SHERROD CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient_____

Patient SSN_____

Address_____

_____

City State Zip

Email_____

Sex: M F Age____ Birth Date_____

☐Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation_____

Employer_____

Employer Addr:_____

Spouse's Name_____

Spouse's DOB_____

Whom may we thank for referring you?

2 PAYMENT INFORMATION

Insurance ID # _____

__Auto Insurance Claim __Commercial Insurance

__No Insurance (Self Pay) __Medicare

__ Worker's Compensation

If this is a Commercial Insurance Claim, please fill out the following "Assignment and Release" and provide your health insurance card to the receptionist so she can make a copy of the card. We will file the insurance claim for you.

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependant) have insurance coverage with _____ and assign directly to Sherrod Chiropractic, PLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

3 PHONE NUMBERS

Home_____ Work_____ Ext._____

Cell_____ Best number to reach you_____

May we remind you of your next appointment via text msg?

Yes No (Circle One) If yes, what number? _____

IN CASE OF EMERGENCY, CONTACT:

Name_____ Relationship_____

Phone_____ Alt Ph_____

4 ACCIDENT INFORMATION

Is condition due to an accident? __Y __N Date_____

Type of accident ___Auto ___Work ___Home ___Other

To whom have you made a report of your accident?

___Auto Ins ___Employer ___Work Comp. ___Other

Information for Auto Claims Only:

Name of Auto Insurance:_____

Claim #_____ Ph#_____

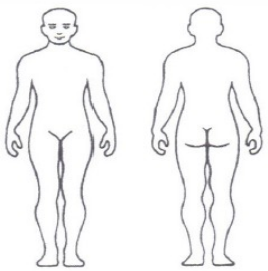
Adjuster's Name:_____

5 PATIENT CONDITION

Reason for Visit_____

When did your symptoms appear?_____

Mark an **X** on the picture for pain and mark an **O** for numbness and/or tingling.



1.) On a scale of 1-10, how bad is the discomfort at its worst? _____ At it's best? _____

2.) Circle the onset of the discomfort: Gradual or Sudden

3.) Since the problem began, have the symptoms been: better ,worse, same? _____

4.) What aggravates the discomfort? _____

5.) What percentage worse is the discomfort after it is aggravated (0-100%)? _____

6.) How many minutes will the discomfort remain that way? _____

7.) What relieves the discomfort?_____

8.) What is the quality of discomfort? _____

9.)When is the discomfort at its worst? (Circle one) Afternoon Morning Evening Before bed

10.) In general, would you say that your overall health is:

____ Excellent ____Very Good ____Good ____Fair ____ Poor

Patient Signature X_____ Date_____

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therpay ☐ Chiropractic Services ☐ None ☐ other_____

Name and addres of others doctor(s) who have treated your condition_____

Date of last: Physcial Exam_____Spinal X-Ray_____Blood Test_____
Spinal Exam_____Chest X-Ray_____Urine Test_____
Dental X-Ray_____MRI, CT Scan, Bone Scan_____

Please place a mark to indicate if you have had any of the following:

☐ AIDS/HIV	☐ Emphysema	☐ Migraine Headaches	☐ Rheumatic Fever
☐ Alcoholism	☐ Epilepsy	☐ Miscarriage	☐ Scarlet Fever
☐ Allergy Shots	☐ Fractures	☐ Mononucleosis	☐ Stroke
☐ Anemia	☐ Glaucoma	☐ Multiple Sclerosis	☐ Suicide Attempt
☐ Appendicitis	☐ Goiter	☐ Mumps	☐ Thyroid Problem
☐ Arthritis	☐ Gout	☐ Osteoporosis	☐ Tonsillitis
☐ Asthma	☐ Heart Disease	☐ Pacemaker	☐ Tuberculosis
☐ Bleeding Disorders	☐ Hepatitis	☐ Parkinson's Disease	☐ Tumors/Growths
☐ Breast Lump	☐ Hernia	☐ Pinched Nerve	☐ Typhoid Fever
☐ Bronchitis	☐ Herniated Disk	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ High Cholesterol	☐ Prostate Problem	Whooping Cough
☐ Chemical Dependency	☐ Kidney Disease	☐ Prosthesis	O Other_____
☐ Chicken Pox	☐ Liver Disease	☐ Psychiatric Care	_____
☐ Diabetes	☐ Measles	☐ Rheumatoid Arthritis	

EXERCISE	**Work Activity**	**Habits**	
☐ None	☐ Sitting	☐ Smoking	*Packs/Day*_____
☐ Moderate	☐ Standing	☐ Alcohol	*Drinks/Week*_____
☐ Daily	☐ Light Labor	☐ Coffee/Caffiene	*Drinks/Week*_____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	*Reason*_____

Are you Pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had: Description Date

Falls_____
Head Injuries_____
Broken Bones_____
Dislocations_____
Surgeries_____

People choose chiropractic care for a number of reasons. How long you decide to benefit from chiropractic care is always up to you. Please check the type of care you desire so that we can meet your needs whenever possible.
___Relief Care ___Corrective Care ___Maintenance Care ___Check here if you'd like the Doctor to decide the best type for you

By my signature below, I authorize Sherrod Chiropractic, PLC to release any information deemed appropriate to any doctor, insurance company or attorney in the course of my treatment or in order to process any claim for reimbursement of charges. I hereby assign all the right, title and interest relative to insurance benefits to Sherrod Chiropractic, PLC. I clearly understand and agree that I am personally responsible for payment of all services rendered to me. Further, in the event that my account is turned over for collection, I understand that I will be responsible for any charges, attorney fees, collection costs and court cost incurred in collecting the balance.

By my signature below, I acknowledge that there are inherent risks involved with spinal manipulation. In 1995, Rand reported the risk of serious complication approximate 1 in 1 million to 1 in 1.5 million. I authorize the doctor to diagnose and treat my condition as deemed appropriate, including the use of spinal manipulation. I understand the above information and guarantee that this form was completed correctly to the best of my knowledge.

SIGNATURE_____ **DATE**_____

IF MINORS, PARENT/GUARDIAN SIGNATURE_____ **DATE**_____

(CMS requires providers to report the following for the government EHR incentive program)

Patient's Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker/ Occasional Smoker/ Former Smoker/ Never Smoked

Race (Circle one): American Indian or Alaska Native/ Asian/ Black or African American/ White (Caucasian) Native Hawaiian or Pacific Islander/ Other/ I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino/ Not Hispanic or Latino/ I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Vitamins/Herbs/Minerals	Dosage and Frequency (i.e. once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Do you have any other allergies? _____

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

I received a copy of Notice of Privacy Practices.

Patient Signature: _____ **Date:**_____

For office use only

Height:_____ Weight: _____ Blood Pressure:_____/_____

Heart rate: _____ Resp.: _____ Temp: _____ Ortho: _____

Neuro.:_____ X-rays_____