

B. PATIENT'S COMPLAINTS (CONTINUED)

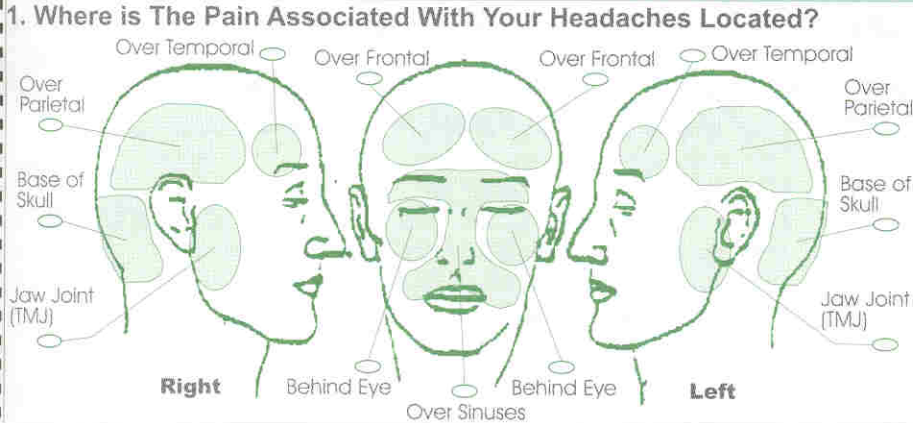
2. How Did Your Complaint(s) Begin[1]?
 Unknown Suddenly Gradually
3. What Happened To Cause Or Re-Agravate Your Complaint(s)?
 Cause Not Known Auto Accident
 Work Accident/Injury Home Accident
 Personal Injury Sport Injury
- Other - Describe: _____
4. How Would You Rate Your Overall Pain Today Where 0 Is No Pain And 10 Is The Worst Pain[1]?
 No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible
5. When Are Your Symptoms Worse?
 Morning Afternoon Evening Night
 Always The Same
6. What Makes Your Condition Better?
 Nothing Stretching Heat
 Rest Exercise Ice
 Sitting Standing Medications
 Other

7. What Makes Your Condition Worse?
 Nothing Coughing Reaching Standing
 Sneezing Lifting Sitting Pulling
 Bending Walking Straining at Stool Turning
 Other
8. Have Any Of Your Complaint(s) Existed In The Past? Yes No
 If Yes, Indicate Below
 Neck Upr Back Mid Back Low Back Ribs
 Shoulder Arm Elbow Forearm Wrist Hnd/fgrs
 Buttock Hip Thigh Knee Leg/calf Ankle
 Foot Others: _____
9. Have You Had Any Recent Treatment For Your Conditions OUTSIDE Of This Office[1]?
 Yes No If Yes, List Dates, Treatments, And Doctors.
10. Since Your Symptoms Began, Have You Noticed A Change In?

Bowel Function	<input type="radio"/> Yes	<input type="radio"/> No	<input checked="" type="radio"/> No To All
Bladder Function	<input type="radio"/> Yes	<input type="radio"/> No	
Sexual Function	<input type="radio"/> Yes	<input type="radio"/> No	

C. HEADACHES

If You Are Experiencing Headaches, Please Fill Out This Section Otherwise Skip To Section D.



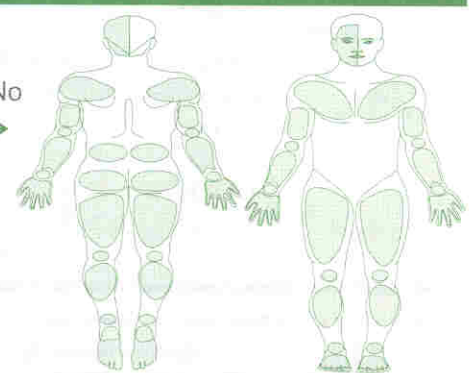
6. What Seems To Bring On Your Headaches?
 Physical Activity Caffeine
 Excessive Stress Certain Foods
 Alcohol Menstrual Period
 Other
7. How Often Do They Occur[1]?
 Times/Week: 1 2 3 4 5 6 7 8 9
 Times/Month: 1 2 3 4 5 6 7 8 9
 Other
8. How Long Do Your Headaches Last[1]?
 Less Than 1 Hour From 1-3 Hours
 Longer Than 3 Hours All Waking Hours
 Several Hours To Days
 Other

2. On What Date Did Your Headaches Begin[1]?
 Date: / / Same As Neck/Back Complaints
3. How Does The Intensity Of Your Headaches Rate[1]?
 No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible
4. What Describes Your Pain?
 Dull Sharp Aching Stabbing
 Deep Vice-Like Burning Throbbing/Pulsating
 Other
5. When Do Your Headaches Usually Start?
 Constant/Anytime Awake Wake Up With In Morning
 At Midday During Evening

9. Do Your Headaches Wake You From Sleep[1]?
 No Sometimes Always
10. Do Any Of The Following Occur With Your Headaches?
 Nausea/Vomiting Weakness
 Tremor Vision Problems
 Dizziness Light/Sound Sensitivity
 Other
11. What Makes Your Headaches Better?
 Nothing Rest Lying Down Ice/Cold Packs
 Massage Standing NSAIDS (Aspirin, Tylenol, etc.)
 Other

D. OTHER COMPLAINTS

Do you have any other complaints not covered on this form[1]? Yes No
 If Yes, Describe other complaints in detail and mark body areas on Figures. →



HEALTH QUESTIONNAIRE-HISTORY

Patient's Name

F. HABITS/ACTIVITIES

What Are Your Current Habits? Packs Per Day
 Smoking..... Never <1 1-2 2-3 3-4 5+

Caffeinated Drinks..... Never <1 1-2 2-3 3-4 5+

Alcohol Consumption..... Never <1 1-2 2-3 3-4 5+

Drug/Substance Abuse.. No Yes If Yes, Discuss With Doctor

Exercise..... Never <1 1-2 2-3 3-4 5+

Kinds Of Exercise You Do:
 Walking Jogging Cycling Swimming
 Golf Tennis Strength Training
 Other:

E. REVIEW OF SYSTEMS

Are You Currently Suffering From Any Of The Symptoms Listed Below? If This Is A Re-Examination Mark Only New Symptoms Since Your Last Exam.

None Of The Symptoms Listed Below No New Symptoms Since Your Last Exam

- | | |
|---|--|
| <input type="radio"/> General Fatigue | <input type="radio"/> Skin Rash |
| <input type="radio"/> Weakness | <input type="radio"/> Redness Of Skin |
| <input type="radio"/> Fever (continuous) | <input type="radio"/> Skin Itching |
| <input type="radio"/> Loss Of Sleep | <input type="radio"/> Skin Dryness |
| <input type="radio"/> Chills (continuous) | <input type="radio"/> Eczema(red, inflamed skin) |
| <input type="radio"/> Weight Change (unplanned) | <input type="radio"/> Hair Changes (unplanned) |
| <input type="radio"/> Night Sweats | <input type="radio"/> Nail Changes (unplanned) |
| <input type="radio"/> Headaches | <input type="radio"/> Bruise Easily |
| <input type="radio"/> Dizziness | <input type="radio"/> Cough (chronic) |
| <input type="radio"/> Fainting | <input type="radio"/> Wheezing (chronic) |
| <input type="radio"/> Convulsions | <input type="radio"/> Difficulty Breathing |
| <input type="radio"/> Nervousness | <input type="radio"/> Swollen Extremities |
| <input type="radio"/> Anxiety | <input type="radio"/> Blue Extremities |
| <input type="radio"/> Depression (prolonged) | <input type="radio"/> Varicosities (visible veins) |
| <input type="radio"/> Phobias (excessive fears) | <input type="radio"/> Rapid Heart Beat |
| <input type="radio"/> Memory Loss Or Impairment | <input type="radio"/> Chest Pain |
| <input type="radio"/> Mood Swings (excessive) | <input type="radio"/> Heart Palpitations |
| | <input type="radio"/> Heart Murmur |
| <input type="radio"/> Hearing Trouble | <input type="radio"/> Decreased Appetite |
| <input type="radio"/> Ringing in Ears | <input type="radio"/> Increased Appetite |
| <input type="radio"/> Pain in Ears | <input type="radio"/> Abdominal Pain |
| <input type="radio"/> Ear Discharge | <input type="radio"/> Hemorrhoids |
| <input type="radio"/> Vision Trouble | <input type="radio"/> Excess Gas |
| <input type="radio"/> Pain in Eyes | <input type="radio"/> Vomiting (excessive) |
| <input type="radio"/> Eye Discharge | <input type="radio"/> Diarrhea (excessive) |
| <input type="radio"/> Nose/Sinus Pain | <input type="radio"/> Constipation (excessive) |
| <input type="radio"/> Excessive Drainage | <input type="radio"/> Heartburn/Indigestion |
| <input type="radio"/> Nose Bleeds (chronic) | <input type="radio"/> Painful Urination |
| <input type="radio"/> Nasal Infections (chronic) | <input type="radio"/> Inability To Hold Urine |
| <input type="radio"/> Absence Of Smell | <input type="radio"/> Frequent Urination |
| <input type="radio"/> Mouth Sores | <input type="radio"/> Urinary Retention |
| <input type="radio"/> Bleeding Gums | <input type="radio"/> Bed-wetting |
| <input type="radio"/> Enlarged Glands | <input type="radio"/> Irregular Menstruation |
| <input type="radio"/> Absence Of Taste | <input type="radio"/> Painful Menstruation |
| <input type="radio"/> Abnormal Taste Sensation | <input type="radio"/> Abnormal Vaginal Bleeding |
| <input type="radio"/> Tonsillitis/Infected Tonsils | <input type="radio"/> Sterility |
| <input type="radio"/> Difficulty With Swallowing | <input type="radio"/> Impotence |
| <input type="radio"/> Heat/Cold Intolerance | <input type="radio"/> Lumps In Breast(s) |
| <input type="radio"/> Sugar In Urine | <input type="radio"/> Redness/Itching of Breast |
| <input type="radio"/> Goiter (enlarged Thyroid gland) | <input type="radio"/> Dimpling of Breast(s) |
| <input type="radio"/> Tremor (shaking) | <input type="radio"/> Discharge from Breast(s) |
| | <input type="radio"/> Breast Pain |

Other (Please Describe)

G. MEDICAL HISTORY

1. HEALTH CARE

a. Have You Ever Been To A Chiropractor? Yes No

b. Do You Have A Family Physician Yes No

Date Of Last Physical Exam: _____

Physician's Name: _____

Address: _____

Phone: () _____

c. Have You Been Hospitalized In The Past? Yes No

Date & Reason For Hospitalization: _____

d. Have You Ever Had Surgery? Yes No

Date, Reason, Results Of Surgery: _____

e. Have You Ever Had A Serious Accident/Injury? Yes No

List Date & Describe Injury:

Auto: _____

Work-Related: _____

Personal: _____

Sports Injury: _____

Other: _____

f. Are You Currently Taking Any Vitamins, Minerals, Or Herbs? (List Supplements) Yes No

g. Are You Currently Taking Any Medications? Yes No

For What Condition(s) Are You Taking Medication?

Anti-inflammatory (Aspirin, Ibuprofen, Motrin, etc.):

Pain/Analgesics: _____

Anti-Depressants: _____

Muscle Relaxants: _____

Blood Pressure Pills: _____

Antibiotics: _____

Birth Control Pills: _____

Corticosteroid: _____

Other: _____

In The Past Have You Use Any Of The Following?

Birth Control Pills Corticosteroid

h. Are You Allergic To Any Medications? Yes No

List Medications: _____

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. 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. 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.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. 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.

Name of Patient

Date



AUTHORIZATION, ASSIGNMENT, ACKNOWLEDGEMENT AND UNDERSTANDING

Authorization to release information: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand and agree to allow McLeod Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

Assignment of Payment: My attorney and/or insurance company are hereby requested to pay direct to McLeod Chiropractic Center any monies due on account, the same to be deducted from any settlement made of my behalf. Furthermore, it is understood that I, the undersigned, agree to pay the full amount of the charges, should my condition be such that is not covered by my policy, or, if for any reason, the insurance company and/or attorney refuses to pay my claim.

Medicare Assignment: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

Consent to care for a minor: I hereby authorize McLeod Chiropractic Center to administer care as deemed necessary to:

Child's name

I hereby acknowledge that I am receiving (or are about to receive) health care services at McLeod Chiropractic Center and that I have been advised that McLeod Chiropractic Center is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by the insurance proceeds or out of the settlement of a liability case.

I understand that if it is determined either:

- A. that there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to McLeod Chiropractic Center or to make other provisions for the protection of the interest of McLeod Chiropractic Center, or
- B. a liability claim exists and my attorney refuses to agree to protect the interest of McLeod Chiropractic Center, or if I have not engaged the services of an attorney: then payment of services at McLeod Chiropractic Center will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

Patient Name

Patient Signature

Date Signed

Witness

PROFESSIONAL COURTESY

As a professional courtesy, I authorize McLeod Chiropractic Center to provide my medical doctor with a report for my medical record. Please send to:

Name of Medical Doctor

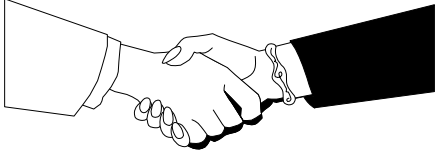
Office Name

Office Address

(____)_____
Telephone

Patient Name

Patient Signature



Terms of Acceptance

When a patient seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that they both be seeking and working for the same goals.

Chiropractic has one goal. It is important that a patient understand this goal and the means that it will be used to attain it. In this way there will be no confusion, misunderstanding or disappointment.

Patients usually want their conditions, ailments or symptoms treated. This is not the goal of the chiropractor. The purpose of chiropractic is to restore and maintain the integrity of the spinal cord and its nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine called vertebrae. Tiny misalignments of the vertebrae, which interfere with the functions of the nerve pathways are called subluxations. They come from many causes and prevent the body from working properly.

By means of chiropractic adjustments, subluxations are corrected, restoring normal nerve function. The goal of chiropractic is to correct these subluxations so that every part of the body may have a proper nerve supply at all times. This allows the innate healing ability of the body to work at maximum efficiency.

With the proper nerve supply, health improves. In some cases, symptoms clear up quickly, for others, the process is slower: in some it is only partial, or not at all.

Regardless of the disease, the chiropractor is not offering to diagnose, treat or cure it. His goal is to allow the body to do its job as best it can without nerve interferences. This goal is accomplished by the correction of vertebral subluxations.

The chiropractic examination and adjustment are not substitutes for other types of health care, just as other types of care do not take the place of chiropractic.

At the McLeod Chiropractic Center, we utilize "Open Room Adjusting" in which multiple adjusting tables are side by side and you will often be treated while other patients are in the room. We have found this arrangement has many benefits for our patients. The greater efficiency allows us to greatly shorten waiting time (most days you will not have to wait at all) and the doctor's advice on healthy living is beneficial for all to hear. Personal or embarrassing topics will not be discussed in this open forum but anything you discuss with the doctor can and will be overheard by other patients.

If you wish to discuss a private matter with the doctor, please notify a team member at the front desk so you may be seen separately. It is not necessary for you to tell the team member the subject of this discussion. We have a separate room to adjust those patients that do not want to participate in Open Room Adjusting. Please note that, if you make this choice, your wait will be longer to see the doctor and your choice of appointment times will be limited. If you wish to be adjusted away from the Open Adjusting Room, please notify the team member at the front desk for special accommodations.

I, _____ have read and fully understand the above statements.
Print Name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

signature

date

Appointment Reminders and Health Care Information Authorization

Your Chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.

Also, by signing this form, you are giving authorization to use your basic information, such as: name, address, phone number, email address, etc. to use for communication and/or appreciation services such as: birthday cards, referral boards, USPS and/or email newsletters, notices/letters, appointment reminders, reactivation letters, etc.

You may restrict how your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to redisclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of the date printed below. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above.

Name(Print)

Date

Signature

Authorized Provider Representative

CONFIDENTIAL PATIENT INFORMATION

DATE ___/___/___

PLEASE PRINT

PATIENT INFORMATION:

FULL NAME _____ DATE OF BIRTH ___/___/___ AGE ___ Male Female

ADDRESS _____ APT# _____ SSN _____ - _____ - _____

CITY _____ STATE _____ ZIP CODE _____ HOME PHONE (____) _____

ALTERNATE PHONE (CELL): (____) _____ EMAIL ADDRESS: _____

EMPLOYER'S NAME _____ OCCUPATION _____

WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____

WORK PH. # (____) _____ EXT. _____ DATE SYMPTOMS BEGAN: ___/___/___

MARITAL STATUS: SINGLE MARRIED WIDOWED HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT _____ PHONE _____

CLAIM INFORMATION:

IS YOUR CONDITION DUE TO AN AUTO ACCIDENT A PERSONAL INJURY A WORK INJURY OTHER TYPE OF CLAIM: CASH GROUP HEALTH INS PERSONAL INJURY WORKER'S COMP MEDICARE I WILL BE PAYING TODAY BY CASH CHECK VISA MASTERCARD AMEX DISCOVER OTHER

INSURANCE INFORMATION:

RELATIONSHIP TO INSURED? SELF SPOUSE OTHER CHILD SPOUSE: _____INSURED'S EMPLOYER SAME AS ABOVE _____INSURED'S SSN SAME AS ABOVE SSN _____ - _____ - _____ INSURED'S DOB SAME AS ABOVE ___/___/___

PRIMARY INSURANCE CO. _____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE#(____) _____

POLICY NUMBER _____ GROUP NUMBER _____

SECONDARY INSURANCE CO. _____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE#(____) _____

POLICY NUMBER _____ GROUP NUMBER _____

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian Signature: _____ Date: _____