PATIENT INTRODUCTION FORM

CLEVELAND CHIROPRACTIC ASSOCIATES, INC.

Name:____________________________________ Date____________ Birthdate____________ Age___
Address:____
City:______________________________State:_______ Zip:_____________ SS # __________________
Phone: (h)_________________________ (c)__________________________cell provider______________
Text Reminders: YES or NO
Email:____ Email Reminders: YES or NO
Married____ Single____ Other____ Name of Spouse____________________ No. of Children:______
Employer:______________________________________Occupation:____________________________
Emergency Contact:____ Ph# _________________________

Person responsible for this account if other than the patient? _________________________________
For my balance my preferred payment method: ☐ Cash ☐ Check ☐ Credit Card ☐Car/Work Ins.
How did you learn of this clinic:____

Insurance Information, Consent of Professional Services and Release of Information, Our Office Policy

I understand and agree that health and accident insurance policies are in 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 collections 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. However I clearly understand and agree that all serviced rendered to me are charged directly to me and I am personally responsible for payments. 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.

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 clinic services that he/she deems necessary in my care: and I further authorize him/her to disclose all or any part of my (patients) record to any person or corporation which is or maybe 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 clinics charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensations carriers, welfare funds, or the patients employer. Upon request, we have the detailed informed consent form but by signing below you accept all the possible chiropractic adjustment risk factors and authorize chiropractic care.

I understand that a no show fee of $45.00 after the SECOND missed appointment may be applied when no cancellation notice is given. Calling the office 24 hours in advance allows us to help another patient in your missed time slot. We truly understand that accidents can happen and are flexible with certain circumstances.

____ __________________
Patient / Parent-Guardian Signature (this represents a long term authorization for all occasions of service) Date

HIPPA NOTICE REQUIREMENTS

The practice is required by federal law to maintain the privacy of your protected health information (PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy with respect to your PHI. Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law. Is required to abide by the terms of this Privacy Notice. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains. Will distribute any revised Privacy Notice to you prior to implementation. Will not retaliate against you for filing a complaint.

Patient Signature ____Date________________

HEALTH QUESTIONNAIRE 1

CLEVELAND CHIROPRACTIC ASSOCIATES, INC.

Please list your current complaints

1.________________________________
How long ?______________
Is it:
- ❑ Dull
- ❑ Sharp
- ❑ Ache
- ❑ Numb / Tingling
- ❑ Stabbing
- ❑ Pain Radiates to__________________

- ❑ Constant
- ❑ Occasional
- ❑ Staying the same
- ❑ Getting worse

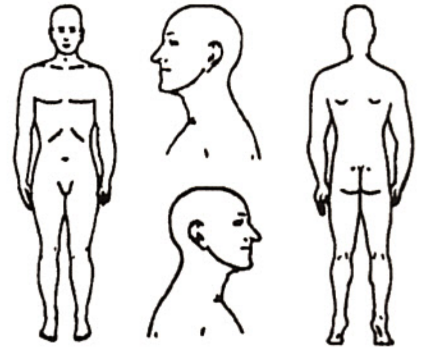
- ❑ Mild
- ❑ Moderate
- ❑ Severe
- ❑ Worse in the morning
- ❑ Worse in the evening

2.________________________________
How long ?______________
Is it:
- ❑ Dull
- ❑ Sharp
- ❑ Ache
- ❑ Numb / Tingling
- ❑ Stabbing
- ❑ Pain Radiates to__________________

- ❑ Constant
- ❑ Occasional
- ❑ Staying the same
- ❑ Getting worse

- ❑ Mild
- ❑ Moderate
- ❑ Severe
- ❑ Worse in the morning
- ❑ Worse in the evening

3. Does your condition affect: Sleep Work Daily Routine Sitting Standing



4. What makes it better? ________________________________
5. What makes it worse?________________________________
6. What Doctor's have you seen for this?________________________
7. Types of treatment?________________________________
8. Results ________________________________

Notes. ______________________________
____
____
____
____

ARE YOU PREGNANT?
❑ YES ❑ NO

CHIROPRACTIC HISTORY
When did you last see a chiropractor:__________________ Dr.______________________________
Why did you see the Chiropractor?______________________________ Were you helped:_________
Reason for changing Chiropractors:______________________________

HEALTH QUESTIONNAIRE 2

Patient: ______________________________ Please mark each of the conditions that apply to you

Past	Present		Past	Present		Past	Present	
❑	❑	Low back pain	❑	❑	Lung problems	❑	❑	Medication side effects
❑	❑	Mid back pain	❑	❑	Difficulty breathing	❑	❑	Cancer __________
❑	❑	Pain between shoulders	❑	❑	Kidney problems	❑	❑	HIV positive
❑	❑	Neck Pain	❑	❑	Thyroid problems	❑	❑	Blood thinner use
❑	❑	Pain all over	❑	❑	Sleep problems	❑	❑	Diabetes
❑	❑	Muscle aches	❑	❑	Depression	❑	❑	Cold hands and feet
❑	❑	jaw pain	❑	❑	Cigarette / tobacco use	❑	❑	Varicose veins
❑	❑	Trouble walking	❑	❑	Alcohol / Drug use	❑	❑	Gall Bladder trouble
❑	❑	Leg / Foot Numbness	❑	❑	High Cholesterol	❑	❑	Abdominal pain
❑	❑	Dizziness	❑	❑	High blood pressure	❑	❑	Constipation
❑	❑	Fainting	❑	❑	Low blood pressure	❑	❑	Diarrhea
❑	❑	Headaches	❑	❑	Stroke history	❑	❑	Hemorrhoids
❑	❑	Migraines	❑	❑	Pacemaker	❑	❑	Digestive problems
❑	❑	Fibromyalgia	❑	❑	Urinary problems	❑	❑	Difficulty swallowing
❑	❑	Tension / Irritability	❑	❑	Eye problems	❑	❑	Sinus
❑	❑	Bruise easily	❑	❑	Ringing in ears	❑	❑	Allergies __________
❑	❑	Neurological problems	❑	❑	Ear problems	❑	❑	Asthma
			❑	❑	Dental problems	❑	❑	Auto-Immune disorder

1. List any medications you are taking: ______________________________
2. Please list all doctors you are currently seeing: ______________________________
3. Has any Doctor or other professional advised you to "Go see a Chiropractor" ❑ YES ❑NO Name ______________

PAST HISTORY

List any past auto collisions: ______________ Care received? ______________
List any past work injuries: ______________________________
List any past sports, recreational, or home injuries ______________________________
Please describe any past conditions and treatment received: ______________________________
Please list any past hospitalizations and surgeries: ______________________________

FAMILY HISTORY

Father's side: ❑ Heart Disease ❑ Cancer ❑ Diabetes ❑ Neurological problems ❑ Arthritis Other__________

Mother's side: ❑ Heart Disease ❑ Cancer ❑ Diabetes ❑ Neurological problems ❑ Arthritis Other__________

Is there any other family history? __________

***************DO NOT WRITE BELOW THIS LINE***************

Patient Accepted? ❑ YES ❑ NO Doctor's Signature ______________________