Medicare Patient Information Form

Today's Date:	Date of Birth:

Name:	☐ Male ☐ Female	Age:	☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

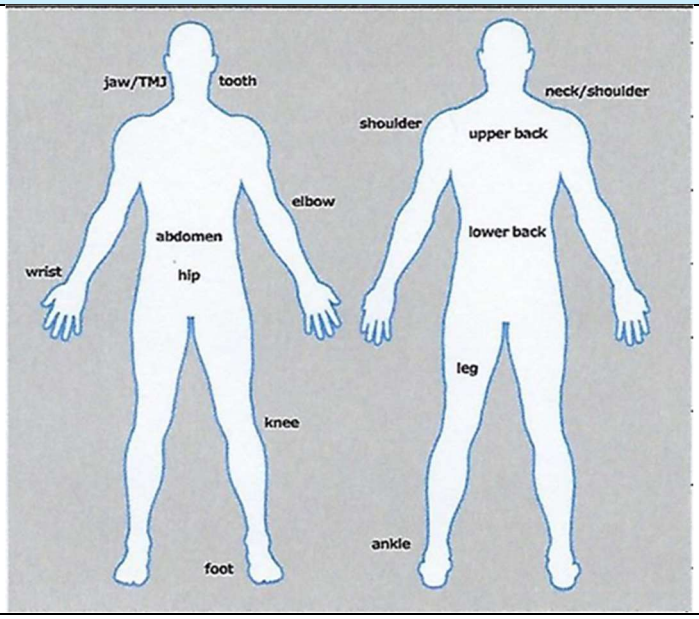
Address:	City:	State:	Zip:

Email:	Cell Phone:	Home Phone:

INSURANCE

Who is responsible for this bill?:	Relationship to patient:
Insurance Company:	I.D. #:
Do you have any additional Insurance?: ☐ Yes ☐ No	
If Yes, name of Insurance:	I.D.#
Primary Care Physician:	

CURRENT HEALTH CONDITION



Please circle areas of discomfort

Chief Complaint: (why are you here today?)

Body Area Involved: ☐ Cervical (neck) ☐ Upper Extremity (arms, wrist, hands) ☐ Spine (mid-back), ribs, pelvis (low-back) ☐ Lower Expremity (legs, feet, toes)

Condition: ☐ New ☐ Recurring ☐ Exacerbation ☐ Chronic

Mechanism of Onset: ☐ Auto ☐ Fall ☐ Over Exertion ☐ Unknown ☐ Slip or Fall ☐ Other ☐ Work ☐ Lifting ☐ Repetitive Motion ☐ Slept Wrong ☐ No injury

Symptoms: ☐ Pain ☐ Stiffness ☐ Numbness ☐ Weakness

Location: ☐ Left ☐ Bilateral ☐ Right

Quality: ☐ Burning ☐ Sharp ☐ Dull/Aching ☐ Stabbing ☐ Tightness ☐ Radiating ☐ Shooring ☐ Diffuse ☐ Localized ☐ Throbbing ☐ Tingling ☐ Other

On a scale of 0-10, (10 being the worst) Rate your symptoms (Resting):	0	1	2	3	4	5	6	7	8	9	10
On a scale of 0-10, (10 being the worst) Rate your symptoms (with Activity):	0	1	2	3	4	5	6	7	8	9	10

Duration, Symptom(s) Started:

Symptom(s) Worsened:

Symptom(s) Last Occurred:

Injury Occurred:

Accident Occurred:

Timing Worse in the: ☐Morning ☐Afternoon ☐Night ☐W/Activity ☐Constant ☐Intermittent

Associated Signs & Symptoms: ☐Blurred Vision ☐Headaches ☐Nausea ☐Sleep Disturbance ☐Vision Problems ☐Irritability ☐Mood Swings ☐Stiffness ☐Depression ☐Radiating ☐Localized Tingling ☐Ringing in Ears ☐Dizziness

Quality of Headaches: ☐Dull ☐Sharp ☐Aura ☐Stabbing ☐Throbbing ☐No Aura

☐Radiation: ☐Left ☐Right ☐Bilateral
☐Weakness: ☐Left ☐Right ☐Bilateral

Other Assoc. Signs & Symptoms: ☐Aches ☐Fever ☐Numbness ☐Runny Nose ☐Tingling ☐Cold Limb ☐Heartburn ☐Pale Bluish Skin ☐Stiffness ☐Vomiting ☐Dizziness ☐Muscle Spasm ☐Panic ☐Sweating ☐Weakness ☐Fatigue ☐Nausea ☐Pins & Needles ☐Swelling

Modifying Factors – Symptoms Better With: ☐Activity ☐Cold ☐Massage ☐OTC Meds ☐Rest ☐Sitting ☐Twisting ☐Bending ☐Heat ☐Movement ☐RX Meds ☐Stretching ☐Standing ☐Walking ☐Nothing

Since condition began, has anything permanently helped you? ☐Yes ☐No

Has anything that you have done done, thus far, fixed your problem? ☐Yes ☐No

RELATIVE CONTRAINDICATIONS

Do you have any of the following conditions? ☐Joint Hypermobility ☐Osteoporosis/Ostopenia ☐Benign Bone Tumors ☐Bleeding Disorders ☐Progressive Radiculopathy ☐Blood Thinners

NOTE: If you currently have, or had, one of the above listed conditions, Medicare requires that we advise you that spinal manipulation and other forms of dynamic thrust **may be contraindicated** in your condition. By signing below, you consent to care and agree to inform this office if another health care provider tells you that you have one of these conditions.

Signature: Date:

ABSOLUTE CONTRAINDICATIONS

Do you have any of the following conditions? ☐Rheumatoid Arthritis ☐Ankylosing Spondylitis ☐Ligament Laxity ☐Joint Dislocation ☐Recent/Unstable Joints ☐Unstable/Missing Dens at C2 ☐Spinal Cancer ☐Spinal/Joint Infection ☐Arterial Aneurysm ☐Vertebrobasilar Insufficiency Syndrome ☐Myelopathy/Cauda Equina Syndrome

NOTE: If you currently have, or have had, one of the above listed conditions, Medicare requires that we advise you that spinal manipulation and other forms of dynamic thrust **is absolutely contraindicated** in the region of the spine that is affected. By signing below, you agree to inform this office if another health care provider tells you that you have one of these conditions.

Signature: Date:

DAILY ACTIVITIES: ON A SCALE OF 0-10, TO WHAT LEVEL ARE YOU EXPERIENCING SYMPTOMS WHILE PERFORMING THESE ACTIVITES											
Activity (Check applicable column)	0 No Effect	1	2	3	4	5	6	7	8	9	10 Unable to do
Bending:											
Care – Infirm Family:											
Carrying Groceries											
Change Pos. -Sit-Stand:											
Climb Stairs:											
Driving:											
Extended Computer Use:											
Eating:											
Household Chores:											
Kneeling											
Lift Children:											
Lifting:											
Pet Care:											
Reading (Concentration):											
Self Care:											
Self Care (Bathing):											
Self Care (Dressing):											
Self Care (Shaving):											
Sexual Activities:											
Sleep:											
Sitting:											
Standing:											
Walking:											
Yard Work:											

PREVIOUS TREATMENT			
Previous Chiropractic Care:	☐ Yes, if yes, who? (name) ☐ No		
Have you seen other Doctors for this Condition?	☐ Yes, if yes, who? (name) ☐ No	Location of Office:	Type of Treatment:

PLEASE READ CAREFULLY AND SIGN BELOW

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Precision Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Precision Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered to me will be immediately due and payable. I agree that I am responsible for all bills incurred at this office. I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

Guardian or spouse's signature of authorizing care: (signature indicates consent to treat)		Date:
Patient (print name):	Patient's Signature:	Date: