exodus CHIROPRACTIC

Staff only		T1 T2 T3
AP Cerv	AP Lumbo	AP Thor
Lat Cerv	Lat Lumbo	Lat Thor
Platinum ID#		

120 Seaboard Lane, Suite B, Franklin, TN 37067

Personal Information

Name:		Age:	Today's Date: / /	
Address:				
City / State / Zip:				
Cell #		Home #		
Email Address:				
Male: ☐ Female: ☐	Single ☐	Married ☐	Widowed ☐	Other ☐
DOB: / /	Patients SSN: - -		Occupation:	
Employer's Name:				
Spouses Name (if applicable):		Spouses Occupation:		
Names and Ages of Children (if applicable):				
Who or Where can we thank for referring you?:				

Your Health Profile

Health Concerns List According to Severity	**Rate of Severity** 1 = Mild 10 = Worst Imaginable	**When Did These Problems Begin?** Rough Estimates or Exact Time	**Injury Related?** Yes or No
1.			
2.			
3.			
4.			

Are the symptoms constant or do they come and go?:_____

If you are experiencing pain, how would you describe it and does it travel? _____

☐ Sharp	☐ Swollen	☐ Dull Ache	☐ Numbness	☐ Stiffness	☐ Shooting	☐ Throbbing
☐ Burning	☐ Cramping	Does it Travel?: ☐ Yes ☐ No				
These symptoms interfere with my:			☐ Work	☐ Sleep	☐ Family	
			☐ Daily Routine	☐ Recreation	☐ Personality	
Since the Problem Started, it is:			☐ About the same	☐ Getting Better	☐ Getting Worse	

What makes it better?: _____

What makes it worse?: _____

Staff Notes Only:

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 & Needles in Legs	☐ Fainting	☐ Neck Pain
☐ Pins & 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	☐ Light Bothers Eyes	☐ Urinary Problems	☐ Heartburn
☐ Mood Swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers
☐ Dry/Cracked Skin	☐ Difficulty Focusing Attention	☐ Dry Eyes	☐ Poor Memory

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

Other health professional names seen for this:

Diagnosis:	Condition:	Date:

What was done?:

List all medications, supplements, & vitamins that you are taking & why (Prescribed & Non-prescribed):

_____

Have you had Surgery?	
Type:	Date:
Type:	Date:
Type:	Date:
List any accident and/or injuries: auto, work related or other (especially related to current condition)	
Type:	Date:
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: _____ Sleep: _____ General Health: _____

Other Comments or Concerns: _____

_____

Staff Notes Only:

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 Provider:_____ Are you responsible for this account? ☐ Yes ☐ No

Subscriber's Name:_____ DOB:___/___/_____ SS#:___-___-_____

Relationship to Patient (if not self):_____

Is patient covered by additional insurances? ☐ Yes ☐ No

*Secondary Insurance Company:*_____

Accident Information

Is the patient's condition due to an accident ☐ Yes ☐ No Date of Injury: _____

Type of Accident? ☐ Auto ☐ Work ☐ Home ☐ Other

If auto accident, 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 $198 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 I 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 your 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**

Health History of Family Members

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							
Migranes							
Nervousness							
Neuritis							
Neuralgia							
Pinched Nerve							
Sinus Trouble							
Smoker							
Sports Activities							
Stomach Trouble							
Deceased							
Orthotics/Shoe inserts							

Exodus Chiropractic ***Christopher Boles D.C.***

Please list in order of priority (disrupts your life most) the health concerns that brought you in today. Once well, what are some important **health** and **life goals** you would like to achieve?

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

_____ _____

Signature **Date**

Staff Notes Only: