CONFIDENTIAL PATIENT HEALTH RECORD Today's Date: _____/_____/_____

How did you hear about us?

Family _____ | Friend _____ | Dr. _____ | Internet | Drove By | Insurance Plan

PERSONAL INFORMATION:

First:_____ Middle: _____ Last:_____ Sex: Male | Female

Address:_____

City: _____State:_____ Zip: _____

Home Phone:_____-_____ Cell Phone:_____-_____

Status: Single | Married | Divorced | Widowed Birth Date: _____/_____/____ Age:_____

Social Security #: _____/_____/_____ Spouses Name:_____

Children (Name/Age):_____

EMERGENCY CONTACT:

Name: _____ Phone #: (_____) _____-_____

Address: _____

Relationship: Spouse | Relative | Friend | Other_____

CURRENT HEALTH CONDITION:

What brings you in today? _____

When did this condition BEGIN? _____/_____/_____ Has it ever occurred before? Y/N When? _____/_____/_____

Is the condition related to: Auto | Job | Home Injury | Slip / Fall | Lifting | Slept Wrong | Unknown Cause

Explain:_____

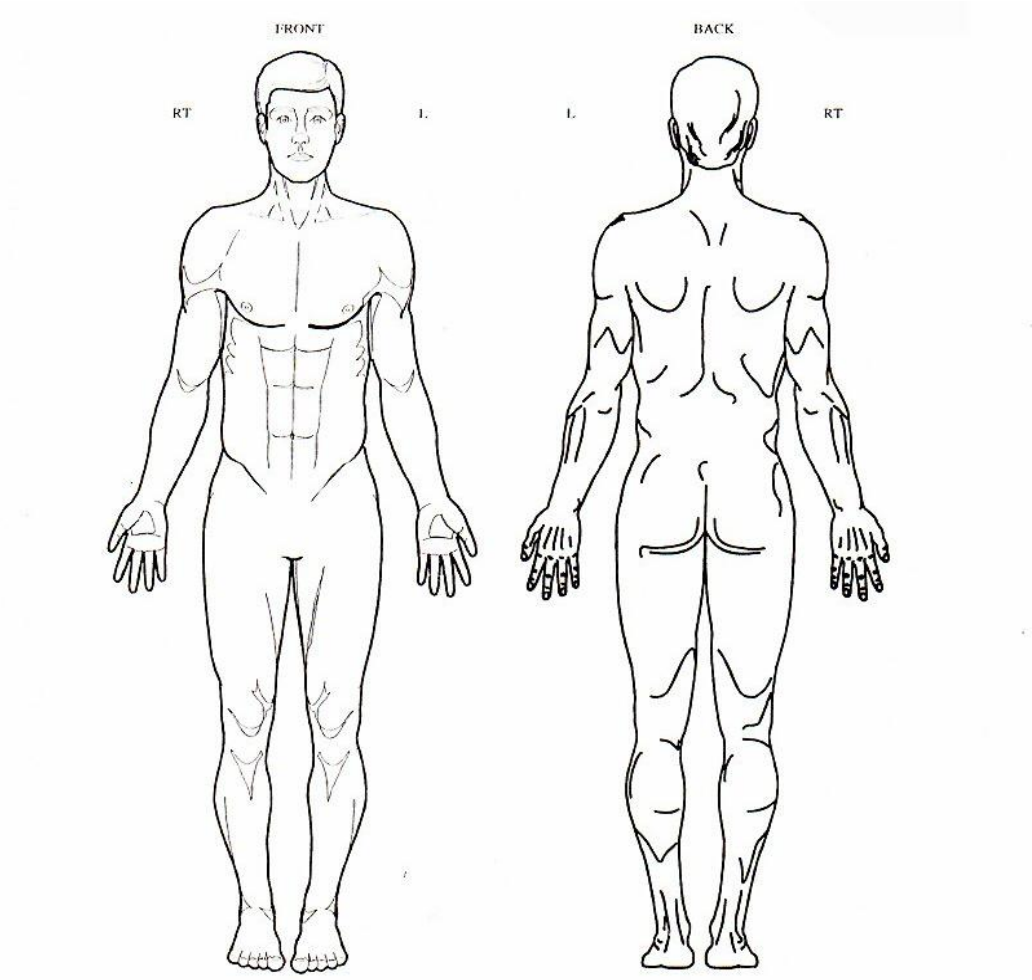
Date of Accident: _____/_____/_____ Time of Accident: _____ am | pm

Have you seen other doctors for CONDITION? N | Y If yes, who? (Name)_____

Type of Treatment? _____

Were you satisfied with the results of your treatment? N | Y Explain: _____

Use the letters below to indicate the type and location of your sensations right now.
Key A=Ache | B=Burning | N=Numbness | P=Pins & Needles | S=Stabbing



Current Medication (s): List **ANY/ALL** medications your **CURRENTLY** taking:			
Medication	Dosage	For What Condition?	How long have you been taking this?

Do you wear any of the following? Heel Lifts | Innersoles | Arch Supports | Orthotics | Other_____

REVIEW OF SYSTEMS:

Below is a list of symptoms that may seem unrelated to the purpose of your appointment.
However, these questions must be answered carefully as the problems can affect your overall course of care.

Please **CIRCLE** all that apply:

CONSTITUTIONAL:

Chills	Daytime Drowsiness	Fatigue	Chills
Night Sweats	Weight Gain	Weight Loss	Night Sweats

EYES/VISION:

Blindness	Blurred Vision	Cataracts	Blindness
Double Vision	Eye Pain	Glasses	Double Vision
Itching	Tearing	Contact Lenses	Itching

EARS, NOSE and THROAT:

Bleeding	Dentures	Difficulty Swallowing	Discharge
Dizziness	Ear Drainage	Ear Pain	Fainting
Frequent Sore Throats	Headaches	Hearing Loss	History of Head Injury
Hoarseness	Loss Sense of Smell	Nasal Congestion	Nosebleeds
Postnasal Drip	Rhinorrhea (runny nose)	Sinus Infections	Snoring
Tinnitus (ringing in the ears)	TMJ Problems		

RESPIRATION:

Asthma	Cough	Coughing Up Blood	Shortness of Breath
Sputum Productions	Wheezing		

CARDIOVASULAR:

Angina	Chest Pain	Claudication	Heart Murmur
Heart Problems	High Blood Pressure	Low Blood Pressure	Palpitations
Orthopnea	Ulcers	Shortness of Breath	Swelling of Legs
Varicose veins			

GASTROINSTESTINAL:

Abdominal Pain	Belching	Black - Tarry Stool	Constipation
Diarrhea	Vomiting Blood	Heartburn	Hemorrhoids
Indigestion	Jaundice	Nausea	Rectal Bleeding
Abnormal Stool Color	Abnormal Stool Consistency	Vomiting	

FEMALE:

Birth Control	Breast Lumps/Pain	Burning Urination	Cramps
Frequent Urination	Hormone Therapy	Pregnancy	Urine Retention
Vaginal Bleeding	Vaginal Discharge		

MALE:

Burning Urination	Erectile Dysfunction	Frequent Urination	Hesitancy/Dribbling
Prostate Problems	Urine Retention		

ENDOCRINE:

Cold Intolerance	Diabetes	Excessive Appetite	Excessive Hunger
Excess Thirst	Unusual Hair Growth	Goiter	Hair Loss
Heat Intolerance			

SKIN:

Changes in Nail Texture	Changes in Skin Color	Hair Growth	Hair Loss
Hives	History of Skin Disorders	Itching	Paresthesia
Rash	Skin Lesions / Ulcers	Varicosities	

NERVOUS SYSTEM:

Dizziness	Facial Weakness	Headache	Limb Weakness
Loss of Consciousness	Loss of Memory	Numbness	Seizures
Sleep Disturbance	Slurred Speech	Stress	Strokes
Tremor	Unsteadiness of gait	Loss of Balance	

PSYCHOLOGIC:

Anxiety	Loss or Change in Appetite	Behavioral Change	Bi-Polar Disorder
Confusion	Depression	Insomnia	Memory Loss
Mood Change			

ALLERGY:

Anaphylaxis	Food Intolerance	Itching	Nasal Congestion
Rash	Sneezing		

HEMATOLOGIC:

Anemia	Bleeding	Blood Clotting	Blood Transfusion
Bruising Easily	Fatigue	Lymph Node Swelling	

PAST HEALTH HISTORY

PREVIOUS CHIROPRACTIC CARE:

Doctor's Name: _____ Location: _____ Date of Last Visit: ____/_____/_____

Were you satisfied with your care? Yes or NO

Why? _____

CHILDHOOD ILLNESS - List ALL Health Conditions:

_____ Date:____/___/_____ _____ Date:_____/_____/_____

_____ Date:____/___/_____ _____ Date:_____/_____/_____

ADULT ILLNESS - List ALL Health Conditions:

_____ Date:____/____/____ _____ Date:_____/_____/_____

_____ Date:____/____/____ _____ Date:_____/_____/_____

SURGERIES - List ALL Surgeries Procedures:

_____ Date:____/ ___/____ _____ Date:_____/_____/_____

_____ Date:____/____/____ _____ Date:_____/_____/_____

INJURIES:

Back Injury	Date:_____/_____/_____	Disability	Date:_____/_____/_____
Broken Bones	Date:_____/_____/_____	Soft Tissue Injury	Date:_____/_____/_____
Motor Vehicle Accident	Date:_____/_____/_____		

SOCIAL HISTORY:

TOBACCO: Quit Smoking

Smoke	Chew
#_____ Per Day | Week | Month	#_____ of Cans Per Day | Week | Month

INSURANCE INFORMATION:

Who Is Responsible For Your Bill?

Myself ONLY	Spouse	Worker's Comp
Auto Insurance	Medicare	

Personal Health Insurance Carrier:_____ Health ID Care #:_____

Policy Holder's Name:_____ Group #: _____

Policy Holder's Birthdate: _____/_____/_____ Primary Care Physician:_____

Policy Holder's Social Security # _____-_____-_____

WORKERS COMPENSATION INJURY:

Have you filed an injury report with your employer? Yes or No

Date: ____/_____/_____

Insurance Carrier: _____

Policy Number:_____

Carrier's Phone: (_____) -_____

Adjuster:_____

Claim Number: _____

AUTO & PERSONAL INJURY:

Insurance Carrier / Lawyer _____

Policy Number: _____

Address:_____

Claim Number:_____

Phone:_____

Adjuster: _____

Fax:_____

Belleville Area Chiropractic

Office Policies and Procedures

Symptoms: Regardless of the reason you came to our office, it is important to understand the difference between symptoms and their cause. As your spine is corrected, you will have good and bad days. Don't get caught up in this rollercoaster; it is normal. You will be happiest and get the best results if you understand that this is a process designed to get you functioning at your peak level and on the road to wellness. This takes time and is a lifelong process. Stay focused and patient on this outcome so you are pleased with your results and enjoy your journey.

Health Insurance: If you have health insurance that covers chiropractic, we will submit your claims electronically. You may want to call your insurance company to verify coverage limits and deductible. Insurance coverage is an agreement between you and your insurance company. You are ultimately responsible for services received in our office and will be billed directly if your insurance company denies or delays payment of claims. In our office the patient must stay current with their account, i.e. co-pays, percent's, deductibles. This must be paid at the time of the visit, or in accordance with a pre-determined payment schedule. This is the patient's responsibility. In event of a default by the patient, in the event of any account balance due, the patient's account will be referred to our collections firm. The patient agrees to pay any and all legal fees incurred.

Appointments: A certain number of adjustments in a given time period are necessary to get the best results from your care and create wellness in your life. Therefore, it is absolutely necessary that you keep your appointments. If you need to change an appointment, please call 24 hours in advance to reschedule so you can stay on target for wellness. If a patient fails to keep current with their prescribed treatment plan, and at a later date the insurance carrier performs an audit of a patient's file, and determines that the patient's treatment was not medically necessary for any reason, and the insurance carrier demands repayment of previously paid charges, the patient will be responsible for payment to be issued to this office for any amounts this office had to re-pay to the insurance carrier. This re-payment is to be made within 15 days of written notification to the patient, by this office.

Auto Accidents: If your health condition is the result of an auto accident or a personal injury, this office will directly bill all charges to the following simultaneously: the patient's automobile insurance carrier, the third party liability carrier, and if applicable, any attorney representing the patient. The patient is responsible for any underpayment that results. The patient directly assigns to Dr. Dawn M. Robinson-Murphy (DBA Belleville Area Chiropractic) all benefits, if any, and all rights under the insurance policy, otherwise available to the patient, and assign all benefits payable to the patient, or on the patients behalf, for the medical services rendered to the patient by Dr. Dawn M. Robinson-Murphy.

Workers Comp: If your health condition is a result of a work related injury, this office will directly bill the Workers Compensation Insurance Carrier of the employer.

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

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

I also acknowledge that I have received the Belleville Area Chiropractic / (HIPPA) Notice of Privacy Practices for protected health information.

Patient's Print Name: _____

Patient's Signature: _____ Date: ____/_____ /_____

Consent to Treat Minor (print name): _____

Guardian or Spouse's Signature of Authorizing Care: _____ Date: ____/_____ /_____