

# PATIENT INFORMATION FORM

Date \_\_\_\_\_  
First Name \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Age \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status ( S M W D ) Spouse's Name \_\_\_\_\_  
Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_ Referred By \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Financial Information ( Insurance \_\_\_\_\_ Work Comp \_\_\_\_\_ Automobile \_\_\_\_\_ Cash \_\_\_\_\_ )  
Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Insured's SS# \_\_\_\_\_ Insured's DOB \_\_\_\_\_ Insured's Work Phone ( ) \_\_\_\_\_  
Insured's Employer \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group/Policy/Claim # \_\_\_\_\_  
Insurance Comp. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Customer Service Provider # ( ) \_\_\_\_\_  
Attorney Name (if applicable) \_\_\_\_\_ Phone # ( ) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

What is your major complaint? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did this condition develop? (What caused it?) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When was the very first time you were aware of this problem? \_\_\_\_\_  
\_\_\_\_\_



PLEASE  
MARK  
AREAS  
OF  
PAIN



Is this condition due to an: **A)** Auto accident **B)** Work Injury **C)** Other **D)** Unknown Cause **E)** Illness

Are the symptoms: **A)** Improving **B)** Getting Worse **C)** About the same **D)** Intermittent (comes and goes)

Circle any activities that aggravate your condition: **A)** Walking **B)** Standing **C)** Sitting **D)** Lying **E)** Bending **F)** Lifting

Have you had these symptoms before? ( Y / N ) If so, when? \_\_\_\_\_ **G)** Twisting **H)** Coughing

Have you seen another doctor for this condition? **A)** MD **B)** Chiropractor **C)** Osteopath **D)** Acupuncturist **E)** Dentist

Drs. Name \_\_\_\_\_ Date Consulted \_\_\_\_/\_\_\_\_/\_\_\_\_ Diagnosis \_\_\_\_\_

Current Medications \_\_\_\_\_

Previous Surgeries \_\_\_\_\_

Previous Accidents or Injuries \_\_\_\_\_

(WOMEN ONLY) Is there any possibility of pregnancy at this time? Yes \_\_\_\_\_ No \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered 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 and treatment, and fees for professional services rendered me will be immediately due and payable. Overpayments will be available for refund only after being credited to outstanding balances.

PATIENT'S SIGNATURE

## SYMPTOM SURVEY

<p>12) GENERAL SYMPTOMS: (Circle as many as apply)</p> <p>A) Nervousness B) Irritability C) Fatigue D) Depression</p> <p>E) Loss of Sleep F) Tension G) PMS H) Jaw Pain</p>	<p>18) MIDBACK: (Circle as many as apply)</p> <p>A) Pain -                    1) Left 2) Right 3) Both</p> <p style="padding-left: 40px;">Pain Level - 1)Mild 2) Moderate 3) Severe</p> <p style="padding-left: 40px;">Pain Type - 1) Sharp / Stabbing 2) Dull Ache</p> <p>B) Muscle Spasm - 1) Left 2) Right 3) Both</p>
<p>13) HEAD: (Circle as many as apply)</p> <p>A) Headache - 1) Mild 2) Moderate 3) Severe</p> <p style="padding-left: 40px;">How often: ( 1 2 3 4 5 6 ) Per ( Day / Wk /Mo.)</p> <p style="padding-left: 40px;">Are they: 1) Sharp      2) Dull</p> <p style="padding-left: 40px;">Are they: 1) Constant 2) Intermittent</p> <p style="padding-left: 40px;">Where located: 1) Back of head 2) Forehead</p> <p style="padding-left: 80px;">3) Temples 4) Rt. Side</p> <p style="padding-left: 80px;">5) Lt. Side 6) Behind eyes</p> <p>B) Light head      C) Memory loss D) Fainting</p> <p>E) Blurred vision    F) Double vision G) Sensitivity to light</p> <p>H) Loss of balance I) Hearing loss J) Ringing in ears</p>	<p>19) CHEST: (Circle as many as apply)</p> <p>A) Deep Chest Pair - 1) Left 2) Right 3) Both</p> <p style="padding-left: 40px;">Pain Level - 1) Mild 2) Moderate 3) Severe</p> <p>B) Pain around Ribs - 1) Left 2) Right 3) Both</p> <p>C) Shortness of Breath</p> <p>D) Irregular Heartbeat</p>
<p>14) NECK: (Circle as many as apply)</p> <p>A) Pain - 1) Left side 2) Right Side 3) Both</p> <p style="padding-left: 40px;">Pain Level - 1) Mild 2) Moderate 3) Severe</p> <p style="padding-left: 40px;">Pain increased by: 1) Forward movement</p> <p style="padding-left: 80px;">2) Backward movement</p> <p style="padding-left: 80px;">3) Rotate head lft. 4) Rotate head rt.</p> <p>B) Stiffness C) Muscle Spasm D) Grinding / Grating sounds</p>	<p>20) ABDOMINAL SYMPTOMS:(Circle as many as apply)</p> <p>A) Pain -                    1) Mild 2) Moderate 3) Severe</p> <p>B) Nervous Stomach C) Nausea D) Gas E) Constipation</p> <p>F) Diarrhea G) Heartburn H) Indigestion I) Loss of Appetite</p>
<p>15) SHOULDERS: (Circle as many as apply)</p> <p>A) Pain in Joint -                    1) Left 2) Right 3) Both</p> <p>B) Pain Across Shoulder -        1) Left 2) Right 3) Both</p> <p>C) Limitation of Movement -    1) Left 2) Right 3) Both</p> <p>D) Tension -                    1) Left 2) Right 3) Both</p>	<p>21) LOWBACK: (Circle as many as apply)</p> <p>A) Upper Lumbar Pain -</p> <p>B) Lower Lumbar Pain -</p> <p>C) Sacro-Iliac Pain -</p> <p>D) Muscle Spasm -</p> <p>Lowback Pain Level - 1) Mild 2) Moderate 3) Severe</p>
<p>16) ARMS: (Circle as many as apply)</p> <p>A) Pain in Upper Arm -            1) Left 2) Right 3) Both</p> <p>B) Pain in Elbow -                    1) Left 2) Right 3) Both</p> <p>C) Pain in Forearm -                1) Left 2) Right 3) Both</p> <p>D) Pins &amp; Needles (Arm) -        1) Left 2) Right 3) Both</p> <p>E) Pins &amp; Needles (Forearm) -    1) Left 2) Right 3) Both</p> <p>F) Numbness in Arm -                1) Left 2) Right 3) Both</p> <p>G) Numbness in Forearm -         1) Left 2) Right 3) Both</p>	<p>22) HIPS &amp; Legs: (Circle as many as apply)</p> <p>A) Pain in Buttocks -            1) Left 2) Right 3) Both</p> <p style="padding-left: 40px;">Pain Level - 1) Mild 2) Moderate 3) Severe</p> <p>B) Pain in Hip Joint -            1) Left 2) Right 3) Both</p> <p style="padding-left: 40px;">Pain Level - 1) Mild 2) Moderate 3) Severe</p> <p>C) Pain Down Leg -                1) Left 2) Right 3) Both</p> <p style="padding-left: 40px;">Location - 1) Front 2) Back 3) Side</p> <p>D) Numbness Down Leg - 1) Left 2) Right 3) Both</p> <p style="padding-left: 40px;">Location - 1) Front 2) Back 3) Side</p> <p>E) Pins &amp; Needles (Leg) - 1) Left 2) Right 3) Both</p> <p style="padding-left: 40px;">Location - 1) Front 2) Back 3) Side</p> <p>F) Knee Pain -                    1) Left 2) Right 3) Both</p> <p>G) Leg Cramps -                    1) Left 2) Right 3) Both</p>
<p>17) HANDS: (Circle as many as apply)</p> <p>A) Pain in Wrist -                    1) Left 2) Right 3) Both</p> <p>B) Pain in Hand -                    1) Left 2) Right 3) Both</p> <p>C) Pins &amp; Needles (Hand) -        1) Left 2) Right 3) Both</p> <p>D) Numbness (Hand) -                1) Left 2) Right 3) Both</p>	<p>23) FEET: (Circle as many as apply)</p> <p>A) Ankle Pain -                    1) Left 2) Right 3) Both</p> <p>B) Swollen Ankle -                1) Left 2) Right 3) Both</p> <p>C) Foot Pain -                    1) Left 2) Right 3) Both</p> <p>D) Numbness of Feet - 1) Left 2) Right 3) Both</p> <p>E) Swollen Feet -                1) Left 2) Right 3) Both</p> <p>F) Cramps -                    1) Left 2) Right 3) Both</p>

# **INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE**

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I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

**IRREVOCABLE**  
**ASSIGNMENT, LIEN AND AUTHORIZATION**  
***INSURANCE BENEFITS AND ATTORNEY***

To whom it may concern:

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to Corey G. Clements D.C. (aka Clements Chiropractic Center) such sums as may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefit, No-fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided.

In the event my insurance company, obligated to make payments to me upon the charges made by this Office for their services, refuses to make such payments, upon demand by me or this Office, I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due the Office for their services. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize the Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Office be given power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

This notice is effective as of \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Corey Clements, D.C. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Facility Signature

\_\_\_\_\_  
Date