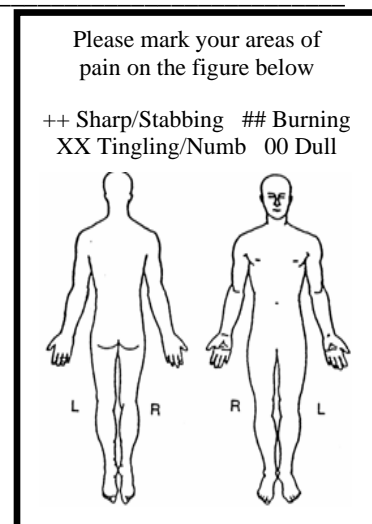


CONFIDENTIAL PATIENT INFORMATION

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: _____

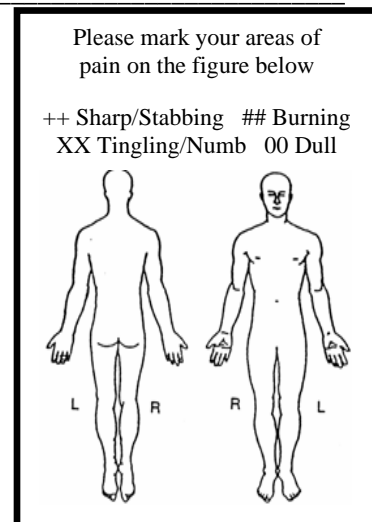
PRIMARY CONDITION

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

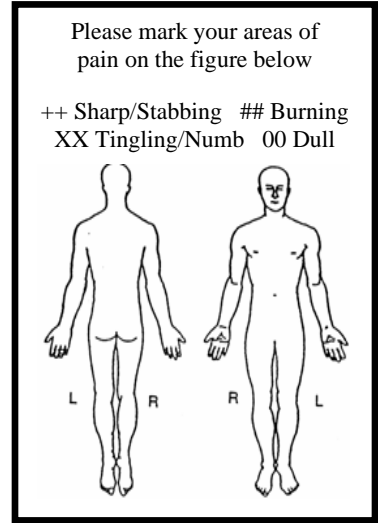
Is this the result of an automobile accident: Y N Work related injury: Y N

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 practice 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 office 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

I have read and understand the information above.

Print Name: _____ Sign: _____ Date: _____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

To: 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 comprise, 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: _____

WORKERS COMPENSATION QUESTIONNAIRE

Name: _____ Date: _____

Have you retained legal counsel for this injury? YES NO If yes, give name and address:

INJURY DESCRIPTION

Date present injury was received _____ Time of Injury _____ AM / PM Overtime __ Yes __ No

Who saw the accident? _____ Title _____

Who reported the accident? _____ Title _____

What medical attention was rendered? _____

By whom __ Nurse __ M.D. __ D.O. __ D.C. __ Other employee __ Other _____

How did the injury occur? _____

CHIEF COMPLAINT _____

Symptoms _____

Since the injury, are your symptoms __ Improving __ The Same __ Getting Worse

JOB SPECIFICS

If working on a machine, give description _____

Do you use foot or hand levers? __ Yes __ No Do you work overhead? __ Yes No __

Do you have to reach? __ Yes __ No Where? _____

Movements on the job: Do you move to your __ Right __ Left __ Up __ Down __ Under __ Over

Do you pick up or lift __ Yes __ No If "Yes" how much? _____ How often? _____

From where to where? _____

Do you lift from __ Ground __ Bench __ Platform __ Box __ Pallet __ Other (Please Describe) _____

Do you lift in or out of a machine? __ Yes __ No If working at a machine, do you __ Sit __ Stand __ Kneel

Is your work environment cluttered? __ Yes __ No If "yes", with what? _____

Is your work area __ Oily __ Dirty __ Slippery __ Other _____

In your job do you push or pull? __ Yes __ No If "Yes" give specifics _____

Do you use a cart? __ Yes __ No What kind __ Two-wheel __ Four-wheel Condition __ Good __ Bad __ Other

Total amount of weight being pushed or pulled on a daily basis _____

OFFICE WORK SPECIFICS

If your injury has occurred from office work only, please fill out the following: (Give percentage if applicable)

__ Sit at desk __ Walk __ Stand __ Stoop __ Hold __ Carry __ Other

Do you operate office machinery? __ Yes __ No If "Yes" what type? _____

Do you carrying anything of pick anything up? __ Yes __ No If "Yes" what? _____

If your work is at a desk give specifics of computer and phone positions _____

WORKERS COMPENSATION QUESTIONNAIRE (Page 2)

WORK HISTORY

Give a job description of work performed for each job classification or source of employment for the proceeding ten years.

1. _____
2. _____
3. _____
4. _____
5. _____

Was a pre-employment exam performed or required? Yes No Date _____ Doctor _____

Have you ever applied for Workers' Compensation benefits before? Yes No Date _____

Reason _____

Was there a time loss for work? Yes No From _____ To _____ Year _____

State the degrees of recovery _____

Did you retain legal counsel for these injuries? Yes No If "Yes" give name and address _____

PRESENT WORK HISTORY

What is the job classification of your normal job? _____

Were you performing your normal job? Yes No What shift were you working? _____

How long have you been at your present job? _____ Has there been absenteeism caused from job injury? Yes No

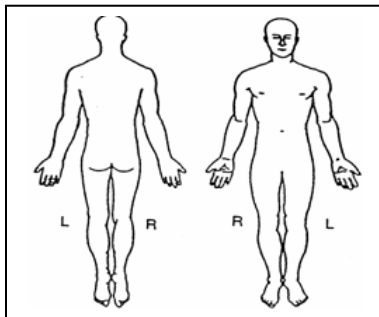
If "Yes" explain _____

Average work week _____ Hours _____ Days

How many employees are in the plant? _____ How many employees per shift _____ How many employees do your job? _____

What is the current injury ratio for that job? _____ How many employees have been injured doing your job? _____

Do you like your job? Please explain _____



Mark Pain Area

- ++ Burning
- 00 Stabbing
- Sharp
- || Constant

Patient Signature Date

Staff 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: _____

WORKERS' COMPENSATION AUTHORIZATION FORM

Patient Name: _____ Date: _____

Address: _____

Date of Accident: _____

Employer: _____

Address: _____

TO THE PATIENT: It is necessary that your employer sign the following Authorization for treatment and return to our office. If not, you will be responsible for payment.



TO THE EMPLOYER: I acknowledge the work related injury of the above named patient. You are authorized to render the appropriate care needed for this injury and we will file the proper forms with our insurance carrier.

Authorized By: _____

Title: _____

Date: _____

Telephone # _____

PLEASE RETURN THIS FORM IMMEDIATELY TO:

Clinic Name: _____

Attention: _____

Address: _____

Telephone: _____