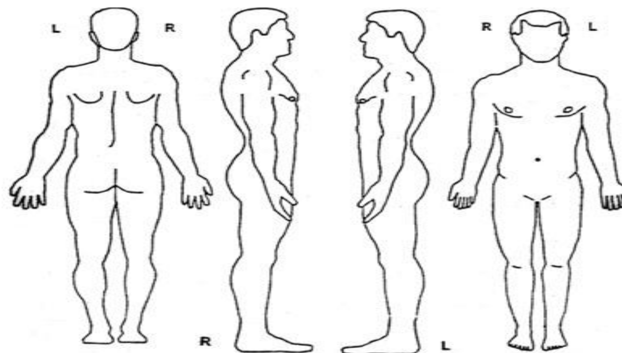
ALVIS CHIROPRACTIC

Name:_________________________________ **Birthdate**:__________ **Age**:_____ **Phone#:**___________________________
Address:____ZIP____________Email:_________________________________
Employer: ____________________Work Address:____Occupation:__________________
Marital Status: □Single □Married Spouse Name: ______________________Spouse Phone:______________# of Children:___
Emergency Contact: □Spouse □Other:__________________________Phone #:_____________________________________
Preferred form of contact for you: □Phone Call (___)____-_____ □TEXT to (____)____-______ □Email (above)
May we add you to our email list so you receive periodic updates via email? □YES □NO
Who/what directed you to **ALVIS Chiropractic**?____
Who is responsible for payment? □Self □Spouse □Other____
Do you have Insurance? □No □Yes

Primary Insurance Carrier:____________________	**Secondary Insurance Carrier:**______________________________
Group#:____________________________________ _	Group#:____
Member ID#:_______________________________	Member ID#:____
Phone:_____________________________________	Phone:____

Indicate on the drawings where you have pain/symptoms ►



How would you describe the type of pain? (Check all that apply)
□Sharp □Stabbing □Burning □Achy □Dull □Stiff & Sore
□Numbness □Tingling □Weakness
□Radiating Pain: if yes indicate where: ________________

How often do you experience your symptoms?
□ Intermittently (1-25% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Constantly (76-100% of the time)

Average Pain Intensity: (circle appropriate number)

Last 24 hours:	0	1	2	3	4	5	6	7	8	9	10
Past Week:	0	1	2	3	4	5	6	7	8	9	10

What makes it better? □Ice □Heat □Rest □Movement □Stretching □OTC □Other_____________
What makes it worse? □Sit □Stand □Walk □Lying □Sleep □Overuse □Other________________

HEADACHES: □No □Yes If Yes; FREQUENCY: ___#per Day ___#per Week ___#per Month
Average INTENSITY (circle one): 0 1 2 3 4 5 6 7 8 9 10

Your Height: ____ ___ Current Weight: ____

Other Doctor(s) seen for this condition:____

What date did your symptoms start?____

How did your symptoms start?____

What concerns you most about your problem?____

How are your symptoms changing with time? □ Getting Better □ Staying the same □ Getting Worse

How much have your symptoms interfered with your usual daily activities? □Not at all □A little bit □Moderately □Quite a bit □Extremely

What activities do you do at work?

Activity:	A little of the day	Half the day	Most of the day
Sit	□	□	□
Stand	□	□	□
Computer work	□	□	□
On the Phone	□	□	□

Has the problem interfered with your work? □None □A little bit □Moderately □Quite a bit □Extremely

What activities do you do outside of work?____
What activities does your condition prevent you from doing?____

How do you rate your overall health? □Poor □Fair □ Good □Very Good □Excellent
What level of exercise do you do? □None □Light □Moderate □Strenuous

Indicate if any *immediate* family members have been diagnosed with any of the following:
□Rheumatoid Arthritis □Diabetes □Lupus □Heart Problems □Cancer □ALS(Lou Gehrig's Disease)

For each of the conditions below, indicate Past or Present condition by an "X" in the box.

Past	Present	Past	Present	Past	Present
□	□Headaches	□	□High Blood Pressure	□	□Diabetes
□	□Neck Pain	□	□Heart Attack	□	□Excessive Thirst
□	□Upper Back Pain	□	□Chest Pains	□	□Frequent Urination
□	□Mid Back Pain	□	□Stroke	□	□Smoking/Tobacco Use
□	□Low Back Pain	□	□Angina	□	□Allergies
□	□Shoulder Pain	□	□Kidney Stones	□	□Depression
□	□Elbow/Upper Arm Pain	□	□Kidney Disorders	□	□Systemic Lupus
□	□Wrist Pain	□	□Bladder Infection	□	□Epilepsy
□	□Hand Pain	□	□Painful Urination	□	□Dermatitis/Eczema/Rash
□	□Hip Pain	□	□Loss of Bladder Control	□	□HIV/AIDS
□	□Upper Leg Pain	□	□Prostate Problems		
□	□Knee Pain	□	□Abnormal Weight Gain/Loss		
□	□Ankle/Foot Pain	□	□Loss of Appetite		
□	□Jaw Pain	□	□Abdominal Pain	**Females ONLY**	
□	□Joint Pain/Stiffness	□	□Ulcer	□	□Birth Control Pill
□	□Arthritis	□	□Hepatitis	□	□Hormone Replacement
□	□Rheumatoid Arthritis	□	□Liver/Gall Bladder Disorder	□	□Pregnancy
□	□Cancer	□	□General Fatigue		
□	□Tumor	□	□Muscular Incoordination		
□	□Asthma	□	□Visual Disturbances		
□	□Chronic Sinusitis	□	□Dizziness		

List all *presciption* medications you are currently taking:______________________________
List all *over-the-counter* medications you are currently taking:______________________________
Have you ever been hospitalized & Why?______________________________
List all surgical procedures you have had:______________________________
Is there anything else pertinent to your visit today?______________________________

Financial Agreement

I understand and agree that I am financially responsible for payment of all services rendered to me by ALVIS CHIROPRACTIC. I understand that my health insurance coverage may have certain restrictions and limitations, such as authorization requirements and non-covered services. Since I have chosen to obtain the services, I agree to be financially responsible for any and all related charges if they are not covered by my insurance. I understand that ALVIS Chiropractic will prepare necessary reports and forms to assist me in making collection from my insurance company and that any insurance payments made to ALVIS Chiropractic will be credited to my account upon receipt. I understand that if I suspend or terminate my care and treatment, any outstanding fees for professional services rendered to me will be immediately due and payable.

Consent of Professional Services and Release of Information

I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he deems necessary in any case; and I further authorize him to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Privacy Notice Review

I have been provided a copy of the ALVIS CHIROPRACTIC Privacy Notice for review and I understand that I can ask questions about the privacy practices at any time. In addition, I understand I can request a copy of the ALVIS CHIROPRACTIC Privacy Notice at any time.

Patient's Signature: ______________________________ Date:_____________

Doctor's Signature: ______________________________Reviewed Date:_____________

For info on HIPPA Privacy Act: www.hhs.gov/ocr/hipaa/privacy