Danville Chiropractic: 1995 E. Main St, Danville IN 46122 Phone 317-745-5100

Patient Name____ Date of Birth: ______/______/______

Nickname: ____ Social Security#_________-_________-_________

Address: ____City ____________ State______ Zip___________

Email Address: ____ Age:_________ ☐ Male ☐ Female

Cell Phone (________)_________________________ Other(________)___________________________ Circle Primary Number

Check appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other: ______________

Occupation: ____ Employer:____

Employer Address/City/St/Zip: ____

Employer Telephone: (________)___________________

Spouse/Patient's Guardian Name _______________________________ Spouse's Employer______________________________

Who may we thank for referring you in? ____

How did you hear about us? ☐ Referral ☐ Mail ☐ Facebook ☐ Google ☐ Location ☐ Insurance ☐ Other: _______

Person to contact in case of an emergency_______________________________ Phone______________________________

Family Medical Doctor: ____ Phone: ____________________________

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐ YES ☐ NO

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

____ ______________________________

Parent or Guardian Signature Date

Responsible Party

Name of The Person responsible for this account ____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other: ____

Social Security#__________-__________-_____________ Date of Birth: _________/_________/_____________

Address/City/St/Zip____

Cell Phone (_______) ____________________________________ Other: (_______)_____________________________________

E-Mail ____

Is the person currently a patient at our office? ☐ Yes ☐ No

Patient Name____ Date of Birth: ______/______/______

Do you have any medical insurance? ☐ No ☐ Yes (if yes, complete the following)

Name Primary Insurance Company: ____ ________________________

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other: ________________________________

Primary Insured Name: ____

Date of Birth: _________/_________/____________ Social Security#_________-_________-____________

Primary ID/Member Number:___________________________________ Group # ______________________________

Name Secondary Insurance Company: ____ ________________________

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other: ________________________________

Secondary Insured Name: ____

Date of Birth: _________/_________/____________ Social Security#_________-_________-____________

Secondary ID/Member Number:___________________________________ Group # ______________________________

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Peak Health Chiropractic PC, dba Danville Chiropractic** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been* or *will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of ___________________, 20 ______. x____

(Patient signature)

x____ x____

(Signature of Guardian if applicable) (Please print patient name)

Patient Name______________________________ Date of Birth: ______/______/______

Health History

Chief Complaint: ______________________________

History of Present illness:

Location: ______________________________
(Where is the pain/problem?)

Quality: ______________________________
(Example: normal vs abnormal color, activity, etc..)

Severity: ______________________________
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: ______________________________
(How long have you had this pain/ problem? When did it start?)

Timing: ______________________________
(Does the pain/problem occur at a specific time?)

Context: ______________________________
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms ______________________________
____
(What other associated problems have you been having?)

Modifying Factors ______________________________
____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles	NO	YES	Anemia	NO	YES	Back Trouble	NO	YES	Hepatitis	NO	YES
Mumps	NO	YES	Bladder Infection	NO	YES	High Blood Pressure	NO	YES	Ulcer	NO	YES
Chicken Pox	NO	YES	Epilepsy	NO	YES	Low Blood Pressure	NO	YES	Kidney Disease	NO	YES
Whooping Cough	NO	YES	Migraine Headaches	NO	YES	Hemorrhoids	NO	YES	Thyroid Disease	NO	YES
Scarlet Fever	NO	YES	Tuberculosis	NO	YES	Asthma	NO	YES	Bleeding Tendency	NO	YES
Diphtheria	NO	YES	Diabetes	NO	YES	Hives of Eczema	NO	YES	Any other Disease	NO	YES
Smallpox	NO	YES	Cancer	NO	YES	AID & HIV	NO	YES	(Please List)		
Pneumonia	NO	YES	Polio	NO	YES	Infectious Mono	NO	YES	______________		
Rheumatic Fever	NO	YES	Glaucoma	NO	YES	Bronchitis	NO	YES	______________		
Arthritis	NO	YES	Hernia	NO	YES	Mitral Valve Prolapses	NO	YES	______________		
Venereal Disease	NO	YES	Blood or Plasma Transfusion	NO	YES	Stroke	NO	YES	______________		
						Date of Last Check Xray	________				

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
______________________	__________	______________________
______________________	__________	______________________
______________________	__________	______________________

Medication: (include nonprescription)

____
____

Are you taking any medications (prescription or over the counter) for acid indigestion?
O NO O YES if yes what type: ______________________________

Have you ever taken Fen-Phen/Redux? NO YES

Patient Social History:

Marital Status	Single	______	Married	______	Seperated	______	Divorced	______	Widowed	______
Use of Alcohol	Never	______	Rarely	______	Moderate	______	Daily	______		
Use of Tobacco	Never	______	Rarely	______	Moderate	______	Daily	______		
Use of Caffinee	Never	______	Rarely	______	Moderate	______	Daily	______		
Use of Drugs	Never	______	Rarely	______	Moderate	______	Daily	______		
Excessive Exposure At home or Work to	Fumes	______	Dust	______	Solvents	______	Airborne Particles	______	Noise	______

CLINICIAN SIGNATURE: ______________________________ **DATE REVIEWED:** ______________________

Patient Name____ Date of Birth: ______/______/______

Family Medical History:

	Age	Disease	If Deceased, Cause of Death
Father	_________	____________________	____________________
Mother	_________	____________________	____________________
Siblings	_________	____________________	____________________
	_________	____________________	____________________
	_________	____________________	____________________
Spouse:	_________	____________________	____________________
Children:	_________	____________________	____________________
	_________	____________________	____________________
	_________	____________________	____________________

Indicate which of the below you have experienced in the last 1-2 months.
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory					
Asthma	1	2	3	4	5
Stuffy Nose	1	2	3	4	5
Hay Fever	1	2	3	4	5
Sore Throat	1	2	3	4	5
Chronic Cough	1	2	3	4	5
Frequent Sneezing	1	2	3	4	5
Itchy/Watery Eyes	1	2	3	4	5
Drainage	1	2	3	4	5
Earache or Ear Infection	1	2	3	4	5
Itching	1	2	3	4	5
Hoarseness	1	2	3	4	5
Shortness of Breath	1	2	3	4	5
Wheezing	1	2	3	4	5

Neurological					
Headaches	1	2	3	4	5
Migraines	1	2	3	4	5
Dizziness	1	2	3	4	5
Numbness	1	2	3	4	5
Tingling	1	2	3	4	5
Pins and Needles in Hands and Feet	1	2	3	4	5

Muscular/Skeletal					
Muscle Aches	1	2	3	4	5
Fibromyalgia	1	2	3	4	5
Arthritis	1	2	3	4	5
Joint Pain	1	2	3	4	5
Low Back Pain	1	2	3	4	5
Neck Pain	1	2	3	4	5
Wrist/Hand Pain	1	2	3	4	5
Elbow Pain	1	2	3	4	5
Shoulder Pain	1	2	3	4	5
Hip Pain	1	2	3	4	5
Knee Pain	1	2	3	4	5
Ankle/Foot Pain	1	2	3	4	5
Pain b/t Shoulder Blades	1	2	3	4	5

General					
Fatigue	1	2	3	4	5
Malaise	1	2	3	4	5
Weakness, tiredness	1	2	3	4	5
Lightheadedness	1	2	3	4	5
Irritability	1	2	3	4	5
Constipation	1	2	3	4	5
Diarrhea	1	2	3	4	5
Feeling foggy	1	2	3	4	5
Forgetfulness	1	2	3	4	5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

______________________________________ ____________________

Signature of the Patient, Parent or Guardian Date

Doctor's Review

______________________________________ ____________________

Signature of Doctor Date

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME:_______________________________________ DOB:_______________ DATE:______________ Acct# _______________

For any YES answer, please notify the Doctor.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment:____

2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment:____

3. Do your hands or arms fall asleep regularly? NO YES
   Comment:____

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment:____

5. Do you suffer from a loss of handgrip strength? NO YES
   Comment:____

6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment:____

7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: :____

8. Do your legs or feet fall asleep regularly? NO YES
   Comment:____

9. Do you have reduced feeling (sensation) or swellings in your legs, feet? NO YES
   Comment:____

10. Do you suffer from cold hands or feet? NO YES
    Comment:____

11. Do you suffer from headaches, dizziness or memory loss? NO YES
    Comment:____

12. Do you have difficulty maintaining your balance? NO YES
    Comment:____

13. Do you suffer from vertigo or blurred vision? NO YES
    Comment:____

14. Do you suffer from a reduced hearing capacity? NO YES
    Comment:____

15. Do you suffer from ringing in your ears? NO YES
    Comment:____

16. Do you have bladder or bowel control problems on a regular basis? NO YES
    Comment:____

Provider Statement of Patient/Client Rights and Responsibilities

- Patients/Clients have the **right** to be treated with dignity and respect.
- Patients/Clients have the **right** to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
- Patients/Clients have the **right** to have their treatment and other patient information kept private. Only by law may records be released without patient permission.
- Patients/Clients have the **right** to access care easily and in a timely fashion.
- Patients/Clients have the **right** to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
- Patients/Clients have the **right** to share in developing their plan of care.
- Patients/Clients have the **right** to the delivery of services in a culturally competent manner.
- Patients/Clients have the **right** to information about the organization, its providers, services, and role in the treatment process.
- Patients/Clients have the **right** to information about provider work history and training.
- Patients/Clients have the **right** to information about clinical guidelines used in providing and managing their care.
- Patients/Clients have a **right** to know about advocacy and community groups and prevention services.
- Patients/Clients have a **right** to freely file a complaint, grievance, or appeal, and to learn how to do so.
- Patients/Clients have the **right** to know about laws that relate to their rights and responsibilities.
- Patients/Clients have the **right** to know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's rights and responsibilities policy.
- Patients/Clients have the **responsibility** to treat those giving them care with dignity and respect.

- Patients/Clients have the **responsibility** to give providers the information they need, in order to provide the best possible care.
- Patients/Clients have the **responsibility** to ask their providers questions about their care.
- Patients/Clients have the **responsibility** to help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan.
- Patients/Clients have the **responsibility** to let their provider know when the treatment plan no longer works for them.
- Patients/Clients have the **responsibility** to tell their provider about medication changes, including medications given to them by others.
- Patients/Clients have the **responsibility** to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- Patients/Clients have the **responsibility** to let their provider know about their insurance coverage, and any changes to it.
- Patients/Clients have the **responsibility** to let their provider know about problems with paying fees.
- Patients/Clients have the **responsibility** not to take actions that could harm others.
- Patients/Clients have the **responsibility** to report fraud and abuse.
- Patients/Clients have the **responsibility** to openly report concerns about quality of care.
- Patients/Clients have the **responsibility** to let their provider know about any changes to their contact information (name, address, phone, etc.).
- Patients/Clients have the **right** and the **responsibility** to understand and help develop plans and goals to improve their health.

I have read and understood my rights and responsibilities.

____ ____________________

Patient Signature Date

CHIROPRACTIC CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the Doctor of Chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations, and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, 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 for any future condition(s) for which I seek treatment.

Patient/Guardian Signature ________________________________ Date __________________

Witness Signature ____ Date __________________