ADVANCED HEALTH CHIROPRACTIC

ACUPUNCTURE PAPER WORK

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential

GENERAL INFORMATION

Name_____ Date _____/_____/_____ Sex _____

DOB _____/_____/_____ Age _____ Height_____ Weight _____

Have you lost or gained weight recently? If so, how much, were you trying to, and over how much time? _____

Address_____

City_____ State_____ Zip _____

Phone: Home_____ Work_____

Cell_____

Email:_____

Can we leave a message if necessary? _____

Occupation:_____

Employer_____

Emergency Contact: Name _____ Phone: _____

Have you had acupuncture before? Yes No

If yes, list condition(s) treated?

_____

Referred by: _____

Who is your medical doctor?_____

Date of last visit? _____ Reason? _____

How long has it been since you have had a complete medical exam? _____

Major Complaint

What is your primary reason for this visit?

_____

What do you think is the cause of this condition?_____

How long have you had this condition? Is it getting worse?_____

_____

What seems to make it better?_____

What seems to make it worse?_____

Does this condition interfere with your Sleep/ Work/ Other _____

Have you received treatment for this complaint? Yes No

If yes, what was done?_____

Did it help? Not at all/ Somewhat/ Very effective/ Not sure

Do you have any specific questions that you would like to discuss today?_____

_____

DIET

What did you eat for breakfast, lunch and dinner yesterday?(Breakfast , lunch, dinner, snacks)

_____

_____

Was this a typical day for you? _____Yes _____No

Do you consume alcohol? _____Yes _____ No If yes, how many times per week? _____

Do you consume caffeine? ____Yes _____ No If yes, how many times per week?_____

List medications or food supplements you are taking.

_____

_____

List serious illnesses, accidents or surgeries.

_____

_____

Check illnesses that have occurred in blood relatives.

__Diabetes __High blood pressure __Stroke __Cancer __Heart disease __Kidney disease

Other _____

Check symptoms you have or have had in the last year, circle if currently experiencing symptoms:

□ Depression	□ Difficulty in focusing	□ Dizziness
□ Easily startled	□ Excessive anger	□ Excessive fear
□ Excessive worry	□ Fatigue/tiredness	□ Headaches
□ Loss of sleep/poor sleep	□ Loss or gain of weight	
□ Nervousness/irritability	□ Overwhelmed by life	

Check conditions you have or have had in the past:

□ AIDS	□ Allergies	□ Anemia
□ Arthritis	□ Bleeding disorders	□ Breast lump
□ Cancer	□ Diabetes	

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

□ Tremors and/or Cramps □ Swollen joints

Pain, weakness, numbness in:

□ Arms or Hips □ Back Legs □ Feet

□ Neck □ Hands □ Shoulders

□ Other_____

EYES/EAR/NOSE/THROAT/RESPIRATORY

□ Asthma/wheezing □ Blurred or failing vision □ Difficulty breathing

□ Earache □ Enlarged glands □ Eye pain

□ Frequent colds □ Gum trouble □ Hay fever

□ Hoarseness □ Loss of hearing □ Nose bleeds

□ Persistent cough □ Ringing in ears □ Sinus problems

SKIN

□ Boils □ Bruise easily □ Dry skin

□ Itching/rash □ Sensitive skin □ Sore won't heal

□ Sweats

GENITO/URINARY

□ Blood/pus in urine □ Frequent urination □ Lowered libido

□ Inability to control urine □ Kidney infection/stones

CARDIOVASCULAR

□ Chest pain □ Hardening of arteries □ Pain over heart

□ High or low blood pressure □ Previous heart attack □ Poor circulation

□ Rapid/irregular heart beat □ Swelling of ankles

GASTROINTESTINAL

□ Belching, gas or bloating □ Colon trouble □ Constipation

□ Diarrhea □ Difficulty swallowing □ Excessive hunger

□ Distention of abdomen □ Gall bladder trouble □ Hemorrhoids (piles)

□ Indigestion □ Nausea □ Pain over stomach

□ Poor appetite □ Vomiting

FOR MEN ONLY

□ Erection difficulties □ Penis discharge □ Prostate trouble

FOR WOMEN ONLY

□ Bleeding between periods □ Clots in menses □ Irregular cycle

□ Excessive menstrual flow □ Extreme menstrual pain □ PMS

□ Menopausal symptoms □ Previous miscarriage #_____ □ Live Births #_____

□ Scanty menstrual flow Could you be pregnant?_____

HEAD

□ Headaches □ Difficulty concentrating □ ADD/ ADHD

□ Forgetful □ Head feels heavy □ Changes in hair

EMOTIONAL WELL-BEING

CHILDHOOD

□ Childhood Stress □ School Stress □ Family Stress

□ Personal relationships □ Stress of being sick □ Abuse

ADULTHOOD

□ Work related stress □ Stress of commuting □ Loss of loved one

□ Relationship stress □ Change in lifestyle □ Abuse

□ Change in vocation

GRADE YOUR MENTAL HEALTH

□ Excellent □ Good □ Fair

□ Poor □ Getting Better □ Getting Worse

Patient Print Name :_____ Date: _____

Patient Signature: _____

Advanced Health Chiropractic
FINANCIAL POLICY

CASH PATIENTS: Patients without the benefit of chiropractic coverage on their insurance are **responsible to pay 100%** of their charges as services are rendered. If care becomes extensive, a **payment agreement** can be provided which will spell out a monthly amount.

GENERAL INSURANCE: As a courtesy to you we will bill your insurance company and wait for payment. The insured is responsible for knowing their insurance benefit coverage. Every attempt will be made to determine an estimate of the insured's coverage, but because the insurance policy is a unique agreement between your employer and the insurance company, **we can make no guarantees**. **We cannot become involved in disputes between you and your insurance company** regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered services, coinsurance, coordination of benefits, pre-existing conditions or "reasonable and customary charges", etc., other than to supply factual information when necessary. Each guest is ultimately responsible for the timely payment of their account.

Your obligation is to pay any and all deductibles and co-payments as you go. **You are also responsible for any "non-covered" services. If your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim and after 90 days you will be responsible for payment in full for any outstanding balance. Remember, the care and services were provided to *you* and not your insurance company. You are responsible for all cost incurred in this office.**

MEDICARE: As a participating provider with Medicare, we will accept what Medicare approves for your adjustments. Please be aware that **Medicare covers only chiropractic adjustments**. Medicare does not pay for any other services performed at our office, including but not limited to the New Patient Exam.

WORKERS COMPENSATION: It is your responsibility to provide all necessary billing information to this office before or the day of your initial visit. If you have retained an attorney, you are also further required to provide this office with all attorney information. If you are a Missouri Workers Compensation patient, the laws require you, to get your employer's approval to come to this office. Without this approval, Missouri Workers Compensation will not pay for your care.

PERSONAL INJURY: All patients involved in a personal injury, such as a motor vehicle accident, are required to provide all necessary billing information and attorney information to this office before or the day of your initial visit. If you have retained an attorney you will be asked to sign a lien to protect any outstanding balance in this office at the time of settlement. **Any outstanding balance not paid at the time of settlement is YOUR responsibility.**

CANCELLATION/NO SHOW POLICY FOR APPOINTMENTS: We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
First No Call/No Show - $0
Second (and beyond) No Call/No Show - $25 fee; this will not be covered by your insurance company.

COLLECTIONS FEE: If your account goes 90 days + with no payment and payment arrangements are not made your account will be sent to collections and a $25 fee will be added to cover costs.

I understand the information above and agree to the financial policy

PATIENT SIGNATURE: _____
PRINTED NAME: _____
DATE: _____

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