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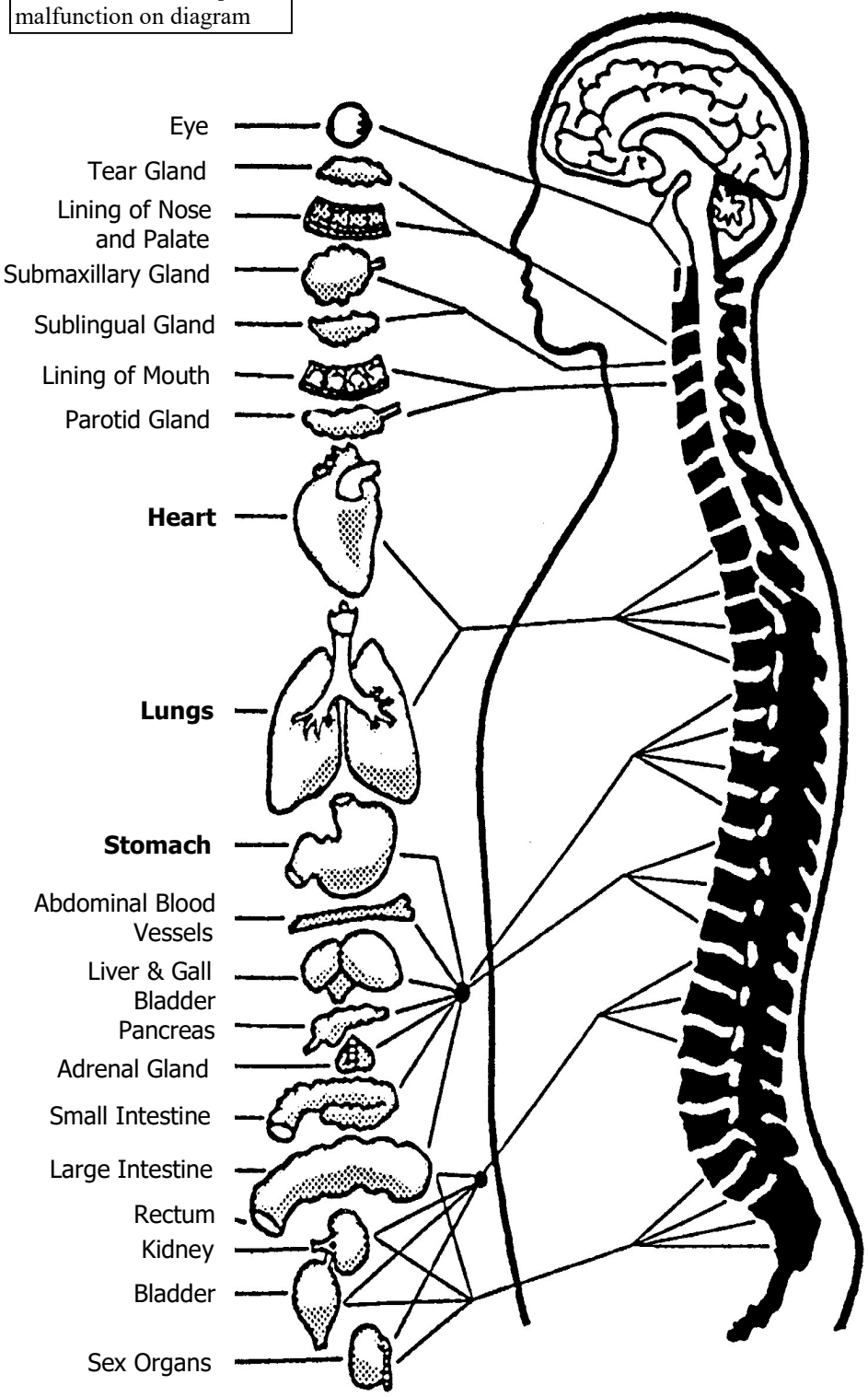
Martin Chiropractic

Health Questionnaire

Please circle area of pain or malfunction on diagram



Are you now or have you suffered from any of the following… Check Appropriate Box.

Past	Present	No	
☐	☐	☐	Eye disorders
☐	☐	☐	Loss of Taste
☐	☐	☐	Headaches
☐	☐	☐	Nervousness
☐	☐	☐	Trouble Sleeping
☐	☐	☐	Dizziness
☐	☐	☐	Loss of Smell
☐	☐	☐	Sinus Trouble
☐	☐	☐	Ear Disorders
☐	☐	☐	Frequent Sore Throats
☐	☐	☐	Asthma
☐	☐	☐	Hay Fever/Allergies
☐	☐	☐	Persistent Coughs
☐	☐	☐	Stomach Problems
☐	☐	☐	Rheumatic Fever
☐	☐	☐	Tuberculosis
☐	☐	☐	Heart Disease
☐	☐	☐	High Blood Pressure
☐	☐	☐	Diabetes
☐	☐	☐	Poor Digestion
☐	☐	☐	Nausea
☐	☐	☐	Vomiting
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Abdominal Pains
☐	☐	☐	Hemorrhoids
☐	☐	☐	Urinary Disorders
☐	☐	☐	Bed Wetting
☐	☐	☐	Menstrual Disorders
☐	☐	☐	Sex Problems
☐	☐	☐	Tension
☐	☐	☐	Irritability
☐	☐	☐	Fatigue

Patient's Name

Date

Case #

Symptoms related to the Autonomic Nervous System

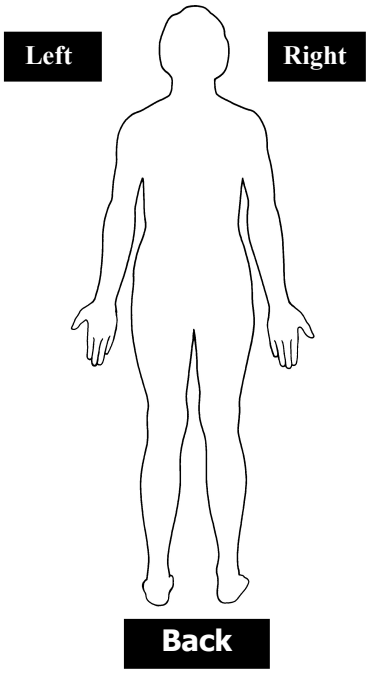
Chiropractic deals with the relationship between your spine and nervous system.

The Nervous System's function is to control and coordinate all the other organs and structures. Pinched or irritated nerves may interfere with the function and thus cause a wide variety of symptoms.

Name _____ Date _____ Case # _____

Symptoms that can be related to Spinal Nerves

Please mark area of pain on diagram.



Past	Present	No		Past	Present	No	
☐	☐	☐	Scalp Disorders	☐	☐	☐	Low Back Pain
☐	☐	☐	Head Pain or Headaches	☐	☐	☐	Low Back Weakness
☐	☐	☐	Neck Pain	☐	☐	☐	Low Back Stiffness
☐	☐	☐	Shoulder Pain or Stiffness	☐	☐	☐	Hip Pain or Stiffness
☐	☐	☐	Arm Pain	☐	☐	☐	Buttock Pain
☐	☐	☐	Tennis Elbow	☐	☐	☐	Leg Cramps
☐	☐	☐	Loss of Arm Power	☐	☐	☐	Tingling, Numbness, or Pain of Leg
☐	☐	☐	Loss of Grip	☐	☐	☐	Knee Trouble
☐	☐	☐	Tingling, Numbness, or Pain of Hand	☐	☐	☐	Foot Trouble
☐	☐	☐	Mid Back Pain	☐	☐	☐	Tingling, Numbness, or Pain of Foot
☐	☐	☐	Mid Back Tension				
☐	☐	☐	Pain in Ribs				

No Symptoms _____ Extreme Symptoms

Please place an "X" on the line above to indicate your level of PAIN.

Family History

	Self	Father	Mother	Brother	Sister	Mat.Grands	Pat. Grands	Children
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Aneurysm	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol Use (Past or present)	☐	☐	☐	☐	☐	☐	☐	☐
Tobacco Use (Past or present)	☐	☐	☐	☐	☐	☐	☐	☐
Drug Use (Past or present)	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐
Family Members Still Alive	☐	☐	☐	☐	☐	☐	☐	☐
Other Hereditary Disorders	☐	☐	☐	☐	☐	☐	☐	☐

How many children do you have? _____

What are their current ages? _____

Personal Habits

Type	Amount	Per *
Exercise		
Dairy Products		
Soda Pop		
Coffee/Tea		
Alcoholic Beverages		
Tobacco (any type)		
Drugs (any type)		
Vitamins		

* Please write Day, Week, or Month as applicable.

Occupation

What is your trade? _____

Does your job require you to:

☐ Sit ☐ Stand ☐ Bend ☐ Walk ☐ Lift

How much? _____

Please list your medications, including amount and frequency. Also list any allergies to meds. Use additional sheet if necessary.

_____ _____

_____ _____

Dr.'s Notes: _____

_____

_____

MARTIN CHIROPRACTIC
PATIENT CONDITION INFORMATION

Name:_____ Case # _____

Main complaint and symptoms: _____

Describe the pain: ☐ Sharp ☐ Dull ☐ Tightness ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing

Does the pain radiate into your arms or legs? ☐ Yes ☐ No Which? _____

How frequent is the condition? ☐ Constant ☐ Intermittent ☐ Daily ☐ Night only

How long does it last? ☐ All Day ☐ Few Hours ☐ Minutes

When did you *first* notice this problem? _____

Date & cause of most recent aggravation: _____

Has your condition ☐ Improved ☐ Gotten worse or ☐ Stayed the same since its onset?

Was your condition ☐ Caused or ☐ Aggravated by an accident? ☐ Yes ☐ No.

If your above answer is yes, please check the type of accident? ☐ Auto ☐ On the Job ☐ Other.

Describe the Accident _____

What makes your condition worse? ☐ Sitting ☐ Standing ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting

Other _____

Does anything make it feel better? _____

Have you had any previous treatment for this or similar conditions? ☐ Yes ☐ No.

When? Treated how long? _____Who treated you? _____

Results? _____

Have you been under previous chiropractic care? ☐ Yes ☐ No Who? _____

List and describe the nature of any Trauma or Injury: _____

Hospitalizaions:	**Date**	**Reason**	**Treating Hospital**
	_____	_____	_____
	_____	_____	_____

Women: Is there any possibility that you're pregnant? ☐ Yes ☐ No Date of Last Menstrual Period: _____

INFORMED CONSENT

Informed consent is more than just a signed document. The following categories will be or have been discussed.

- What's wrong? Or your diagnosis.
- What tests will be ordered; the reason for them; and results expected to achieve.
- Whether or not Chiropractic can be helpful and potential risk factors for your particular condition(s).
- Alternative treatments and your options.
- A treatment plan outlined for your case with expected time frame for results.
- Cost of this Treatment.

These categories have been discussed with me in my report of findings; and I am authorizing the doctor to treat my conditions within the parameters outlined, to the best of his ability.

PATIENT'S SIGNATURE: _____ **DATE:**_____

Martin Chiropractic, 5905 W. Rolling Hills Dr. Bridgeport, MI 48722 (989) 777-8282

Case #

MARTIN CHIROPRACTIC

PATIENT INFORMATION

NOTE: PLEASE COMPLETE THIS FORM WITH YOUR SIGNATURE AT THE BOTTOM OF THE PAGE

Patient's Name: _____ Nickname: _____

Social Security #:_____ E-mail Address:_____

Address: _____ Home Phone: (_____)_____

City: _____ State _____ Zip _____ Cell Phone: (_____)_____

Birth Date: _____ Sex: M F Race:_____ Marital Status: M S W D Spouses Name:_____

Your Employer _____ Phone: (_____)_____
Address: _____
Name & Address of your physician: _____

- A **Patient-Centered Medical Home (PCMH-N)** is a trusting partnership between a doctor led health care team and an informed patient. It includes an agreement between the doctor and the patient that acknowledges the role of each in a total health care program. **Do you want a report sent to your family physician?** ☐ Yes ☐ No

Name and address of Nearest Relative not living with you _____

_____City _____ State _____ Zip _____ Phone (_____)_____

Who referred you to our office at **MARTIN CHIROPRACTIC?** _____

INSURANCE INFORMATION*

**Please complete this section in full if you are covered by insurance or are entitled to receive benefit payments.*

This information will assist us in helping you obtain the benefits to which you may be entitled.

Cardholder: _____ D.O.B. _____Relationship to Cardholder: _____

Cardholder's Employer: _____ Address: _____

Name of Insurance Company: _____

Enrollee ID/Contract#: _____ Group# _____

PATIENT CERTIFICATION AND SIGNATURE.

I certify that the above information is true and correct. I hereby authorize the release of any information required to secure payment for services rendered. I also authorize and direct that any insurance or medical coverage benefit payments to which I may be entitled shall be paid directly to **MARTIN CHIROPRACTIC.**
I understand and agree that I am financially responsible for and will promptly pay any non-covered services including, but not limited to, deductible and copay.

The patient understands and agrees to allow this chiropractic office to use their Patient Health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

PATIENT'S SIGNATURE_____ DATE _____

PATIENT MARTIN CHIROPRACTIC
FINANCIAL INFORMATION

ON THE JOB INJURY
Worker's Compensation pays in full of chiropractic care. We cannot accept you as a Work Comp case until we have written authorization from your employer. Upon being released from care, a three-month time period is allowed for settlement of your claim. If a settlement has not be reached within this time period, or if you have suspended or terminated your care without your doctor's approval, payment for services is due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS
Please present your auto insurance forms as soon as possible. If an attorney is handling your case, please notify the insurance department in our office right away. Although you are ultimately responsible for your bill, our office will wait for settlement to be paid as long as you are an active patient. If you suspend or terminate care, any fees or services are due immediately.

GROUP OR INDIVIDUAL INSURANCE
Your insurance is an agreement between you and your insurance company, not between your insurance company and this office. As a courtesy to our patients, our office will complete any necessary insurance forms at no charge, and file them with your company to help you collect. It is to be understood and agreed that services rendered are charged to you directly and you are personally responsible.

PATIENTS WITHOUT INSURANCE
- We request that 100% of the first visit be paid at the time of service.
- We are happy to accept your check, MasterCard, Visa or Discover Card.

MEDICARE
We do accept assignment from Medicare. **Medicare will provide payment for adjustments only.** You will be required to pay your 20% co pay on your adjustments after your deductible has been satisfied. We will bill your secondary insurance for your exam, x-rays, extremity adjustments, and tractions, if applicable. You will be responsible for what your insurance does not pay.

HEALTH MAINTENANCE ORGANIZATION (HMO)
We do accept assignment of many types of Health Maintenance Organizations. Patients are required by their HMOs to get referrals from their family physicians in order for their HMO insurance to cover their services at our office. The referrals must be dated for the date of services prior to office visit.

INSURANCE COVERAGE & PAYMENT
Copays and deductible amounts are due on the date of service. Martin Chiropractic will make every effort to verify your insurance benefits. **However, please note, verification does not guarantee payments**. You are asked to authorize Martin Chiropractic to furnish information regarding your case to your insurance company and to assign all benefits as a result of the claim. This permits us to follow up if benefits are other than anticipated. It also permits us to keep abreast of recent developments with local insurance companies, which enables us to continue to provide you with the most up-to-date information available.

SIGNATURE: _____ Date:_____ Case#_____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. **The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. "In the course of providing care, providers will share either written or electronic patient information with other providers who are involved in the patient's care, as appropriate." As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.**
2. **The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.**
3. **A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.**
4. **The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.**
5. **Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.** *If you do not wish to receive further information from this office, please contact us at 989-777-8282.*
6. **For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.**
7. **Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures.**
8. **Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.**
9. **This notice is effective on the date state below.**
10. **If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.**

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

SIGNATURE: _____ Date:_____ Case#_____