Patient Name: _____ Date: _____

Subjective Complaint - Please **Circle** All Areas That Apply To Your Complaint

Head Neck Shoulder Arms Elbow Wrist Chest Abdomen Mid-Back Lower Back
Sacral Pelvis Buttocks Hips Legs Knee Ankle Foot Sinus

Is this the original complaint? Yes No

Rate your pain from 1 - 10 with a score of 10 being severe. 0 1 2 3 4 5 6 7 8 9 10

Do you feel that Chiropractic is helping you reach your goal? Yes No

If you are an existing patient, today are you: Improved No Change Worse Exacerbation

_____

_____

Objective Findings

1 Inc tone
2 Sp w/TP
3 Sp w/TP & Ref
4 Sp w/guard

Glutl R L _____
Pirif R L _____
QLum R L _____
T-Spn R L _____
L-Spn R L _____

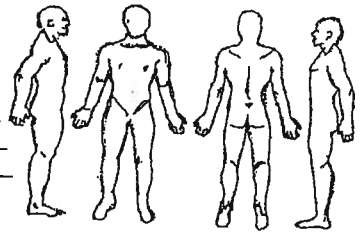
Rhomb R L _____
Lev Sc R L _____
C-Spn R L _____
Occip R L _____
Trap R L _____

SCM R L _____
Subscap R L _____
Scalene R L _____
Rot Cuff R L _____
_____ R L _____

Segmental Dysfunction Treatment

Level	Pain	Manipulation
C _____	_____	_____
T _____	_____	_____
L _____	_____	_____
S _____	_____	_____

Shou _____ Hip _____
Elbo _____ Knee _____
Wrist _____ Ank _____



Myofascial Release

1 2 3 4 _____
1 2 3 4 _____
1 2 3 4 _____
1 2 3 4 _____

Assessment/Re-exam Details

_____
_____
_____
_____

Plan

Continue PTP _____
_____
_____

Physiotherapy

Premod _____ Interferential _____ US _____
Russian _____ Micro_____ Int. Seg _____
Neuro Re-ed _____ Exercise _____ H/C_____

Recommended Frequency

Daily 1x 2x 3x 4x 5x Thswk Nxwk 10days 2wks 3wks 4wks 1mo PRN #wks_____

Treatment Codes (office use only)

NPX1 M1 M3 MED1 MED3 EM MR ES US H C IST NRED EXER TOSV OV

MRN

The Bone Joint Chiropractic

New Patient Application

Personal Information

Patient Name:_____

Date of Birth:_____ Age:_____ Sex: M F

Address:_____

City:_____ Zip:_____ State:_____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Driver's License #:_____

Social Security #:_____

Marital Status: S M D W

Employer:_____

Work Address:_____

City:_____ State:_____ Zip:_____

Spouse Information

Name:_____

Date of Birth:_____

Employer:_____

Cell Phone Number:_____

Work Phone Number:_____

Nearest Living Relative (not living with you)

Name:_____

Home Phone:_____

Cell Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Other Information

Who's responsible for bill? Self Employer Ins

Who referred you to our office?_____

Treatment Information:

What is your major complaint?_____

_____

Do you have any additional problems or comments?_____

_____

I authorize the doctor and staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I recognize it is my responsibility to inform this office of any changes in my medical status. Potential complications to these treatments may include stroke, disc herniation, fracture, and other less severe problems. You are encouraged to discuss those possibilities and any preexisting condition with the doctor prior to undergoing treatment. Fees are due at the time services are rendered. Patients understand that they are financially responsible for services rendered. If you have any questions, please ask your doctor. When you have full understanding, please sign and date below.

Patient or Guardian Signature:_____ Date:_____

THE BONE JOINT CHIROPRACTIC

PATIENT HISTORY

NOTE: The following questions may not seem to relate to your current health problem, but they are very important for the doctor to determine how well you may respond to chiropractic care and in determining the true cause of your problem.

ILLNESS – CIRCLE ANY OF THE FOLLOWING ILLNESSES YOU HAVE HAD OR HAVE

Angina	Diabetes	Hemorrhoids	Polio
Asthma	Diverticulitis	Hepatitis	Rheumatic Fever
Cardiac Disease	Emphysema	Hypoglycemia	Spinal Cord Injury
Cirrhosis	Epilepsy	Lupus	Thyroid problems
Chrohn's Disease	Gallbladder Disease	Multiple Sclerosis	Tuberculosis
Concussion	Gout	Pneumonia	Ulcers
Convulsions	Heart Attack	Arthritis	Cancer
Fracture	Stroke	Any Others:_____	

SURGERY – CIRCLE ANY OF THE FOLLOWING SURGERIES YOU HAVE HAD

Appendectomy	Gallbladder	Hysterectomy	Stomach
Bladder	Heart	Kidney	Tonsillectomy
Breast	Hemorrhoidectomy	Lung	Tubal Ligation
Cesarean Section	Hernia Repair	Prostate	Vasectomy
Colon	Any others:_____		

SYMPTOMS – CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOW OR PAST

Abdominal Pain	Ringing in ears	Loss of memory	Recent weight loss
Allergies	Eyes bothered by light	Nervous	
Drink alcohol	Face flushed	Numbness in fingers	**MEN ONLY**
Loss of balance	Fainting Spells	Numbness in toes	Urinate Frequently
Blood in Stool	Fatigue	Pins & Needles Arms	Difficulty starting urine
Shortness of Breath	Feet cold	Pins & Needles Legs	Wake to urinate
Buzzing in Ears	Fever	Palpitations	
Chest Pain	Can't Eat Certain Foods	Use more than one pillow	
Chewing Difficulty	Foot/ankle swelling	Sleeping Problems	**WOMEN ONLY**
Chronic Constipation	Generally run down	Loss of Smell	Birth Control Pills
Cold Sweats	Hands Cold	Smoke	Implants, IUD
Coughing up blood	Head feels heavy	Swallowing difficulty	Menstrual Cramping
Coughing up sputum	Headaches	Loss of taste	Menstrual Pain
Persistent Cough	Loss of hearing	Vision blurring	Date of Last menstrual
Chronic Diarrhea	Jaw pops or clicks	Tension	Period_____
Dizziness	Leg cramps sleeping	Lifts or orthotics	Pregnant or possible
Pain in ears	Leg cramps walking	Recent weight gain	

ARE YOU CURRENTLY TAKING ANY MEDICATIONS: YES NO PLEASE LIST

_____

_____

WHAT ARE YOUR LEISURE ACTIVITIES_____

WHAT ARE YOUR WORK ACTIVITIES_____

DO YOU HAVE CHILDREN: YES NO List age and sex of child

_____

LIST PERTINENT MEDICAL HISTORY FOR YOUR RELATIVES (parents, grandparent, siblings)

_____

We invite you to discuss with us any questions regarding our services. We cannot promise a care for any symptom, disease, or condition resulting from treatment in this clinic. We will always give our best care, and if the results are not acceptable, we will refer you to another provider who will assist your situation.

Patient Authorization for MEDICARE PATIENTS

I authorize the physician and/or staff of TBJC to release to the social security administration, Health Care Financing Administration or its intermediaries or carriers any information needed for this or any Medicare claim, I permit a copy of this Authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who may cause Medicare payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare.

Patient signature_____Date_____

Patient Authorization for PPO and HMO PATIENTS

I authorize the physician and/or staff of TBJC to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me care. I authorize and request my above named insurance company to pay directly to The Bone Joint Chiropractic the amount due for services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

Patient signature_____ Date_____

Patient Authorization for ALL PATIENTS

I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees relating to the collection of my debt. I also authorize my physician and TBJC to photograph me for medically related documentation purposes.

Patient signature_____ Date_____

Special Accommodations

If a patient requires an accommodation for their appointment, the individual or his/her representative must notify TBJC of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week's notice. Under the American with Disabilities Act, "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company." If a patient who has requested accommodations does not provide a minimum of 24 hours' notice to cancel the appointment or does not show to the scheduled appointment, all charges incurred by TBJC is the patient's responsibilities.

Patient signature_____Date_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Notice to patients: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgement, if you wish. ***I acknowledge that I have received a copy of the TBJC'S Notice of Privacy Practices.***

_____	_____	_____
Printed name	Signature	Date signed