RUNNELS CHIROPRACTIC

Runnels Chiropractic
32 South 9th Street - Richmond, IN 47374
(765) 96 CHIRO (24476)
www.runnelschiro.com

1. PATIENT INFORMATION

Today's Date _____

Full Name _____ SSN _____ Age_____ DOB _____

Gender: ◯ M ◯ F Address _____ City _____ State ____ Zip_____

Height _____ Weight ____ Race _____ Ethnicity: Hispanic or Latino / Not Hispanic or Latino / I decline to answer

Preferred Language _____ Occupation _____ Where Employed _____

Home Phone _____ Cell Phone _____ Email: _____

◯Married ◯ Single ◯Divorced ◯Separated ◯Widowed Spouse's Name_____

_____ (Initials) I understand that by providing an email and/or cell phone I will receive appointment reminders via one or both methods. I have the option of choosing one or both.

_____ (Initials) I understand it is my responsibility to inform the front desk if I want the appointment reminders option to be disabled.

How did you hear about us? (Please provide name of person, if applicable) _____

2. HEALTH HISTORY

1. ☐ Yes ☐ No Skin, hair or nail problems
2. ☐ Yes ☐ No Mouth and/or throat problems
3. ☐ Yes ☐ No Nose and/or sinus problems
4. ☐ Yes ☐ No Ear problems
5. ☐ Yes ☐ No Eye problems
6. ☐ Yes ☐ No Breathing problems
7. ☐ Yes ☐ No Smoke tobacco
   Status: Every day smoker / Occasional smoker
   Former smoker / Never smoked
   Start Date (Optional): _____
8. ☐ Yes ☐ No Heart/blood vessel problems
9. ☐ Yes ☐ No Blood/lymph node problems
10. ☐ Yes ☐ No Digestive problems
11. ☐ Yes ☐ No Genital problems (e.g. prostate, testicular, vaginal)
12. ☐ Yes ☐ No Urinary problems (including kidney or bladder)
13. ☐ Yes ☐ No Mental health problems
14. ☐ Yes ☐ No Gland and/or hormone problems
15. ☐ Yes ☐ No Allergy or immunity problems
16. ☐ Yes ☐ No Muscle, tendon or ligament problems
17. ☐ Yes ☐ No Bone or joint diseases

FEMALES--ADDITIONAL HEALTH HISTORY

18. ☐ Yes ☐ No Menstrual problems
19. ☐ Yes ☐ No Taken any form of birth control
    If yes, which type? _____
20. ☐ Yes ☐ No Currently pregnant.
    If yes, how far along are you? _____ weeks/months
    If yes, when was your last menstrual period? _____
21. ☐ Yes ☐ No Breast problems

3. PAST HISTORY

22. List all diseases that you have had in the past (including childhood diseases): _____

_____

23. Have you ever been diagnosed with a particular condition such as diabetes, cancer, AIDS, etc.:

_____

24. Have you ever suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones?

☐ Yes ☐ No If yes, describe accident including date of accident: _____

_____

25. List all surgeries (including appendix, tonsils, ear tubes, wisdom teeth):

_____ Date: _____

_____ Date: _____

_____ Date: _____

26. Have you ever been hospitalized for any reason other than surgery? ☐ Yes ☐ No

What? _____ When? _____

27. Medications: Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis: _____

Medication Allergies: _____ Reaction: _____

28. Have you ever had cancer? ☐ Yes ☐ No If yes, describe: _____

_____

4. FAMILY HISTORY

29. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases/conditions? ☐ Yes ☐ No If yes, describe: _____

_____

5. SOCIAL HISTORY

30. In what position do you usually sleep and how well? _____

31. Do you exercise on a regular basis? ☐ Yes ☐ No If yes, how? _____

32. How do you spend your spare time (hobbies, etc.)? _____

33. How would you describe your diet? ☐ Balanced ☐ Fair ☐ Poor ☐ Excessive ☐ Restrictive

SOCIAL HISTORY (cont'd)

34. Do you use: ☐ Caffeine ☐ Tobacco ☐ Nicotine ☐ Recreational Drugs ☐ Alcohol
35. Describe your work (select all that apply):

    Type: _____ ☐ Retired ☐ Professional ☐ Physical Labor ☐ Driver ☐ Athlete

    ☐ Clerical ☐ Factory ☐ Homemaker ☐ Student ☐ Child

    Physical Demands: ☐ Heavy ☐ Moderate ☐ Mild ☐ Sedentary

    Stress Level: ☐ High ☐ Medium ☐ Low

6. ADDITIONAL HISTORY

36. If there is any information about your health history that was not requested, please fill it in below: _____

    _____

37. Please describe your current complaint. In other words, what brought you here? Is it related to an accident or injury? _____

38. Who is your medical doctor? _____

39. Have you had any spinal imaging within the past year? ☐ Yes ☐ No If yes, where? _____
40. Have you ever seen a chiropractor before? ☐ Yes ☐ No If yes, date? _____
41. Have you ever seen a physical therapist before? ☐ Yes ☐ No If yes, date? _____
42. Have you had previous treatment(s) for your current condition? (check all that apply):

☐ Physical Therapy	☐ Biofeedback	☐ Acupuncture
☐ Occupational Therapy	☐ Psychological Counseling	☐ Massage
☐ Chiropractic	☐ Psychiatric Treatment	☐ Trigger Point Injections
☐ TENS	☐ Bed Rest	☐ Epidural or other spinal injections

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

NOTICE TO PATIENTS

We work hard to provide the best, most efficient and affordable chiropractic healthcare. In order to provide our high quality of service and efficiency we must keep our costs down. We work for you. However, we do reserve the right to dismiss you as a patient if you miss more than 3 appointments without prior notice. This arrangement will allow our office to maintain a level of service to each and every patient, as each patient counts on our quality and efficiency of service and care.

Requests by patients for x-rays will be processed in 24 hours. If these are actual films, the patient is responsible for their x-rays once they are released from Runnels Chiropractic until they are returned. If requesting these images on a disc, there may be a charge for subsequent copies.

ASSIGNMENT OF BENEFITS FORM

Name of Policy Holder (print): _____

Social Security Number: _____

☐ Medicare is my primary insurance

☐ _____ is my primary insurance

☐ I am not seeking care in connection with an accident or injury

I request that payment of authorized insurance benefits (including Medicare, if I am a Medicare beneficiary) be made on my behalf to Runnels Chiropractic (the **"Provider"**) for any equipment or services provided to me by the Provider. I authorize the release of any medical or other information necessary to determine the extent of all benefits payable for related equipment or services on my behalf to (i) the Provider, (ii) the Centers for Medicare and Medicaid Services (**"CMS"**), (iii) my insurance carrier, (iv) or other medical entity. A copy of this authorization will be sent to CMS, my insurance company, or other entity if requested. The original authorization will be kept on file by the Provider. I understand that this assignment will remain in effect until revoked, in writing, by me.

I understand that I am financially responsible to the Provider for any charges not covered by healthcare benefits. It is my responsibility to notify the Provider of any changes in my healthcare coverage.

If I am a Medicare beneficiary, I understand that Medicare does not pay for exams, x-rays, physical therapy treatments, or maintenance treatments and that I am responsible for paying for these services out-of-pocket. I also authorize payment of all medical benefits that apply to all occasions for primary and supplemental (Medigap) coverage to be paid to the Provider.

In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the Provider and/or my healthcare insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting financial responsibility, as explained above, for all payment, equipment, and services provided by the Provider. I also understand that in the event it becomes necessary to employ a collection agency service to enforce payment under this Agreement/Contract, I agree to pay for collection costs and fees equal to fifty (50) percent of the delinquent balance associated with the collection thereof, including but not limited to, attorney's fees and court costs. By signing this document, I also acknowledge that I have received a copy of the Provider's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Name of person signing below (print): _____

Relationship to Insured: _____

Signature of Insured or Parent/Guardian: _____

Date: _____

CONSENT FOR TREATMENT AND USE OF PROTECTED HEALTH INFORMATION

Chiropractors focus on dysfunctions that can result from irregularities of spinal structure or movement. Hands-on procedures are usually preferred by most chiropractors to determine structural and functional problems. Manipulation is used to promote normal bodily function thus correcting or preventing these structural deviations. Chiropractic "adjustment" refers to a variety of manual mechanical interventions. Chiropractic adjustments and other procedures are usually beneficial and seldom cause any harm to the patient. In most cases, there is gradual but satisfactory result from chiropractic treatment. Occasionally, the results are less than expected. In rare cases, however, unknown underlying defects, deformities, or pathologies may result in injury to the patient. I understand that results of chiropractic only treatment vary and I have disclosed all known latent pathological defects, illnesses, and deformities to my chiropractor.

_____ _____

Signature Date

I consent to diagnosis and treatment options available to me and consent to receive services from Runnels Chiropractic ("the Practice").

_____ _____

Signature Date

I consent the Practice to use the following methods to remind me of my appointments: a postcard mailed to my address, a message left on the voicemail of any telephone number provided by me to the Practice, a text message to the cell phone number provided by me to the Practice, or a message left with any individual answering any telephone number provided by me to the Practice.

_____ _____

Signature Date

I consent to having treatments performed in an open area, which may be visible to other patients. The Practice will accommodate any reasonable request to discuss matters in private with me.

_____ _____

Signature Date