PATIENT INFORMATION

Name _____ Today's Date _____

Preferred Name _____

Address_____ City_____ State____ Zip_____

Gender M_____ F_____ Other_____ DOB_____ Age _____

Cell Phone (___)_____ Home Phone (___)_____ Work Phone (___)_____

Email Address_____ Referred by:_____

Is it ok to leave a message on your home phone? Yes____ No____

Medical Insurance _____ ID # _____

Level of Education High School ___ Some College ___ College Grad ___ Post Grad ___

Occupation _____ Type of Work _____

Employer Name_____ Address_____

This work requires Sitting ___ Standing ____ Walking ___ Lifting___

Typical Schedule Days ____ Evenings____ Shift ____

Marital Status Single Married Divorced Partnered Widowed

Spouse/Partner Name _____

Spouse's Employer _____

Cell Phone (___) _____ Work Phone (___)_____

Is your spouse/partner a patient of the clinic? Yes ____ No____

Emergency contact other than spouse/partner_____

Cell Phone (___) _____ Work Phone (___)_____

Do we have your permission to share your account or appointment information with a spouse or another person?

Yes ___ No___ Who?_____

Have you been seen by a Chiropractor prior to this visit? Yes_____ No_____

If so, where? _____ When? _____

Reason for visit? _____

Location of Primary Complaint _____

Complaint began when and how? _____

Please circle the type of complaint/pain: dull aching sharp shooting burning throbbing deep nagging

Does this complaint/pain radiate or travel to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

Frequency of pain, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Previous interventions, treatments, medications, surgery, imaging, lab tests or other care you've received for your complaint_____

Location of Secondary Complaint _____

Complaint began when and how? _____

Please circle the type of complaint/pain: dull aching sharp shooting burning throbbing deep nagging

Does this complaint/pain radiate or travel to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

Frequency of pain, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Previous interventions, treatments, medications, surgery, imaging, lab tests or other care you've received for your complaint _____

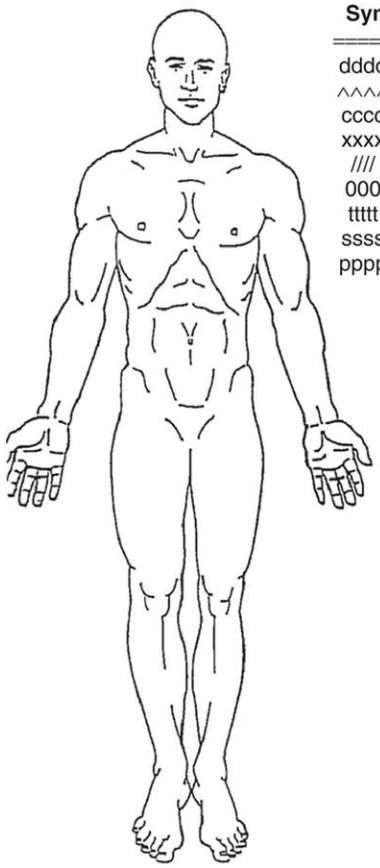
Previous injury or trauma? _____

Broken bone(s)? Yes____ No_____ Which bone(s)? _____

Patient Name _____ Date _____

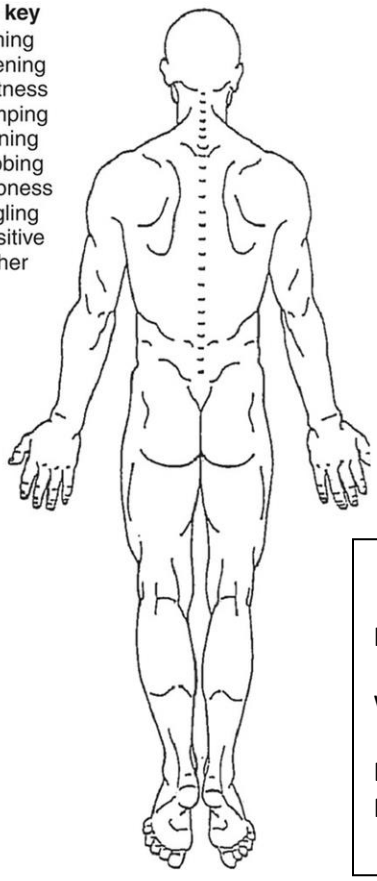
PAIN DIAGRAM

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:



Symptom key

=====	Aching
dddd	Stiffening
^^^^	Tightness
cccc	Cramping
xxxx	Burning
////	Stabbing
000	Numbness
ttttt	Tingling
ssss	Sensitive
pppp	Other



Height_____

Weight_____

Blood Pressure_____

Right Left Left Right

Recreational Activities

__Backpacking	__Biking	__Boating	__Running
__Golfing	__Racquetball	__Tennis	__Rock Climbing
__Skiing	__Soccer	__Swimming	__Walking
__Weight Lifting	__Football	__Basketball	__Volleyball
__Cross Fit	__Dancing	__Yoga	__Other

Patient Name _____ Date _____

Review of Systems

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for awhile, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, Please circle the ones that apply, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Constitution (General Health) □ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer.
Other: _____

Ears, Nose, Mouth & Throat □ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness.
Other: _____

Heart & Blood Vessels □ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Respiratory (Lungs & Breathing) □ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray.
Other: _____

GI (Stomach & Intestines) □ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence.
Other: _____

GU (Kidney & Bladder) □ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) □ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Skin, Hair & Breast □ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) □ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss.
Other: _____

Psychiatric (Mood & Thinking) □ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) □ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) □ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunoligic □ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

Patient Name _____ Date _____

Family and Personal Health History

__Arthritis Parent / Sibling
__Cholesterol Parent/Sibling
__Diabetes Parent / Sibling
__Heart Problem Parent / Sibling
__Thyroid Parent / Sibling
__Cancer Parent / Sibling
__Psychiatric Parent / Sibling
__HB Pressure Parent / Sibling
__ Stroke Parent / Sibling
__Other_____

Immediate Family Deaths

Relation_____ Age at Death___ Cause_____
Relation_____ Age at Death___ Cause_____
Relation_____ Age at Death___ Cause_____
Relation_____ Age at Death___ Cause_____

Pregnancies/Children

Date_____ Outcome _____
Date_____ Outcome_____
Date_____ Outcome_____
Date_____ Outcome_____

What was the date of the beginning your last menstrual period?_____

Surgeries

___Appendectomy	___Gall Bladder	___Rotator Cuff	___Other_____
___ACL	___Lumbar Disc	___Prostatectomy	___Other_____
___Cardiovascular	___Cervical Disc	___Prostate	___Other_____
___Joint Replacement	___Mastectomy	___Hysterectomy	___Other_____
Specify _____	Partial____ Full___	Partial___ Full___	

Prescription Medications (Please List)

_____

_____

Over the Counter Medications and/or Supplements (Please List)

_____

_____

Substance Use

__ Alcohol Past /Present
__Barbiturates Past/Present
__Crystal Meth Past/Present
__Marijuana Past /Present
__Amphetamine Past/Present
__Other_____
__Heroine Past /Present
__Cocaine Past/Present

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature_____ Date_____

FINANCIAL POLICY

In the interest of good health care practice, it is desirable to establish a policy to avoid misunderstandings. Our primary responsibility is to help patients experience good health and we wish to spend our time toward that end. Therefore, we would like to inform you of our financial policy.

- Any estimates for Patient treatment fees, are just an estimate
- Payment is due at the time of your visit
- Nutritional supplements and other supplies must be paid at time of visit
- Cancellation/No Show policy: 24 hour notice is required for all appointment cancellations. A $15.00 fee will be charged to the patient for all late cancellations and no shows.

Self Pay Patients: When you are paying for services on the day of your visit and we are not billing your insurance company, filling out any type of forms or paperwork or waiting for payment, we offer a bookkeeping discount on some services.

Medical Insurance: As a courtesy to patients, we will bill your primary insurance carrier; however we do not bill secondary companies except for Medicare patients. Please be aware that any insurance quote for coverage is not a guaranty of benefits. Co-payments, deductibles and percentages that are patient responsibility are due at the time of service. By signing this form, you are authorizing the release of your records to facilitate claims processing and for continuity of care. You are also authorizing that payments be made directly to Tracy & Keim Chiropractic, LLC. We reserve the right to refuse to do business with any insurance company that requires completion of forms regarding permission for us to carry out our patient treatment plan.

Personal Injury/Auto Insurance: Regardless of who the responsible party is, a claim will be established with your auto insurance company. Please contact your agent, inform them of your care and request forms to set up a claim. You are still personally responsible for your bill but you will not be required to pay as services are rendered. If your balance reaches $800 and your insurer is withholding payment for any reason, you will be required to start paying for services: we do not hold balances over $800.00 we require that you sign a lien form assigning payment to Tracy and Keim Chiropractic, LLC from an insurance company or from an attorney in cases where one has become necessary.

Worker's Compensation: You are not personally responsible for the account unless your claim is partially or totally denied by Worker's Comp. At that point, we can bill your private insurance if you have chiropractic benefits with that company, or we begin collecting from you if no benefits are available.

Medicare: We are non-participating providers but can accept Medicare patients. Medicare only pays toward spinal manipulation related to an incident or injury, and they will send payment to you. You will be required to pay at the time of service for all services or supplies in our office.

Thank you for taking the time to read this policy. If you have any questions, please don't hesitate to ask.

_____ _____

Patient or Guardian Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, (patient name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Tracy & Keim Chiropractic, LLC, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ _____

Date Patient or Guardian Signature

_____

Print Name

PATIENT INFORMED CONSENT FORM

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain informed consent before starting treatment.

I, _____, consent to examination and to the performance of conservative noninvasive treatments for my condition, by Dr. Sharell Tracy, Dr. Richard Keim, and/or Dr. Megan Wagner. I understand that the procedures may consist of manipulations involving movement of my joints and soft tissues, along with physical therapy modalities, rehabilitative exercises, x-rays, K-laser, electric therapies and nutraceuticals.

Although spinal and extremity manipulation is considered to be one of the safest and most effective forms of therapy for musculoskeletal problems, I am aware that, as with any form of therapy, there are possible risks and complications associated with these procedures, which are as follows:

- Soreness: I am aware that like exercise it is common to experience muscle soreness after a few treatments.
- Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
- Joint Injuries: I understand that in isolated cases, underlying physical defects, deformities of pathologies like weak bones from osteoporosis may render that patient susceptible to injury. When osteoporosis, discal degeneration, or other abnormality is detected, extra caution will be employed.
- Physical Therapy burns: Some of the therapies used in this office generate heat and may rarely cause burns. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.
- Strokes: Strokes from chiropractic manipulation are extremely rare. I am aware that nerve or brain damage including stroke is reported to occur one in a million to once in ten million treatments, the same chance as being struck by lightning or having a normal dose of Tylenol cause death.

Tests will be performed on me prior to treatments to minimize the risks of these or any other complication from treatment, and I freely assume these risks. I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, reduced muscle spasm, increased mobility, and improved neurological function. However, I appreciate that there is no certainty that I will achieve these benefits. I realize that the practice of all forms of medicine, including chiropractic, is not an exact science, and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have regarding these procedures or alternative treatments available have been answered to my satisfaction prior to my signing this consent form. I have made my decision voluntarily and freely.

Patient Name:_____ DOB_____

Patient or Guardian Signature_____ Date _____

Doctor/Witness Signature_____ Date_____