, your Employer, and the Health Insurance Company. Tea Chiropractic and Rehab is **NOT** a party to that contract. Our relationship is directly with you only. We will assist you with understanding your benefit: by verifying coverage, determining deductible amounts, as well as estimating which services are covered and non-covered benefits to the best of our ability at the time of your visit.

3. All charges are the full responsibility of the patient, regardless of insurance coverage. Not all services are a covered benefit in all contracts. You may have a benefit limit for certain services. Some health insurance plans arbitrarily select certain services they will not cover. Fees for these services alone with unpaid deductibles and co-payments are due at the time of service.

4. If the health insurance company does not respond to the claim within 30 days, we ask that you contact the carrier directly to help expedite the process. If the insurance company does not pay the claim in 45 days, we may require that you pay the balance in full.

5. We accept: cash, personal checks, money orders, debit cards, Visa, MasterCard and Discover. Our office charges a $20.00 NSF fee for all returned checks. Your account may be turned over to collections if delinquent for more than 90 days from the date of the first monthly statement sent. You are responsible for all fees, including a $20.00 collection fee, which may incur if action is taken to collect an overdue balance.

We understand that temporary financial difficulties may affect timely payment of your balance. We encourage you to discuss any such issues with us, so that we can assist you in the management of your account.

Thank you for choosing us as your Chiropractic & Rehab provider. We appreciate your trust in us, and the opportunity to serve you.

Patient's Signature: ______________________________________ Date: __________________
(Or Parent/Legal Guardian)