SPECTOR CHIROPRACTIC

Welcome to our Office

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

Privacy Practices:

I have received a copy of the Notice of Privacy Practices for Spector Chiropractic - _____

patient initials

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed, as well as how you may have access to the information.

We may share your health information to:

- treat you
- collect payment
- run our office
- inform you about other services
- discuss your case with family
- do research
- include you in care classes
- thank you for referring other patients
- As a teaching institution, discuss your case with interns and consult with other colleagues

We may use your health information for:

- health and safety reasons
- reporting to law officials
- reporting victims of abuse
- court hearings and filings
- reporting to worker's compensation
- teaching / Instruction

You have the right to:

- request confidential communications
- request a list of whom we share your health information with
- request a copy of your health record (an additional fee may be involved)
- advise our management if you believe your privacy rights have been violated
- ask us to limit information sharing
- amend your protected health information

_____

patient initials

These privacy practices are effective: January 1, 2011
For further information please contact: Ashley Spector, DC 972-746-0212

Consultation & Exam

To begin today's visit, you will be asked to complete confidential health information for us to discuss with you. To learn more about your condition, we will perform preliminary examinations which may include a physical examination, x-rays, and laboratory tests.

If we believe that we may be able to help you, we will give you a report of our findings and recommend a treatment plan. As you advance through treatment, periodic progress evaluations will measure and compare your improvement. We will always inform you of associated fees before we perform any procedure or service. _____

Office Use Only:

Doctor's Signature # Date

I understand and agree to the above information:

Date

Print Name- patient or guardian

Signature- patient or guardian

SPECTOR CHIROPRACTIC

Registration & Account Information

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

confidential health information

File # / Clinic ID	Date

1 PATIENT INFORMATION

last name	first name	m.i.

age	date of birth	social security #	gender ☐ male ☐ female

status ☐ single ☐ married ☐ partnered ☐ widowed ☐ separated ☐ divorced

street	city	state	zip

work phone	extension	home phone	cell phone	e-mail

spouse or guardian last name	first name	m.i.	date of birth

2 EMERGENCY CONTACT

last name	first name	relationship	home phone	work phone	cell phone
last name	first name	relationship	home phone	work phone	cell phone

3 PATIENT EMPLOYMENT

employer name	occupation

address street	city	state	zip

4 QUESTIONS

Who referred you to us?	
How did you hear about our clinic?	
Are you here because you were involved in a vehicle collision?	☐ yes ☐ no
Are you here because you were injured at your place of employment?	☐ yes ☐ no
Are you here because you were involved in another type of accident?	☐ yes ☐ no
Will you be using health insurance to supplement payment to our office*? * If YES, please complete the INSURANCE COVERAGE and INSURED INFORMATION sections of this form.	☐ yes ☐ no

5 INSURANCE COVERAGE

types of insurance

☐ employee group health plan ☐ personal health insurance ☐ health savings account ☐ Medicare ☐ Medicaid

☐ personal injury ☐ Work's Compensation ☐ TRICARE/CHAMPS ☐ CHAMPVA ☐ FECA

primary insurance company	primary ins. ID #	primary ins. group #
secondary insurance company	secondary ins. ID #	secondary ins. group #

I understand and agree to the following:

- My case may not be accepted for treatment at this clinic
- If the doctors believe that I may respond to their care, additional services may be recommended and I will be advised of applicable costs
- There is no guarantee that my health insurance will pay for all or any part of my care
- As the patient or guardian of a patient, I am ultimately responsible for all charges incurred for services rendered
- All payments are due at the time services are rendered

patient or guardian signature

Date

6 INSURED'S INFORMATION

last name	first name	m.i.

street	city	state	zip

employer	age	date of birth	social security #	gender
				☐ male ☐ female

Relationship to patient

☐ Self ☐Spouse ☐ Dependent ☐ Other _____

7 BENEFITS ASSIGNMENT & INFORMATION RELEASE

I authorize the payment of charges be made directly to the doctor(s) of this clinic. This authorization includes:

1. All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy
2. Amounts owed on my behalf from proceeds of any settlement related to my case.

_____

Patient or guardian signature

I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan to request payment benefits to me or my assignee.

_____ _____

Patient or guardian signature Date

OFFICE USE ONLY:

Patient: last name	first name	m.i.	date of birth

FILE # **INTERN NAME & #** **DOC #** **POD#**

INSURANCE VERIFICATION

Person's name that you spoke to?
Last: First:
ID # Extension:

Does the plan have a **deductible?** ☐ yes ☐ no
- Amount for an individual: _____
- Amount for the family: _____
- Amount currently met: _____

After deductible, what % of services do you cover? _____
When does the deductible renew? _____

Does the patient have a **co-pay**? ☐ yes ☐ no
- Amount for the co-pay: _____

What is the max. yearly **benefit**? ☐ yes ☐ no
Does the company **assign benefits** to the doctor? ☐ yes ☐ no
What is the **yearly visit cap**? _____
Are any **special forms** required to file claims? ☐ yes ☐ no

Auto Collision or **Personal Injury** case? ☐ yes ☐ no
- Reported to the insurance company? ☐ yes ☐ no
- Has an application for benefits been filed? ☐ yes ☐ no
- Did the police write a report? ☐ yes ☐ no
- Is auto or PI insurance primary? ☐ yes ☐ no
- Agent name and contact info: _____

_____

Workers' Comp case? ☐ yes ☐ no
- Has the injury been reported? ☐ yes ☐ no
  - Name:
  - Title:
- Is patient currently employed at place of injury? ☐ yes ☐ no
- Name of person authorizing care: _____

_____

Does the plan cover the following **services**?

Therptc. Exercise, Therptc. Activity & Neuro Myo Reedu. ☐ yes ☐ no
Chiropractic Adjustments ☐ yes ☐ no
Modalities by a Chiropractor ☐ yes ☐ no
X-rays: _____ ☐ yes ☐ no
Orthotics, supports, pillows and Nutritional supplements? ☐ yes ☐ no
Other: _____ ☐ yes ☐ no

Address to send claims:

SPECTOR CHIROPRACTIC

Patient Case History

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

confidential health information

clinic id | date

1 PATIENT INFORMATION

last name | first name | m.i.

2 HEALTH COMPLAINTS

Are you here because you were injured while working, in a motor vehicle collision, or in another accident? ☐ yes ☐ no

What services interest you? (mark all that apply)

- ☐ injury prevention
- ☐ balance and coordination training
- ☐ range of motion, mobility, or flexibility therapy
- ☐ treatment for pain
- ☐ spinal and body alignment
- ☐ strengthening and stamina exercise
- ☐ patient education classes
- ☐ body composition counseling
- ☐ nutritional and supplement counseling
- ☐ other: _____

What is your **primary** complaint?

How long have you been experiencing this **primary** complaint?

How does the **primary** complaint feel? ☐ dull/achy ☐ sharp ☐ numb ☐ tingling ☐ burning ☐ cold

How often do you experience the **primary** complaint? ☐ constantly ☐ daily ☐ weekly ☐ monthly ☐ yearly

Using the scale below, rate how your **primary** complaint affects your life. (mark only one box below)

1	2	3	4	5	6	7	8	9	10
no pain or discomfort	slight discomfort	pain that does not affect my activity	pain that affects my daily activities	pain that prevents performing my daily activities	pain that limits my work schedule	pain that prevents working at all	pain that prevents working and all personal activity	pain that keeps me bed ridden	pain that causes thoughts of suicide

If you have missed work because of your **primary** complaint, what was your last day of work?

What do you believe is causing your **primary** complaint?

List other health complaints (2-5) on the following lines.

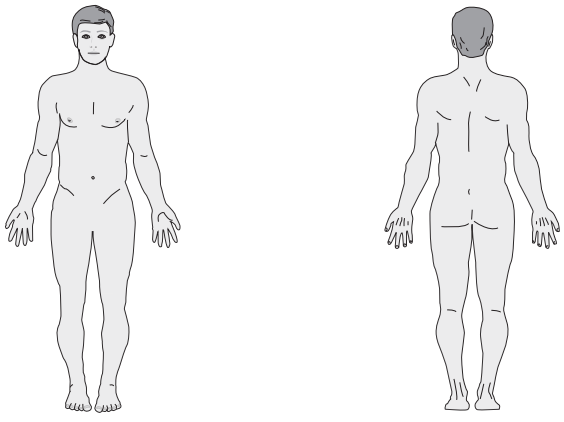
2 _____ 4 _____

3 _____ 5 _____

Do you have any other condition other than what brings you here? ☐ yes ☐ no
If YES, list it here:

Please mark the areas of all of your complaints on the diagrams to the right. Include any descriptors or comments, concerning your health complaints that were not mentioned above.

N = numbness
T = tingling
P = pain
W = weakness



clinic doctor signature, date

3 LIFESTYLES & HABITS

How many hours of television do you watch a day? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

Do you usually snack while watching television? ☐ yes ☐ no

How many hours per day do you use a computer at work or home? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

How many hours per day do you ride in a car or other vehicle? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

How often do you exercise? ☐ daily ☐ 3x's/week ☐ 2x's/week ☐ 1x/week ☐ I don't exercise

How long do your exercise work outs last? ☐ >1 hour ☐ 1 hour ☐ 30 minutes ☐ < 30 minutes ☐ NA

What are your exercise activities? (mark all that apply) ☐ I don't exercise

☐ walking ☐ swimming ☐ weight lifting

☐ stretching/flexibility ☐ yoga/Pilates ☐ resistance bands

☐ running/treadmill/rowing/climbing ☐ group exercise classes ☐ other _____

Do you take a multi-vitamin? ☐ yes ☐ no If YES, what brand do you take?

List any other nutritional supplements you are currently taking.

supplement	reason	supplement	reason
1.		3.	
2.		4.	

Have you ever used tobacco? ☐ never ☐ daily ☐ weekly ☐ monthly ☐ yearly

How many servings of alcohol do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of coffee do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of soda do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

4 FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family. n=never p=previously c=currently

diabetes	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
heart problems	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
kidney problems	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
cancer	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
headaches	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
back pain	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
obesity	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
poor conditioning	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister

5 CONDITIONS

Mark the following conditions as they currently pertain to you.

alcoholism ☐ yes ☐ no	epilepsy ☐ yes ☐ no	low back pain ☐ yes ☐ no	polio ☐ yes ☐ no
anemia ☐ yes ☐ no	goiter ☐ yes ☐ no	measles ☐ yes ☐ no	rheumatic fever ☐ yes ☐ no
appendicitis ☐ yes ☐ no	heart disease ☐ yes ☐ no	mental disorder ☐ yes ☐ no	tuberculosis ☐ yes ☐ no
arthritis ☐ yes ☐ no	HIV positive ☐ yes ☐ no	mumps ☐ yes ☐ no	venereal infection ☐ yes ☐ no
cancer ☐ yes ☐ no	influenza ☐ yes ☐ no	pleurisy ☐ yes ☐ no	whiplash ☐ yes ☐ no
	diabetes ☐ yes ☐ no	pneumonia ☐ yes ☐ no	whooping cough ☐ yes ☐ no

6 INJURIES

clinic doctor signature, date

List any **auto collisions** that you were involved in, either as the driver or passenger, below. Begin with the most recent.

type of collision	type of treatment received	date of collision
1.		
2.		
3.		

List any **job injuries** that you experienced below. Begin with the most recent.

type of job injury	type of treatment received	date of job injury
1.		
2.		
3.		

List any **sports injuries** that you experienced below. Begin with the most recent.

type of sports injury	type of treatment received	date of sports injury
1.		
2.		
3.		

List any **other injuries** caused by falls or impacts. Begin with the most recent.

type of injury	type of treatment received	date of injury
1.		
2.		
3.		

7 HOSPITAL / MEDICINE

Have you had breast implant surgery? ☐ yes ☐ no

Have you had knee or hip replacement surgery? ☐ yes ☐ no

Do you have a pacemaker? ☐ yes ☐ no

Do you have any other implantable medical devices in your body? ☐ yes ☐ no

Mark all of the following procedures as they pertain to you.

vaccinations	☐ yes	☐ no	tubes in ears	☐ yes	☐ no	rectal surgery	☐ yes ☐ no
tonsillectomy	☐ yes	☐ no	appendectomy	☐ yes	☐ no	sinus surgery	☐ yes ☐ no
gall bladder removal	☐ yes	☐ no	female/male surgery	☐ yes	☐ no	hernia surgery	☐ yes ☐ no
back surgery	☐ yes	☐ no	_____			thyroid surgery	☐ yes ☐ no
						stomach surgery	☐ yes ☐ no

List any prescription or over-the-counter medications you are currently taking.

medication	reason	medication	reason
1.		3.	
2.		4.	

Have you ever had a lapse of memory? ☐ yes ☐ no Were you ever knocked unconscious? ☐ yes ☐ no

List any broken bones or dislocations that you had.

Have you ever had a spinal tap or spinal injection? ☐ yes ☐ no

clinic doctor signature, date

8 SYSTEM REVIEW

Mark the following conditions that are **currently** a cause of significant concern for you.

General

☐	consistent fainting	☐	chills	☐	convulsions	☐	depression	☐	dizziness
☐	loss of weight	☐	fatigue	☐	fever	☐	headache	☐	loss of sleep
☐	weight gain	☐	neuralgia	☐	night sweats	☐	wheezing	☐	nervousness

Gastro-Intestinal

☐	constipation	☐	diarrhea	☐	gall bladder problems	☐	hemorrhoids	☐	jaundice
☐	liver problems	☐	nausea	☐	stomach pain	☐	poor appetite	☐	poor digestion
☐	rectal bleeding	☐	vomiting	☐	vomiting blood				

Eye/Ear/Nose/Throat

☐	asthma	☐	crossed eyes	☐	deafness	☐	earache	☐	ear discharge
☐	ear noises	☐	enlarged thyroid	☐	frequent colds	☐	hay fever	☐	hoarseness
☐	nasal obstruction	☐	nose bleeds	☐	pain in eyes	☐	poor vision	☐	sinusitis
☐	sore throat	☐	tonsillitis						

Respiratory

☐	chest pain	☐	chronic cough	☐	difficulty breathing	☐	spitting blood	☐	spitting phlegm

Muscles/Joints/Bones

☐	backache	☐	foot problems	☐	pain bet. shoulders	☐	painful tailbone	☐	stiff neck
☐	spinal curvature	☐	swollen joints	☐	tremors	☐	twitching	☐	weakness

Cardio-Vascular

☐	ankle swelling	☐	high blood pressure	☐	low blood pressure	☐	heart trouble	☐	pain over heart
☐	poor circulation	☐	rapid heart	☐	slow heart	☐	strokes		

Skin or Allergies

☐	bruise easily	☐	dryness	☐	eczema	☐	hives	☐	itching
☐	sensitive skin								

Women

☐	cramps	☐	excessive flow	☐	hot flashes	☐	irregular cycle	☐	painful periods

9 PREGNANCY — WOMEN ONLY

X-rays are contra-indicated during pregnancy. This clinic does not knowingly x-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant let the doctor or assistant know right now.

Are you pregnant? ☐ yes ☐ no On what date did your last period begin?

Do you want to take a pregnancy test now? ☐ yes ☐ no

OFFICE USE ONLY
result of clinic pregnancy test: + -

Mark the following situations as they pertain to you.

tubal ligation	☐ yes ☐ no	complete or partial hysterectomy	☐ yes ☐ no	partner had a vasectomy	☐ yes ☐ no
less than 10 days since the start of my last period	☐ yes ☐ no	taking birth control pills	☐ yes ☐ no		

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services
- It is my responsibility to complete the clinic's forms accurately
- It is my responsibility to notify the doctor if any of my information has changed or requires updating
- Original x-rays are the clinic's property and copies of the original film(s) and report(s) will be released to me upon written request

patient or guardian signature

date