Coastal
CHIROPRACTIC & ACUPUNCTURE
TODD B. WALTERS DC.FIAMA

1705 South McKenzie St. Suite 4 Foley, AL 36535
Phone 251.943.7941 Fax 251.943.6876 Texting 251.241.9997

Date: _____

CONFIDENTIAL PATIENT INFORMATION

Patients Name: _____ Email: _____
Address: _____ City: _____
State: _____ Zip: _____ Home Phone: _____
SS# _____ Cell Phone: _____
Date of Birth: _____ Marital Status: M S W D
Occupation: _____ Employer: _____
Address of Insured (If different than above): _____
Are your present symptoms or conditions related to, or the result of an auto collision, work related injury or other personal injury? (someone else might be responsible for payment?) _____ Yes _____ No

Ins. Company: _____ Ins Phone #: _____
ID#: _____ Group #: _____
Name of Policy Holder: _____ Policy Holder DOB: _____
Policy Holders Employer: _____

Family Physician: _____ (Note: May we send your health information to this provider (Y/N)
Person to contact in case of emergency (Name and Phone) _____
Have you ever been under Chiropractic Care? Y N If so, Who? _____ Last Visit? _____
Have you had any SPINAL X-Rays/MRI's/CT's taken in the last year? Y N If so, Where? _____
What operations have you had? _____ When? _____
Serious Illness: _____ When? _____
Infectious Diseases: _____ When? _____
Do you have a pace maker? Y N Have you ever had any hip or knee replacements Y N
What medications or drugs are you taking? (Check those that apply) Pain Killers_____ Insulin_____
Cholesterol Meds_____ Blood pressure meds_____ Birth control_____ Other_____
What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to *Coastal Chiropractic & Acupuncture* all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that i am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursements or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the applicable insurance policies and/or employee health are plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extend permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation. I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic against such insurers and.or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____
Signature Date

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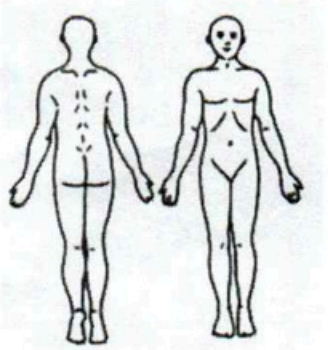
CASE HISTORY

Name: _____

1. Circle the severity (0 = No pain to 10 = sever pain) and frequency of pain (% of the week you experience the pain)

Condition / Problem	**Severity** Minimal Severe	**Frequency (% of week)** Occasional Constant
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain)



2. Symptoms are <u>worse</u> in the (circle what applies)
   - morning
   - afternoon
   - night
   - increase during the day
   - same all day
   - decrease during the day

3. Symptoms (a) is: ☐ sharp ☐ dull ☐ burning ☐ aching ☐ throbbing ☐ numbing ☐ tingling ☐ pins and needles
4. Symptoms (b) is: ☐ sharp ☐ dull ☐ burning ☐ aching ☐ throbbing ☐ numbing ☐ tingling ☐ pins and needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced this before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ☐ improved ☐ gotten worse ☐ stayed the same since it began
10. Circle the things that make your problems worse:
    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping
11. Is there anything you an do to relieve the problem? ☐ Yes ☐ No Describe: _____
12. Have you been treated for this before? ☐ Yes ☐ No How long ago?: _____
13. What treatment did you receive? _____
14. Results of previous treatment? ☐ Good ☐ Poor Comments: _____
15. Were you referred to our office by anyone? _____
16. Is this condition interfering with ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation
17. List any other major injuries you have had, other than those mentioned above: _____

_____

18. Any other musculoskeletal problems? ☐ Yes ☐ No Neurological problems ☐ Yes ☐ No

I certify that the above information is accurate to the best of my knowledge.

Patient Signature_____ Date _____

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Patient Name: _____ Date: _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the Chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause and problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illness or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating heath care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Coastal Chiropractic & Acupuncture. I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women only:

To the best of my knowledge **I am / am NOT** pregnant and **give permission / DON'T give permission** to x-ray me for diagnostic interpretation.

Missed Appointments

There is a possible fee charged for all appointments that are not canceled prior to schedule visits.

Consent to Evaluate and Treat a Minor:

I, _____being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____
Children: _____
Others: _____
No one: _____

May we leave messages regarding your personal healthcare information on any answering device, Y or N

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name _____

Signature _____ Date _____