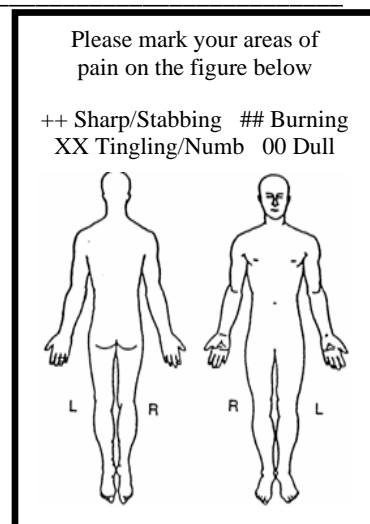


**CONFIDENTIAL PATIENT INFORMATION**

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Home Ph. \_\_\_\_\_ Cell Ph. \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ S.S.# \_\_\_\_\_  
 Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status M S W D How many children? \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Office Ph. \_\_\_\_\_  
 Work Address \_\_\_\_\_ Email Address \_\_\_\_\_  
 Name of Spouse \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Who may we thank for referring you? \_\_\_\_\_  
 Have you had chiropractic care?  Yes  No If so, who was the doctor and when? \_\_\_\_\_  
 Please list your most recent traumas (auto accidents, major falls, sport injuries, etc.):  
 1. \_\_\_\_\_ Date: \_\_\_\_\_  
 2. \_\_\_\_\_ Date: \_\_\_\_\_  
 3. \_\_\_\_\_ Date: \_\_\_\_\_

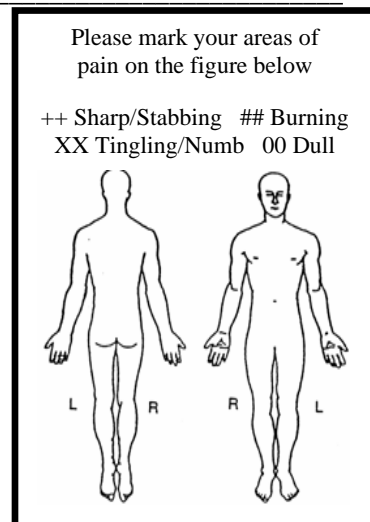
**PRIMARY CONDITION**

Please describe your primary complaint: \_\_\_\_\_  
 When did it start? \_\_\_\_\_ Have you had it in the past:  Y  N When: \_\_\_\_\_  
 Please check the appropriate box: The pain is  constant  it comes and goes  
 From a scale from 1-10 with 10 being the worst circle the level of pain 1 2 3 4 5 6 7 8 9 10  
 Please check the box(es) that best describe the pain:  
 Sharp/Stabbing  Burning  Dull  Tingling  Numbness Other \_\_\_\_\_  
 Does your pain travel from the point of pain?  Y  N If yes, where: \_\_\_\_\_  
 Have you seen any other doctors for this condition:  Y  N Name: \_\_\_\_\_  
 What makes it better: \_\_\_\_\_ Worse: \_\_\_\_\_  
 Do any of the following aggravate your condition?  Walking  Sitting  Coughing  
 Sneezing  Driving  Breathing  Working  Bowel Movements  Sleeping  
 Is this the result of an automobile accident:  Y  N Work related injury:  Y  N  
 If yes, to either question above, please explain: \_\_\_\_\_  
 What other treatment have you had for this condition: \_\_\_\_\_  
 Chiropractic  Physical Therapy  Surgery  Other \_\_\_\_\_  
 \*DOCTOR USE ONLY: \_\_\_\_\_



**SECONDARY CONDITION (If Applicable)**

Please describe your primary complaint: \_\_\_\_\_  
 When did it start? \_\_\_\_\_ Have you had it in the past:  Y  N When: \_\_\_\_\_  
 Please check the appropriate box: The pain is  constant  it comes and goes  
 From a scale from 1-10 with 10 being the worst circle the level of pain 1 2 3 4 5 6 7 8 9 10  
 Please check the box(es) that best describe the pain:  
 Sharp/Stabbing  Burning  Dull  Tingling  Numbness Other \_\_\_\_\_  
 Does your pain travel from the point of pain?  Y  N If yes, where: \_\_\_\_\_  
 Have you seen any other doctors for this condition:  Y  N Name: \_\_\_\_\_  
 What makes it better: \_\_\_\_\_ Worse: \_\_\_\_\_  
 Do any of the following aggravate your condition?  Walking  Sitting  Coughing  
 Sneezing  Driving  Breathing  Working  Bowel Movements  Sleeping  
 Is this the result of an automobile accident:  Y  N Work related injury:  Y  N  
 If yes, to either question above, please explain: \_\_\_\_\_  
 What other treatment have you had for this condition: \_\_\_\_\_  
 Chiropractic  Physical Therapy  Surgery  Other \_\_\_\_\_  
 \*DOCTOR USE ONLY: \_\_\_\_\_



**ADDITIONAL CONDITION** (If applicable)

Please describe your primary complaint: \_\_\_\_\_

When did it start? \_\_\_\_\_ Have you had it in the past:  Y  N When: \_\_\_\_\_

Please check the appropriate box: The pain is  constant  it comes and goes

From a scale from 1-10 with 10 being the worst circle the level of pain 1 2 3 4 5 6 7 8 9 10

Please check the box(es) that best describe the pain:

Sharp/Stabbing  Burning  Dull  Tingling  Numbness Other \_\_\_\_\_

Does your pain travel from the point of pain?  Y  N If yes, where: \_\_\_\_\_

Have you seen any other doctors for this condition:  Y  N Name: \_\_\_\_\_

What makes it better: \_\_\_\_\_ Worse: \_\_\_\_\_

Do any of the following aggravate your condition?  Walking  Sitting  Coughing

Sneezing  Driving  Breathing  Working  Bowel Movements  Sleeping

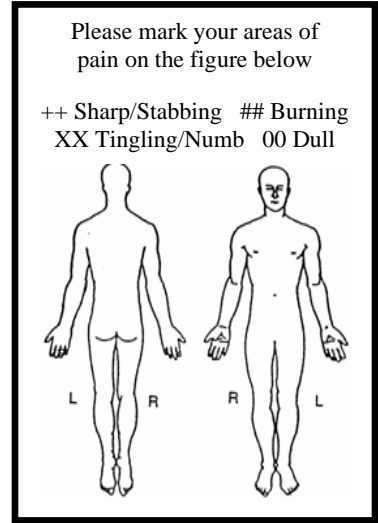
Is this the result of an automobile accident:  Y  N Work related injury:  Y  N

If yes, to either question above, please explain: \_\_\_\_\_

What other treatment have you had for this condition: \_\_\_\_\_

Chiropractic  Physical Therapy  Surgery  Other \_\_\_\_\_

\*DOCTOR USE ONLY: \_\_\_\_\_



**Medication:**

Please list all medications you are currently taking:

- 1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_ 7. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_ 8. \_\_\_\_\_

**Nutrients:**

Please list all nutrients you are currently taking:

- 1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_ 7. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_ 8. \_\_\_\_\_

**Family History:** Insert age and check any box that applies

	Age (if living)	Heart Disease	Diabetes	Cancer	Neck Pain	Low Back Pain	Carpal Tunnel	Headaches
Self								
Mom								
Dad								
Brother								
Sister								
Other								

**Primary Physician**

I authorize Health Solutions to communicate to my primary physician about the care I receive at this office.

Primary physician: \_\_\_\_\_ City: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Female Only:**

Are you currently having menstrual cycles?  Yes  No If yes, when was the first day of your last cycle? \_\_\_\_\_

Is there any chance you are pregnant?  Yes  No **If no, please sign here:** \_\_\_\_\_

**Financial Arrangement:**

Our office has conservative fees and comfortable payment arrangements. We want to make sure that our patients are able to receive the needed care in an affordable manner. If you have insurance coverage, our office will provide the courtesy of billing your insurance company. Although we provide the service of billing the insurance, any payments that are not received from your insurance company within 60 days will ultimately become your responsibility. The amount of your insurance coverage and the out of pocket expense will be discussed in detail and convenient payments plans will be available.

I have read and understand the statements above and give the doctor permission to evaluate me.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT CONSENT FORM****FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.**

I, \_\_\_\_\_ hereby state that by signing this consent, I acknowledge and agree as follows:

\_\_\_ 1. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide analysis and treatment for me, and also necessary for the practice to obtain payment for that treatment and to carry out its healthcare operations. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has encouraged me to read the privacy notice carefully prior to signing this consent.

\_\_\_ 2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.

\_\_\_ I understand that, and consent to, the following appointment reminders that will be used by the practice:

- Postcards mailed to the addresses I have provided.
- Telephoning me at the numbers I have provided and leaving messages for me on my answering machine or with the individual answering the phone.
- Contacting me about any other health related information via phone or mail.

\_\_\_ 4. The practice may use and/or disclose my PHI (which includes information about my health or condition, analysis, and the treatment provided to me) in order for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

\_\_\_ 5. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.

\_\_\_ 6. I understand that this consent is valid as long as I am a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, the practices has the right to refuse to treat me.

\_\_\_ 7. I give Health Solutions permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a private room for these conversations.

\_\_\_ 8. The doctor recommends that my spouse be present at my report of findings visit; therefore I hereby give permission for my protected health information to be disclosed at that time and at any time my spouse contacts the office to check on my status.

\_\_\_ 9. This offices posts a notice for Patient of the Week. If I receive that designation I authorize Health Solutions to post my name in the office.

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat me.

Date: \_\_\_\_\_

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

Patient Name (Signed) \_\_\_\_\_

Patient DOB: \_\_\_\_\_

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal: To restore the health potential of the body by removing spinal nerve impingements (called subluxations) which may be contributing or causing certain health condition. To remove the spinal nerve impingement a specific process is used which is called a chiropractic adjustment. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Although chiropractic has clinically been associated with the reduction of many symptoms and health conditions, we do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. Regardless of what the disease is called, we do not offer to treat it.

When pressure is removed off a nerve, the nerve will begin to heal and that will increase the function of the muscles, joints and organ systems the nerve supplies. Additional information is provided on our website at [www.healthsolutions.net](http://www.healthsolutions.net)

I have read and understand the information above.

Print Name: \_\_\_\_\_ Sign: \_\_\_\_\_ Date: \_\_\_\_\_

## AUTHORIZATION AND ASSIGNMENT OF BENEFITS

### Ramsour Family Chiropractic

1. You are authorized to release any information you deem appropriate concerning my health condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges occurred at this office.
2. I authorize and assign the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services of otherwise obligated to make payment to me or you based in whole or in part upon the charges for your services.
3. I give assignment lien against any claims against a third party whose negligence may have caused my injury, up to the bill for treatment.
4. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name (s) of which I believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you.

Print Name: \_\_\_\_\_ Sign: \_\_\_\_\_ Date: \_\_\_\_\_

## AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please answer all questions completely

Name \_\_\_\_\_ Date \_\_\_\_\_

Please explain in detail how your accident happened \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy No. \_\_\_\_\_ Claim No. \_\_\_\_\_

Driver of other vehicle (if any)

Name \_\_\_\_\_ Ins Co. \_\_\_\_\_ Policy No. \_\_\_\_\_

Driver of vehicle in which you were injured (if applicable)

Name \_\_\_\_\_ Ins Co. \_\_\_\_\_ Policy No. \_\_\_\_\_

Name of your insurance adjuster \_\_\_\_\_

Have you retained an attorney?  Yes  No

If so, his name and address \_\_\_\_\_

Were police notified?  Yes  No

**Was an accident report written?**  Yes  No **Did you bring it today?**  Yes  No

Were you knocked unconscious?  Yes  No If so, for how long? \_\_\_\_\_

You were struck from  Behind  Front  Left Side  Right Side

You were  Driver  Passenger  Front Seat  Back Seat Seatbelt on?  Yes  No

What were the time and date of present injury? \_\_\_\_\_

Where did you feel pain immediately after the accident? \_\_\_\_\_

Where were you taken after the accident? \_\_\_\_\_

What treatment were you given? \_\_\_\_\_

Was any other doctor consulted after your accident?  Yes  No

If "Yes", what was the doctor's name? \_\_\_\_\_  M.D.  D.C.  D.O.  D.D.S

What was the diagnosis? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

How often did you see the doctor? \_\_\_\_\_ How long? \_\_\_\_\_

Have you ever had any complaints in the involved area before?  Yes  No

Is so, what were the complaints? \_\_\_\_\_

Before the injury were you capable of working on an equal basis with other your age?  Yes  No

Are your work activities restricted as a result of this accident?  Yes  No

Since this injury are your symptoms  Improving  Getting Worse  Same

**HEALTH QUESTIONNAIRE**

Please indicate for each of the questions below your experience by use of the following codes:  
 0 – Never had 1-Have had previously 2-Have had since the accident.

**MUSCULO-SKELETAL SYSTEM**

- Low Back Problems
- Pain between shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Ruptures
- Broken Bones

**NERVOUS SYSTEM**

- Numbness
- Loss of Feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle Jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression

**OTHER SYSTEMS**

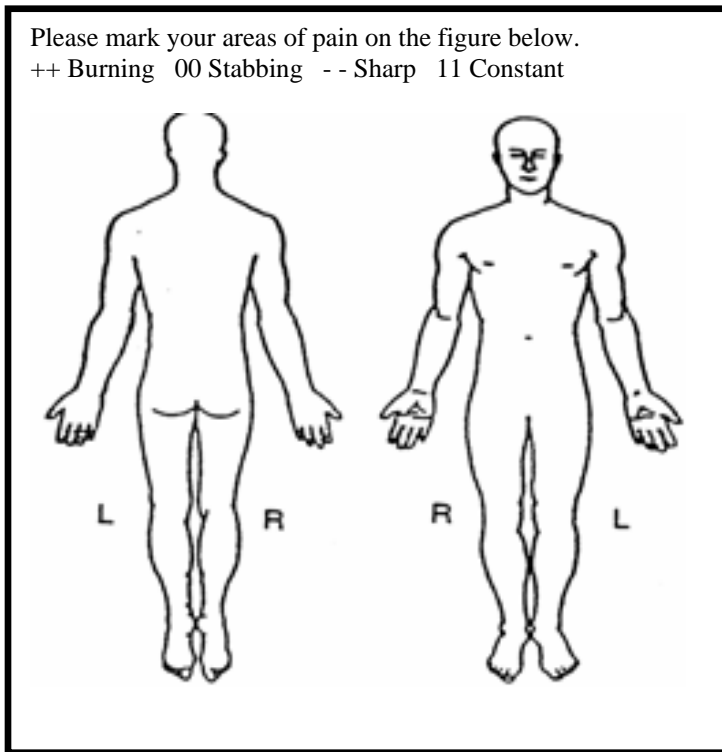
Genito-Urinary System  
 Problem \_\_\_\_\_  
 \_\_\_\_\_

Female Conditions  
 Problem \_\_\_\_\_  
 \_\_\_\_\_

Gastro-Intestinal System  
 Problem \_\_\_\_\_  
 \_\_\_\_\_

Cardiovascular-Respiratory  
 Problem \_\_\_\_\_  
 \_\_\_\_\_

Eye, Ear, Nose and Throat  
 Problem \_\_\_\_\_  
 \_\_\_\_\_



I've filled out this form to the best of my knowledge.

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

\_\_\_\_\_  
 Date

Ramsour Family Chiropractic

Doctor's Lien

To Attorneys: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

I hereby recognize a lien in favor of the above doctor for injuries incurred on \_\_\_\_\_, 20\_\_ and caused by \_\_\_\_\_, whose address is \_\_\_\_\_.

I hereby authorize the above doctor to furnish you, my attorney(s), with a full report of the case history, examination, diagnosis, treatment and prognosis of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney(s), to pay directly to said doctor such sums as may be due and owing him/her for professional services rendered to me both by reason of the aforesaid accident and by reason of any other bills that are due and owing to his/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney(s), or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him/her for services rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of pending payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Patient's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Patient's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

Attorney(s): Please sign, date, and return this document to the doctor's office named above.

The undersigned being attorney(s) of record for the above patient does hereby agree to observe all of the terms and conditions of the above lien and agree(s) to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect the said doctor named above.

Attorney(s)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_