

Patient Entrance History

1. PATIENT INFORMATION

Date _____
 First Name: _____ Middle _____
 Last Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Sex: M F Age: _____ Birthdate _____
 Single Married Divorced Widowed Separated
 Occupation: _____
 Employer: _____
 Employer address _____
 Spouse's Name: _____
 Occupation: _____
 Employer: _____
 Names and ages of children:

 Primary Care Physician: _____
 Who referred you to our office? _____

3. CONTACT INFORMATION

Home _____ Cell _____
 Work _____ Ext. _____
 May we contact you at work? Y / N
 Email Address: _____
 Do you prefer phone or e-mail reminders? _____

EMERGENCY CONTACT

Name _____ Relationship _____
 Home Phone _____ Other phone _____

2. INSURANCE

Will your account be cash or insurance? (please circle)
 (If cash, please sign this section and go to next section.)
 Insurance Co. _____
 Are you covered by additional insurance? Yes No
 If yes, please fill out the following information.
 Insurance Co. _____
 Subscriber's Name _____
 Birthdate _____ SS # _____
 Relationship to patient _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with above named insurance company and assign directly to Dr. Scoles all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether 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. I understand that I am financially responsible for all charges if I do not have insurance.

Responsible Party Signature _____

Relationship _____

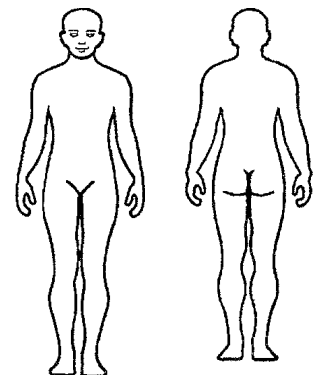
Date _____

4. ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____
 Type of accident Auto Work Home _____
 To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. _____
 Attorney Name (if applicable) _____

5. PATIENT CONDITION

Primary Concern _____
 When did your symptoms appear? _____
 Is this condition getting progressively worse? Yes No Unknown
 Please mark an X on the picture where you continue to have pain, numbness, or tingling.
 Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____
 Type of pain (circle all that apply) Sore Dull Aching Sharp Stabbing
 Burning Tingling Numbness Other _____
 How often do you have this pain? _____
 Does it interfere with your: Work Sleep Daily Routine Recreation
 What makes it feel worse: Bending Laying Down Sitting Standing _____
 What makes it feel better: Lying Down Sitting Standing Rest Movement _____
 What treatment have you already received for your condition? ___ Medications ___ Surgery
 ___ None ___ Physical Therapy ___ Chiropractic ___ Other _____



Last Name: _____ First Name: _____ Date: _____

6. HEALTH HISTORY

Please check any of the following symptoms you have experienced in the past 6 months.

- | | | | |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Tingling or Numbness | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Cold/Flu | <input type="checkbox"/> Loss of Energy/Fatigue | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Mid-Back Pain | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Stressed Shoulders | <input type="checkbox"/> TMJ Problems |
| <input type="checkbox"/> Lower-Back Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Leg and Hip Problems | <input type="checkbox"/> Joint Problems (Please circle area and side) |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Hip <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist |
| | | | RL RL RL RL RL RL |

Have you ever been diagnosed or told you have one of the following diseases, disorders, or medical conditions or had one of the following procedures?

- | | | | |
|------------------------------------|--|---|--|
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Loss of Bowel/Bladder Control |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting/Seizures | <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Congenital Heart Defect |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV+/Aids | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Artificial Bones/Joints |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Cancer _____ | |

Habits

- | | | | |
|----------------------------------|-------------------|--|----------------|
| <input type="checkbox"/> Smoking | Packs/Day _____ | <input type="checkbox"/> Coffee/Caffeine | Cups/Day _____ |
| <input type="checkbox"/> Alcohol | Drinks/Week _____ | <input type="checkbox"/> High Stress Level | Reason _____ |

Description and Date	Exercise <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy
Falls/Accidents _____	Work Activity <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor <input type="checkbox"/> Computer <input type="checkbox"/> Driving
Head Injuries _____	
Broken Bones _____	
Surgeries _____	

7. MEDICATIONS (name and purpose)

Is there anything else which may help us to better understand your history which has not been discussed on this survey? _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Signature _____ Date _____

Patient Name _____

Date _____

HEALTH HISTORY OF FAMILY MEMBERS

Completion of this form is very important. It provides the doctors with valuable information regarding your current level of health. Please fill out family information completely, even for non-blood related family members.

Condition	Self	Father	Mother	Spouse	Brothers	Sisters	Children
Allergies							
Arthritis							
Asthma							
ADHD							
Autism							
Blood Pressure							
Cardiac Problems							
Circulation							
Constipation							
Depression							
Disc Problems							
Ear Infection							
Endometriosis							
Epilepsy							
Fibromyalgia							
Headaches							
Hearing Problems							
Kidney Trouble							
Migraines							
Menstrual Problems							
Mental Problems							
Multiple Sclerosis							
Seizures							
Scoliosis							
Sinus Trouble							
Sleeping Problems							
Stroke							
Stomach Trouble							
Back Pain							
Deceased							

Scoles Family Chiropractic

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or symptoms.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's ability to express its maximum health potential.

We do not offer diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's healing wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

Today's appointment will consist of the consultation, examination, and possible x-rays. The doctors will then review all findings and schedule a special appointment time in which they will explain in detail the results of your examination and go over your personal care plan. That appointment is called your Doctor's Report. We prefer that you schedule this appointment within one week of today's appointment. There is no fee for your Doctor's Report.

	<p><i>X-ray Consent:</i></p> <p>The purpose of the x-rays about to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. I consent to chiropractic spinal x-rays.</p> <p>Signature _____ Date _____</p>
	<p><i>Consent to evaluate and adjust a minor:</i></p> <p>I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.</p> <p>Signature _____ Date _____</p>
	<p><i>Pregnancy Release:</i></p> <p>This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I understand that x-ray can be hazardous to an unborn child. Date of last menstrual cycle _____.</p> <p>Signature _____ Date _____</p>