T1 T2 T3

AP Cerv _______ AP Lumbo _______
Lat Cerv _______ Lat Lumbo _______

9050 Carothers Pkwy.
Suite 105
Franklin, TN 37067

Personal Information

Name. ________________________ Age. _____Date. ___/___/_____
Address. ____
City / State / Zip. ____
Home Phone #_______________ Cell Phone #_________________
Email Address. _________________________
Male._____ Female._____ Single.____ Married.____Separated.___
DOB. ___/___/____ Patient's Social Security #. ____- ___ -_____
Occupation. ______________ Employer's Name.________________
Spouse's Name. ____________ Spouse's Occupation. _____________
Names and Ages of Children. _________________________________
____
Whom may we thank for referring you? __________________________

Your Health Profile

Health Concerns List According to their Severity	Rate of Severity 1 = Mild 10 = Worst imaginable	When did these Problems begin?	Injury Related?
1. ________________	__________	______________	____________
2. ________________	__________	______________	____________
3. ________________	__________	______________	____________
4. ________________	__________	______________	____________

Are the symptoms constant or do they come and go? __________________________
If you are experiencing pain, how would you describe it? (*Please circle all that apply)*

Sharp Dull Ache Numbness Shooting Stiffness
Throbbing Swollen Burning Cramping

Does the pain travel or radiate anywhere? If YES, please describe. ______________
____
These symptoms interfere with my (*Please circle)*. Work Sleep Family
Daily Routine Recreation

Since the problem started, it is . . .

- ❑ About the same
- ❑ Getting Better
- ❑ Getting Worse

What makes it worse? ____
What makes it better? ____

Please identify any and all jobs you have had in the past that have imposed any physical stress on you or your body:____

Other Health Professionals seen for this condition:
Name. _____________________ Date. _________ Diagnosis. _________________
What was done? ____

General Health History.

Please check (x) all symptoms you have had in the last six months, even if they do not seem related to your current health problems

Headaches	Pins and Needles in Legs	☐ Fainting	☐ Neck Pain
Pins and Needles in arms	Loss of smell	☐ Back Pain	☐ Loss of Balance
Dizziness	Buzzing in ears	☐ Ringing in ears	☐ Nervousness
Numbness in Fingers	Numbness in toes	☐ Loss of taste	☐ Upset Stomach
Fatigue	Depression	☐ Irritability	☐ Tension
Sleeping Problems	Stiff Neck	☐ Cold Hands	☐ Cold Feet
Diarrhea	Constipation	☐ Fever	☐ Hot Flashes
Cold Sweats	Lights bother eyes	☐ Urinary Problems	☐ Heartburn
Mood Swings	Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers
Dry/ Cracked Skin	Difficulty Focusing Attention	☐ Dry Eyes	☐ Poor Memory

List all medications and supplements that you are currently taking and why. (Prescription & Non-prescription). ____

____

Please list all vitamins and supplements that you are currently taking. ______________________

____

Have you ever had surgery?

1. Type: ____ Date: ________________________
2. Type: ____ Date: ________________________
3. Type: ____ Date: ________________________

List any accidents and/or injuries: auto, work related or other (especially those related to your present condition)

1. Type: ____ Date: ________________________
2. Type: ____ Date: ________________________

On a scale of 1-10, describe your psychological/emotional stress levels. (1=none, 10=extreme)

Work Related Stress: ________ Personal Related Stress: ________

On a scale of 1-10 (1 being very poor, 10 being excellent), describe your:

Eating Habits: _______ Exercise Habits: ________ Sleep: ________ General Health: _______

Are you interested in Nutrition or Fitness Coaching? YES NO

If yes, how would you like our Dietitian & Personal Trainer to contact you: Email Phone

Other Comments or Concerns. ____

____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to perform an assessment on me in order to make as complete an evaluation as possible. I have read the Privacy Policy or Exodus Chiropractic, or I am aware this document is available for my viewing.

Signature ____________________________________ Date ________________

Insurance Information.

Patient's Name ____________________________ DOB ____________ SS#____________________

Insurance Company _____________________ Are you responsible for this account? ❑ YES ❑ NO

Subscriber's Name ____________________________ DOB __________ SS#___________________

Relationship to Patient (*if not self*) ________________________

Is patient covered by additional insurance? ❑ YES ❑NO Secondary Insurance Co __________________

Accident Information.

Is the patient's condition due to an accident? ❑ Yes ❑ No Date of Injury ________________

Type of accident: ❑ Auto ❑ Work ❑ Home ❑ Other_____________________________________

Who was at Fault? ❑ You or your driver ❑ Other Driver

Do you have medical pay benefits on your auto insurance? ❑ Yes ❑ No ❑ Don't Know

Auto Insurance Company ____________________________ Claim Number ______________________

Agent Name _______________________________________ Phone Number ____________________

Medicare Beneficiary Notice.

All Medicare patients are responsible for their $166 yearly deductible for chiropractic care. Medicare does not cover exams, but requires them before any adjustments of the spine can be performed. Medicare does not cover x-rays, but they may be necessary for treatment to occur. Medicare provides coverage for chiropractic adjustments when Medicare rules are met. ***The patient is responsible for any services that are not covered by Medicare or supplemental insurance.***

Assignment & Release.

I agree to treatment by my doctor and such person's of the doctor's choosing, which may include interns, preceptors, Chiropractic Assistants, etc. and hereby provide my consent for treatment. I, undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Chris Boles (Chiropractor) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You have the right to ask us to restrict the uses or disclosures made for the purposes of treatment, payment, or health care operations. Please refer to our Notice of Privacy Practices for further information.

____ ________________________

Responsible Party Signature **Date**

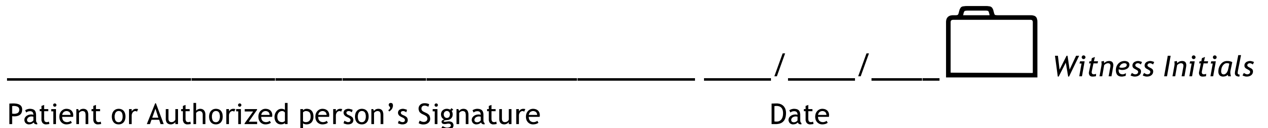
exodus CHIROPRACTIC

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at exodus Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.



____ _____/_____/_____ *Witness Initials*

Patient or Authorized person's Signature Date

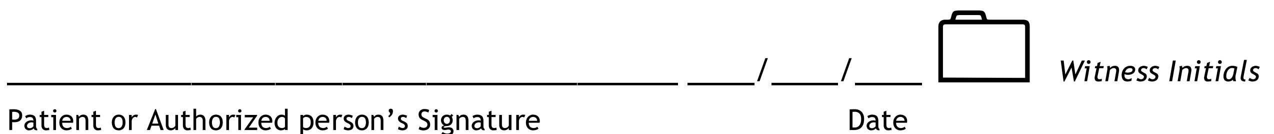
REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.



____ _____/_____/_____ *Witness Initials*

Patient or Authorized person's Signature Date

CMB, DC 2011-2012

HEALTH HISTORY OF FAMILY MEMBERS

The reason for this form is to assist the doctor by providing past health history information for his review.

Condition	Self	Father	Mother	Spouse	Brothers	Sisters	Children
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Disc Problems							
Drinker							
Drug Addiction							
Emphysema							
Epilepsy							
Headaches							
Heart Trouble							
High Blood Pressure							
Kidney Trouble							
Migraine							
Nervousness							
Neuritis							
Neuralgia							
Pinched Nerve							
Sinus Trouble							
Smoker							
Sports Activities							
Stomach Trouble							
Deceased							
Do you use orthotics?							

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Exodus Chiropractic

Christopher Boles D.C.

What are your life goals and where do you see yourself in the next 10 to 20 years?

1.____

2.____

3.____

4.____

5.____

6.____

7.____

8.____

______________________________________ ___________________

Signature **Date**