Patient Information

WELCOME! Please allow our staff to photocopy your driver's license and all available insurance cards.

Full Name ______________________ Gender: M F

Home Phone ______________ Mobile Phone ______________

Address ______________ City ________ State _____ Zip ________

Age _____ Birth Date __________ Marital Status : S M W D Sep No. Children ________

SSN: ______________ Name of Spouse/ Parent or Guardian ______________

Your Employer: ______________ Occupation: ______________

Work Phone: ______________ Email Address ______________

Insured's Name (if not self): ______________ Insured's SSN ______________

Insured's Birth Date: ______________ Insured's Employer: ______________

Who should we contact in case of an emergency? ______________ Daytime Phone: ______________

How did you find out about our office? ______________

I hereby authorize the doctor to treat my condition as he deems appropriate. I agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all copayments and non-covered services. I also understand and agree to pay all copays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond ninety (90) days are subject to a 1.5 monthly finance charge (18% annually).

I understand that the clinic does not promise that an insurance company will pay, nor does the clinic promise that an insurance company will or should pay the fees as charged.

I understand that the clinic will not enter into a dispute with an insurance company over reimbursement or the amount of reimbursement. This is the patient's obligation.

I authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.

I hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

Patient's Signature ______________ Date ______________

Parent or Guardian's Signature ______________ Date ______________

I have received a copy of the HIPAA Privacy Practice

____

Signature

I have been informed of BC/BS Physical Medicine Guidelines

____

Signature

Iowa Chiropractic Center
600 Blairs Ferry Rd
Hiawatha, IA 52233
319-393-3998

NAME________________________ **Date**________________

11. Change in activities of daily living: What do you not do because of this problem?

____

12. Store Bought or Home Remedies: Type/Effect

____

13. Other Professional Care for this Problem:

____

14. Have you had this same or similar condition before? ______

15. Are you currently under a doctor's care for any other condition?

____

16. Are you now or could you be pregnant?______________

17. Have you ever been to a chiropractor before?__________

18. When was your last chiropractic visit? ____________

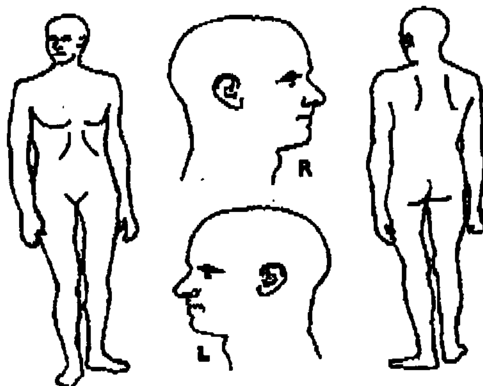
Relief Care
Relief care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care
Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

19. What kind of care are you seeking?

Relief Corrective

20. Please mark any problem areas that you have on the model.



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Check any of the following diseases you have had:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Eczema
- ☐ Anemia

Check any of the following you have experienced in the last six months:

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/ Stiffness
- ☐ Walking Problems
- ☐ Clicking Jaw
- ☐ Heartburn
- ☐ Black/ Bloody Stool
- ☐ Colitis
- ☐ Bladder Trouble
- ☐ Nervousness
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/ Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress
- ☐ Fatigue
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Lung Problems
- ☐ Ankle Swelling
- ☐ Stroke
- ☐ Vision Problems
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Poor/ Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/ Infections
- ☐ Breast Pain/ Lumps
- ☐ Prostate/ Sexual Dysfunction
- ☐ Other

____

____

Intake: Check any that apply to you.

- ☐ Coffee
- ☐ White Sugar
- ☐ Alcohol
- ☐ Cigarettes
- ☐ Tea

These members of my family have the same or similar problems as me.

- ☐ Father
- ☐ Mother
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

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NAME______________________________________

Date___________________

DETAILS OF CHIEF COMPLAINT

Doctor's Notes

1. **Why are you being seen today?**

2. **On a scale of 1-10, with 10 being the most severe, how would you rate your pain?** ______

3. **When did this problem start?**

4. **How did it start?**

5. **Is this due to an automobile or work injury?**

6. **What does the pain feel like?**

7. **What percentage of the day do you experience pain?**

0-25 26-50 51-75 76-100

8. **What aggravates your problem?**

9. **Since the onset, have your symptoms:**

decreased increased remained the same erratic

10. **Change in bodily functions:**

☐	Balance	☐	Bowel Habits	☐	Grip
☐	Coughing	☐	Sexual	☐	Sleep
☐	Menstrual	☐	Vision	☐	Weakness
☐	Urination	☐	Breathing	☐	Coordination
☐	Hearing	☐	Sneezing	☐	Weight
☐	Gait	☐	Diarrhea	☐	Constipation

List any medications you are currently taking:

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