ABOUT YOU

First Name _____ **Middle Name** _____

Last Name _____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **ZIP Code**_____

Mobile Phone ____-____-_____ **Work Phone** ____-____-_____ **Home Phone** ____-____-_____

Email _____

Date of Birth ____ / ____ / _____ **Gender** ☐ Male ☐ Female

Height _____'_____" **Weight** _____ lbs

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Number of Children _____ **Spouse's Name** _____

EMERGENCY CONTACT INFORMATION.

Name _____

Phone ____-____-_____ **Relation To You** _____

INSURANCE INFORMATION

Do you have Insurance? ☐ Yes ☐ No

Insurance Name _____ **Phone** ____-____-_____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **ZIP Code**_____

ID/Policy Number _____ **Group Number** _____

Insured's Name _____ **Insured's Date of Birth** ____ / ____ / _____

REFERRAL INFORMATION.

Referring Physician _____ **Contact information.** _____

Referring Patient _____

Are you working with an attorney? ☐ Yes ☐ No

How did you hear about us?

☐ Word of mouth ☐ Advertisement ☐ Social media ☐ Direct marketing ☐ Internet

REASON FOR VISIT

What is the date of your scheduled appointment? ____ / ____ / _____

How long have you had this complaint?

- ☐ Less than 5 days (Acute)
- ☐ Between 5-30 days (Sub Acute)
- ☐ More than 30 days (Chronic)

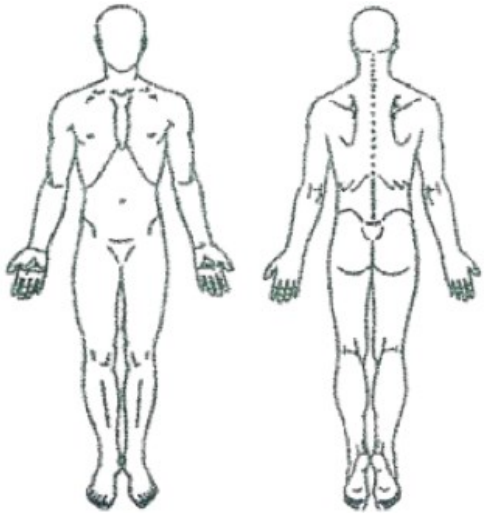
What caused this condition _____

What is the date this condition began? (Skip if due to accident) ____ / ____ / _____

What term(s) describes your discomfort best? _____

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

P - pain
N - numbness
W - weakness
S - shooting
A - Aching



On a scale of 1 to 10, with 10 being the most severe, how do you rate your discomfort?

None										*Unbearable*
0	1	2	3	4	5	6	7	8	9	10

How often do you feel this discomfort? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

How has this complaint changed since the onset? ☐ Worsened ☐ Remained the same ☐ Improved

What activity is most significantly affected by this discomfort? (Explain) _____

_____

What treatment, if any, have you received since the injury? _____

_____

What aggravates this condition? _____

What improves this condition or gives you relief? _____

Have other health care provider(s) performed tests related to this condition? _____

_____

Have you ever had any previous episodes of this condition? _____

_____

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following?

Muscles, Bones or Joints	☐ No	☐ Yes	**Explain:** _____
Nerves, Headaches, Dizziness, or Emotional	☐ No	☐ Yes	**Explain:** _____
Head, Eyes, Ears, Nose or Throat	☐ No	☐ Yes	**Explain:** _____
Heart, Blood Pressure, or Circulation	☐ No	☐ Yes	**Explain:** _____
Shortness of Breath, Coughing, Asthma or Lung Condition	☐ No	☐ Yes	**Explain:** _____
Stomach, Bowels or Digestive Conditions	☐ No	☐ Yes	**Explain:** _____
Genital, Bladder, or Urinary Conditions	☐ No	☐ Yes	**Explain:** _____
Diabetes, Thyroid or Glandular Conditions	☐ No	☐ Yes	**Explain:** _____
Skin or Bleeding Conditions	☐ No	☐ Yes	**Explain:** _____
Do you have any medication allergies?	☐ No	☐ Yes	**Explain:** _____

PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures? ☐ No ☐ Yes **Explain:** _____

Are there any past illnesses or conditions we should be aware of? ☐ No ☐ Yes **Explain:** _____

Do you have a past history of accidents or trauma? ☐ No ☐ Yes **Explain:** _____

Are you presently taking any medication? ☐ No ☐ Yes **Explain:** _____

Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of? ☐ No ☐ Yes **Explain:** _____

WORK SOCIAL HABITS

Current work habits - Choose all that apply.

- ☐ Permanently fully disabled
- ☐ Permanently partially disabled
- ☐ Cannot work due to current condition
- ☐ Full-time (20-40+ hours/week)
- ☐ Part-time (1-19 hours/week)
- ☐ Retired ☐ Student ☐ Homemaker ☐ Unemployed

Personal social habits - Choose all that apply.

- ☐ Smoke or use tobacco products
- ☐ Drink alcohol
- ☐ Drink caffeine
- ☐ Use recreational drugs
- ☐ Other, to be discussed with doctor

Present exercise habits - Choose all that apply.

- ☐ No current exercises
- ☐ Exercises daily
- ☐ Exercises 3+ times per week
- ☐ Cannot return to exercise due to current condition

Diet and nutrition habits - Choose all that apply.

- ☐ Vegan or vegetarian
- ☐ Daily supplements
- ☐ Other

INFORMED CONSENT TO TREATMENT

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I also understand and agree that;

-Full payment is expected at the time services are rendered for cash customers and co-payment and/or co-insurance are due at time of service if using insurance.
-A $10 billing fee will be charged my account if the co-payment or co-insurance is not paid at time of service.
-I understand that any balance not paid by insurance is ultimately my responsibility.
-I understand that I will be billed for my portion of the balance after Beckley Chiropractic Clinic has sent claims to my insurance company(s) and received any payments or responses for the service(s) dates. This may take up to 1 month and in some cases up to 1 year to complete.
-I understand the billing statement I receive from Beckley Chiropractic Clinic reflects only the listed dates of services and may not be a reflection of the total amount I am responsible for.
-I agree to pay any legal and/or collections fees resulting from any action taken to resolve the unpaid balance of my account.
-I agree to allow Beckley Chiropractic Clinic to bill my insurance(s) for the service(s) I have received.
-I authorize the release of any medical information necessary to process my claim(s).
-I hereby assign benefits from my health insurance(s) to Beckley Chiropractic Clinic, Dr. Amber N. Beckley, for all services billed to my insurance company(s) for which I have not paid in full. A copy of this assignment shall be as valid as an original
-A $25 fee will be charged to my account for missed appointments if I do not notify Beckley Chiropractic Clinic beforehand.
-A $50 fee will be charged to my account for missed or canceled after-hours or weekend appointments.

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: _____ **Date:** ____ / ____ / _____