Welcome to Main Place Chiropractic

Today's Date:

1 PATIENT INFORMATION

NAME: _____
first middle last

Address _____ # ____
City/State/Zip _____

Home Phone : (____) _____ - _____
Cell Phone : (____) _____ - _____
Work Phone: (____) _____ - _____

E- mail Address: _____

Sex: ☐ M ☐ F Age____ Birth date ___/___ /___
Social Security # _____-____ - _____
Driver's License # _____
Status: ☐ single ☐ married ☐ widowed ☐ separated
Number of children: ____ List Ages: _____

Employer Information

Occupation: _____
Employer: _____
Emp. Address: _____
City /State/Zip _____

Spousal Information

Name of Spouse: _____
Birth date: ____/____/____
Employer: _____

2 In CASE of EMERGENCY

Name to Contact _____
Relationship _____
Home Phone (____) _____ - _____
Work Phone (____) _____ - _____

3 INSURANCE INFORMATION

Who is responsible for account ? ☐ Self ☐ Other
If other, relationship to patient _____

Insurance Company _____
Group # _____
Member I.D. # _____
If Insurance is under other name:
Subscriber's Name: _____
Subscriber's Social Sec. #: _____ - ____ - _____
Birth Date of Subscriber ____/____/_____

Additional Insurance

Subscriber's Name _____
Relationship to Patient _____
Subscriber's Social Sec # _____ - ____ - _____
Birth Date of Subscriber ____/____/_____
Insurance Co. _____
Group # _____
Member I.D. # _____

4 ACCIDENT INFORMATION

Is Condition due to accident? ☐ Yes ☐ No
If yes, continue.....
Date of accident ____/____/_____
Type of accident: ☐ auto ☐ work ☐ home ☐ other
To whom have you reported your accident?
☐ Auto Ins. ☐ Employer ☐ Ins. Co. ☐ Work Comp.

Attorney Information (If applicable)

Attorney's Name _____
Address _____
City/State/Zip _____
Phone Number (____) _____ - _____

5 *To whom may we thank for referring you to our office ?* _____

☞ Please submit your insurance card so that the front staff can make a copy of it. Thank You !

6 PATIENT CONDITION Patient:

1 Reason for Visit :

- ☐ Headache
- ☐ Neck pain
- ☐ Upper back pain
- ☐ Pain into arms
- ☐ Mid back pain
- ☐ Chest pain
- ☐ Elbow pain
- ☐ Forearm pain
- ☐ Shoulder pain
- ☐ Wrist pain
- ☐ Weak hand grip
- ☐ Cold hands
- ☐ Low back pain
- ☐ Pelvis / Hip pain
- ☐ Pain into legs
- ☐ Knee pain
- ☐ Numbness or tingling into arms / hands
- ☐ Numbness or tingling into legs / foot
- ☐ _____

2 When did your symptoms first occur ?

Onset Date ____/____/____

___days ___weeks ___months ___years

How did it occur ?

- ☐ Chronic
- ☐ Injury
- ☐ Gradually
- ☐ Unknown
- ☐ Stress
- ☐ Work

or describe :

_____

_____

3 Describe your current condition or pain :

- ☐ Sharp
- ☐ Dull
- ☐ Severe
- ☐ Mild
- ☐ Burning
- ☐ Cold
- ☐ Throbbing
- ☐ Hot
- ☐ Shooting
- ☐ Spasm
- ☐ Gripping
- ☐ Stiff
- ☐ Stabbing
- ☐ Tight
- ☐ Numbness
- ☐ Aching
- ☐ Tingling
- ☐ Cramps
- ☐ _____

4 How often do you have this pain ?

- ☐ Occasional (25 % of the time)
- ☐ Intermittent (50 %)
- ☐ Frequent (75%)
- ☐ Constant (100%)

5 What makes your condition worse ?

- ☐ Movement
- ☐ Lying down
- ☐ Sitting
- ☐ Bending
- ☐ Walking
- ☐ Lifting
- ☐ Standing
- ☐ Stooping
- ☐ Work
- ☐ Rest
- ☐ Exercise
- ☐ Sleep
- ☐ Other:_____

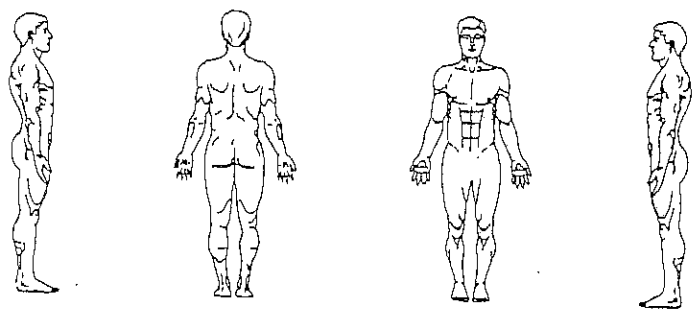
6 Since it began, is your condition:

- ☐ Getting Worse
- ☐ No Change / Same
- ☐ Improving

7 Rate your pain level *(circle a number)* 0 1 2 3 4 5 6 7 8 9 10

No Pain ..... Slight Pain.... ..... Moderate Pain..... Severe Pain

8 Please mark an ***X*** or ***circle*** area where you have pain or symptoms.



9 Please list your current:

Height ___ ft.____in.
Weight _____ lbs.

Recently, have you:

- ☐ lost weight _____lbs.
- ☐ gained weight_____lbs.
- ☐ remained the same

10 Can you perform daily home activities ?

- ☐ Yes
- ☐ Yes, with some help
- ☐ Very Limited
- ☐ Not at all

Can you perform your work duties ?

- ☐ Yes
- ☐ Yes, with some help or caution.
- ☐ Limited to light duty, restrictions
- ☐ None at all

Current Stress Levels

- ☐ None to mild.
- ☐ Average / Normal
- ☐ Moderate
- ☐ Extreme

11 What past treatment have you had for this condition:

- ☐ Chiropractic
- ☐ Physical Therapy
- ☐ Medication
- ☐ Bed Rest
- ☐ Injection
- ☐ Surgery
- ☐ Analgesics
- ☐ Other

Have you had any X-rays, MRI or other diagnostic test(s) for this condition ?

7 PATIENT HEALTH QUESTIONNAIRE

Patient:

- If you ever had a listed compliant in the past, please check that symptom in the **Past column.**
- If you are presently troubled by a particular symptom, check that symptom in the **Present column.**
- Knowledge of these conditions may influence the type of treatment / therapy you receive.

past	*present*		*past*	*present*		*past*	*present*	
☐	☐	Neck pain	☐	☐	Rapid heart beat	☐	☐	Difficulty in Swallowing
☐	☐	Shoulder pain	☐	☐	Chest pains	☐	☐	Emphysema
☐	☐	Upper arm pain	☐	☐	Loss of appetite	☐	☐	Arthritis
☐	☐	Elbow pain	☐	☐	Anorexia	☐	☐	Rheumatoid arthritis
☐	☐	Hand pain	☐	☐	Abnormal Weight Gain ☐	☐	☐	Epilepsy
☐	☐	Wrist pain	☐	☐	Abnormal Weight Loss	☐	☐	Constipation
☐	☐	Upper back pain	☐	☐	Excessive thirst	☐	☐	Ulcer
☐	☐	Low back pain	☐	☐	Chronic cough	☐	☐	Liver / Gall Bladder
☐	☐	Pain in upper leg or hip	☐	☐	Chronic sinusitis	☐	☐	Kidney stones
☐	☐	Pain in lower leg or knee	☐	☐	Heart Burn / Indigestion	☐	☐	Hepatitis
☐	☐	Pain in ankle or foot	☐	☐	Depression	☐	☐	Bladder Infection
☐	☐	Jaw Pain	☐	☐	Aortic Aneurysm	☐	☐	Kidney Disorders
☐	☐	Swelling, Stiffness of Joint	☐	☐	High Blood Pressure	☐	☐	Abdominal pain
☐	☐	Fainting	☐	☐	Angina	☐	☐	Irritable Colon
☐	☐	Visual Disturbances	☐	☐	Heart Attack	☐	☐	Colitis
☐	☐	Convulsions	☐	☐	Stroke	☐	☐	Irregular Menstrual Flow
☐	☐	Dizziness	☐	☐	Asthma	☐	☐	PMS
☐	☐	Headaches	☐	☐	Tumor	☐	☐	Breast Soreness or Lumps
☐	☐	Muscular Incoordination	☐	☐	Cancer	☐	☐	Endometriosis
☐	☐	Tinnitus (ringing in ears)	☐	☐	Blood Disorder	☐	☐	HIV / AIDS
☐	☐	General Fatigue	☐	☐	Dermatitis/Rash	☐	☐	Prostate problems
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	Abnormal Urination

If a Family member has had any of the following, please mark the appropriate box:

☐ Cancer	☐ Rheumatoid Arthritis	☐ Diabetes	☐ Heart Problems	☐ Chronic Headaches
☐ Strokes	☐ High Blood Pressure	☐ Lupus	☐ Lung Problems	☐ Chronic Back Pain

EXERCISE
- ☐ None
- ☐ Light
- ☐ Daily
- ☐ Moderate
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor
- ☐ Repetitive Arm Movements

HABITS
- ☐ Smoking
- ☐ Alcohol
- ☐ Coffee/Caffeine
- ☐ High Stress Level

Hours Sleep _____

MEDICATIONS

_____

_____

_____

Allergies: _____

_____

PAST INJURIES / SURGERIES Date — Description

Falls _____ _____

Head Injuries _____ _____

Auto Accidents / Injuries _____ _____

Work Related Injuries _____ _____

Surgeries _____ _____

Hospitalizations _____ _____

Female Only Are you pregnant and/or possibly pregnant ? ☐Yes ☐ No Due Date: ___/___/___

I certify that aforementioned information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient's Signature or Parent if Minor : _____ Date: _____

Main Place Chiropractic
1111 Town & Country Road, suite 6
Orange, CA 92868

Treating Doctor
- ❑ Timothy J. Doering, D.C.
- ❑ Michael Glandorf, D.C.
- ❑ Douglas French, D.C.
- ❑ Lorri Edwards, D.C.
- ❑ Jay Jazayeri, D.C.

Patient's Name: _____

SIGNATURE ON FILE

- I authorize the use of this form on all my insurance submissions.
- I authorize release of information to all my Insurance Companies .
- I understand I am responsible for my bill.
- I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
- I authorize direct payment to my doctor.
- I permit a copy of this authorization to be used in place of the original.
- I hereby authorize my treating doctor to endorse my name on any two party checks that are made payable in my name and my treating doctor's name (the treating doctor's name designated at the top of this form).

Signature of Responsible Party: X_____ **Date:** _____

OFFICE POLICY

- The patient is required to furnish this office with the insurance information for the company to bill. It is auto insurance, no payment is expected from the responsible party until the patient is released from treatment. Payment in full is expected within five (5) days of settlement with the insurance company. At that time, if no payment or settlement has been received, the patient or responsible party is solely responsible for payment of all services rendered.

- If we are to bill group insurance, payment in full for the first visit is expected at the time of the first visit. The patient is responsible for all charges, such as supplements , orthopedic supplies and the deductible amount not covered by said insurance company. Payment is expected at the time services are rendered unless prior arrangements have been made. Patient is also responsible for any co-insurance due at the time services are rendered.

- If there is no insurance and an attorney is involved, the patient is required to furnish our office with his/her name, address and phone number. A lien will be filed against the suit. No payment will be expected until settlement of said lawsuit. Payment in full for services rendered will be made within five (5) days of the settlement. If no settlement is reached, patient is solely responsible for all charges incurred.

- In the event that the patient has a third party recovery and also has a health care plan that utilizes a managed care program with the said doctor as a contracted provider, the patient understands that upon recovery of third party settlement, the doctor will be eligible to seek payment from the member and/or patient for the difference between the doctor's usual and customary charges and the fee scheduled amounts that the doctor has contracted with the managed care agreement.

- Signing this agreement acknowledges that the responsible party has read and understands the above terms and conditions and agrees never to rescind this document. The court will find this agreement legal and binding.

Signature of Responsible Party: X_____ **Date:** _____

* For Spanish speaking only patient, the contents of this form was translated to the patient by: _____

INFORMED CONSENT to CHIROPRACTIC TREATMENT

Patient's Name:

- I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named above, for whom I am legally responsible) by the doctor of Chiropractic (treating doctor) listed below and/or other licensed doctors of Chiropractic who now or in the future treat me while employed by, working or associated with my treating doctor or serving as back-up doctor for my treating doctor, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

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- I understand that all doctors operating at Main Place Chiropractic are sole proprietor(s) that operate separate individual practices and are not affiliated with any of the other doctor(s) that are also practicing on the premise of Main Place Chiropractic other than serving as back-up doctor for each other in the event that the treating doctor is not available (i.e. vacation relief, sick relief, etc.).

- I have had the opportunity to discuss with my treating doctor of Chiropractic and /or with other office or clinic personnel and/or other doctor serving as back-up treating doctor the nature and purpose of Chiropractic adjustments and procedures. I understand that results are not guaranteed.

- I understand and I am informed that, as in the practice of medicine, in the practice of Chiropractic there are some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

- I have read or have read to me (or translated), the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above - named procedures. I intend this consent form to cover the entire course of treatment for my present condition and /or any other condition(s) for which I seek treatment / care.

Signature of Patient: X :_____ **Date:** _____

- If patient is a minor or physically incapacitated, please indicate relationship to patient and sign at X.

Signature of Patient's Representative: X _____ Date:_____

Relationship to patient: _____

* For Spanish speaking only patient, the contents of this form was translated to the patient by: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
MAIN PLACE CHIROPRACTIC

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **Main Place Chiropractic's** "NOTICE OF PRIVACY PRACTICES," revision date September 26, 2003.

As required by the Privacy Regulations, _____ from
Name of Staff Member
Main Place Chiropractic has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that **Main Place Chiropractic** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

☐ I wish to file a "Request for Restriction" of my Protected Health Information.

☐ I wish to file a "Request for Alternative Communications" of my Protected Health Information.

☐ I wish to object to the following in the "Notice of Privacy Practices:"

_____

_____

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

_____ _____
Signature Date

_____
Print Name

_____
(OFFICE USE ONLY)

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe)_____

_____

_____

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PATIENT'S PAYMENT AGREEMENT

Patient's Name:

- I understand that my insurance or health care plan may not provide for such items as deductibles, co-payments , non-covered services, or charges which exceed insurance company fee limits / allowances.
- In the event that my insurance or health care plan does not provide coverage for all of the above items, I understand that I will remain financially responsible for:

1. Unpaid deductibles
2. Co-payments
3. Non-covered services.

- With the above exceptions, I understand the doctor will accept as payment in full, for services rendered, the proceeds of applicable insurance, or health care plan benefits.
- I will satisfy my portion of the doctor's s charges in the following manner

__ I will pay each visit
__ I will pay weekly
__ I will pay monthly
__ Other _____
__ Due to financial hardship, I am unable to commit any type of payment at this time.

- At the conclusion of my active treatment, I will make new arrangements to satisfy the remaining balance.

INDIVIDUAL CONSIDERATION CONTRACT

- I understand , due to my personal situation and in an effort to enable me to comply with the doctor's recommendations for my condition, this Chiropractic Clinic is extending an Individual Consideration Contract special discount to me. I agree to pay for non-covered services or co-payments in the following manner:

$____ per visit
$____ per week
$____ per month

$ ____ per uncovered service: _____
$ ____ per uncovered service: _____

Signature: X _____ **Date:** _____
(Patient's and/or Responsible Party Signature)