SOUTHEAST
CHIROPRACTIC
THE MOTION CENTERS

Patient Personal/Confidential Data

Patient Name ____ Today's Date ____________
(First) (Middle Initial) (Last)

Home Address ______________________________ City______________ State ____ Zip ____________

Home #____________________ Cell # ______________________ Employer ________________________

Occupation _______________________ Work # ________________________ Date of Birth ____/____/____

Sex: Male / Female Marital Status _____ # of Children _____ Social Security # _______-_______-_______

How did you hear about our office? _______________________ **Email** __________________________

Name of Spouse ___________________________________ Spouse's Date of Birth ______/_______/______

Spouse's Employer ___________________________________ Contact # __________________________

Nearest Relative Not Living With You _________________________ Phone # ________________________

What is the purpose of this appointment? ____

What makes your condition better? ___________________________ Worse? ______________________

Have you ever been under chiropractic care before? ☐ Yes ☐ No Where _____________________________

Name of your Primary Care Doctor ______________________________ Practice Name ________________

Informed Consent to Chiropractic Treatment

I hereby request and consent the performance of chiropractic adjustments and other chiropractic procedures. This includes various modes of physical therapy and diagnostic radiographs performed on me, or on the patient named below, for whom I am legally responsible. I further understand that this may be performed by the Doctor of Chiropractic, Dr. Michael Silver, Dr. Jodie Silver, Dr. Richard Snyder, Dr. Crown Hoffman, Dr. Kate Hoffman, and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. This will include those employed by, working for, or associated with **SouthEast Chiropractic: The Motion Centers**.

I have had the opportunity to discuss with the attending physician and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments or other procedures. I understand that the results are not guaranteed. I understand and am informed that, as in the practice of medicine, the practice of chiropractic carries some risks to treatment, including, but not limited to, fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to anticipate and explain all risk and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedures which the physician feels are in my best interest, at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any conditions(s) for which I seek treatment at this facility.

Patient Signature (or Guardian) ____ **Date** ________

Patient Health Questionnaire

Patient Name ______________________ **Date** ______________

1. When did your symptoms start: ______________ **Describe your symptoms and how they began:**

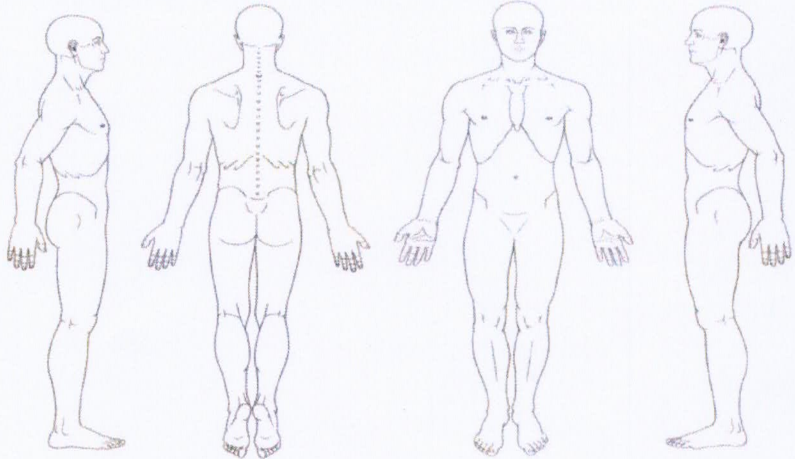
____

____

2. How often do you experience your symptoms?

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)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: ______________________

8. What activities make your symptoms better: ______________________

9. Who have you seen for your symptoms?

① No One ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

a. When and what treatment? ______________________

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* __________ ③ CT Scan *date:* __________
② MRI *date:* __________ ④ Other *date:* __________

10. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

11. What is your occupation?

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

12. What do you hope to get from your visit/treatment (select all that apply)**:**

① Reduce symptoms ③ Explanation of condition/treatment ⑤ How to prevent this from occurring again
② Resume/increase activity ④ Learn how to take care of this on my own ⑥

Patient Signature ______________________ **Date** ______________

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________ **Date** ______________

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [Feet | Inches] Weight [ ] lbs.

For each of the conditions listed below, 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	Condition
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular Incoordination
○	○	Visual Disturbances
○	○	Dizziness

Past	Present	Condition
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

Past	Present	Condition
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Use Tobacco Products
○	○	Drug/Alcohol Dependence
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	HIV/AIDS

Females Only

Past	Present	Condition
○	○	Birth Control Pills
○	○	Hormonal Replacement
○	○	Pregnancy
○	○	

Other Health Problems/Issues

Past	Present	Condition
○	○	
○	○	
○	○	

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ ______________

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

______________ ______________ ______________

______________ ______________ ______________

List all the surgical procedures you have had and times you have been hospitalized:

______________ ______________ ______________

______________ ______________ ______________

Patient Signature ______________________ **Date** ______________

Doctor's Additional Comments

____

____

____

Doctors Signature ______________________ **Date** ______________

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature:____________________________________ **Date:**________________

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any other services that he/she deems necessary in my case: and I further authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the services rendered to me including and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds or employers.

Patients Signature:____________________________________ **Date:**________________

Signature of Parent or Guardian:____________________________ Date:________________

HIPPA POLICY ACKNOWLEDGMENT

I acknowledge that I have read and have been given a copy of the HIPPA POLICY at SouthEast Chiropractic:The Motion Centers.

Patient Signature____________________________________ **Date**________________

Witness ____________________________________ Date________________

Payment Policy

Our Primary goal is to provide chiropractic care to all of our patients and we wish to spend our time and energy toward that end. It is necessary to establish payment policies to avoid any misunderstandings. Therefore, we wish to clarify the following policies of our practice.

1. Payments for office visits are expected at the time services are rendered. Any co-payments and unpaid deductibles due to our office are expected at the time of your visit.
2. Even though you may have an insurance claim pending, you will receive a statement each month for the outstanding balance of your account. We cannot accept responsibility for collecting an insurance claim or for negotiating a disputed claim. Insurance reimbursement is a contract between you and your carrier. You are responsible for your bills regardless of what your insurance pays.
3. Bills which remain unpaid for over 60 days will be charged 1 ½ % per month or part thereof which they are overdue.

I HAVE READ THIS PAYMENT POLICY AND UNDERSTAND THAT REGARDLESS OF MY INSURANCE COVERAGE I MAY HAVE, I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT WITHIN THE USUAL LIMITS OF THIS POLICY.

______________________________ Patient Signature

______________________ Date

Automobile Accidents or Workman's Comp ONLY

It has been our experience that it is wise for our patients to have a complete understanding of our office policy, fees, and insurance filing. If you were involved in an auto accident, or a related injury we will gladly accept your case with the following regulations:

1. If you have an attorney, notify us as soon as possible and ask him/her to send us a letter of representation. All bills will be sent to your attorney for you.
2. If you do not have an attorney, you will need to provide us with a police report and all information for billing the insurance company. No bills or copies of bills, will be given to you or to the insurance company until we have spoken to the adjuster and they have indicated that they will do everything to protect the doctor's interest.
3. If you do not have an attorney and do not give us the information needed to bill the insurance company by your second visit at our office, you will be expected to make a payment at that time. Once your case has been settled and all medical bills paid, if an overpayment exists on your account (due to having more than one insurance) we will forward the overpayment to you. By signing below I am agreeing that I have read and do understand I will not be presented with copies of bills until the proper procedures have been followed.

______________________________ Patient Signature

______________________ Date

Witness: ______________________________