Riverwalk Chiropractic
Patient Summary

PERSONAL INFORMATION

Name: _____ SSN_____

Address:_____

City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Cell Phone: _____Work Phone:_____

Email: _____ Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Spouse/Parents name: _____ Phone Number:_____

Spouse/Parents employer: _____ Phone Number:_____

Emergency Contact_____ Phone: _____

Whom shall we thank for referring you to us? _____

SYMPTOMS: ✓ the symptoms you have experienced in the last 6 months

- ☐ Headaches/Migraines
- ☐ Insomnia/ Sleep Problems
- ☐ Menstrual/ Hormonal Problems
- ☐ Sinus Problems/ Allergies
- ☐ Fibromyalgia

Pain/Tension/Numbness:

- ☐ Neck
- ☐ Shoulders
- ☐ Low Back
- ☐ Legs
- ☐ Arms
- ☐ Hands

- ☐ Diabetes
- ☐ Irritability
- ☐ Dizziness
- ☐ Asthma
- ☐ Bladder Trouble

Digestive Trouble:

- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloating
- ☐ Gas

- ☐ Nervousness
- ☐ Fatigue
- ☐ Weight Trouble
- ☐ Stress/ Anxiety
- ☐ Ringing in Ears
- ☐ Swelling of Feet or Joints
- ☐ High Blood Pressure
- ☐ High Cholesterol

Which of the above bothers you most? _____

1. **How often do you experience your symptoms?**
   - ☐ Constantly (100% of the day)
   - ☐ Frequently (25-75% of the day)
   - ☐ Intermittently (0-25% of the day)

2. **What describes the nature of your symptoms?**
   - ☐ Sharp ☐ Shooting ☐ Numb
   - ☐ Dull Ache ☐ Burning ☐ Tingling

3. **How are your symptoms changing?**
   - ☐ Getting better
   - ☐ Not changing
   - ☐ Getting worse

4. **During the past 4 weeks:**
   a. Indicate the average intensity of your symptoms

None										*worst imaginable*
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

5. **In general would you say your overall health right now is**

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

6. **Who have you seen for your symptoms?**

☐ No One ☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Other

   a. What treatment did you receive?

   _____

   b. What tests have you had for your symptoms?

   ☐ Xrays - date:_____ ☐ MRI - date: _____

   ☐ CT Scan - date: _____ ☐ Other - date: _____

7. **Have you had similar symptoms in the past?**

   ☐ Yes ☐ No

8. **What is your occupation?** _____

9. **ARE YOU PREGNANT? YES/NO Date of last period** _____

Medications

1. **Are you allergic to any medications? YES/NO**

   If YES, Which ones?_____

2. **If you are currently taking any medications, please list them here:** _____

_____

Please answer yes or no:	**YES**	**NO**
Do you smoke?		
Do you exercise regularly?		
Do you eat organic fruits and vegetables regularly?		
Are you currently taking any nutritional supplements?		
Are you exposed to exhaust, or gasoline fumes on a regular basis?		
Do you use any of the following cleaning agents: windex; polish, cleansert, bleach?		
Do you sit in an office with a drop ceiling?		
Do you have any indoor pets?		
Do you have an water purifying system in your home?		
Do you use NSAID's?		
Do you drink coffee regularly?		
Do you eat out in restaurants?		
Do you eat farm raised fish?		
Do you eat meat/poultry from the supermarket?		
Have you taken an antibiotic in the last 5 years?		

I certify that I have reviewed and understand the above information supplied to me, and that it is true and correct to the best of my knowledge. I hereby consent to such treatment, procedures, and patient care which, in the judgment of my chiropractor and/or physician, may be considered necessary or advisable while a patient at Riverwalk Chiropractic.

Patient Signature: _____ Date _____

PATIENT ATTENDANCE POLICY

In order to assure that all patients receive the time and attention they deserve, the following guidelines have been established:

1. If you are late for a scheduled appointment, without notification, you may not be able to be seen that day.
2. If you need to cancel an appointment, please call 24 hours in advance to notify us. If your call is not during our normal business hours, please leave a message on our voice mail.
3. Your appointment time has been reserved for you. We have the right to assess a $45 charge if you miss a scheduled appointment without giving the required notice (no show). This charge is not covered by insurance and will be billed directly to you.
4. If you miss 2 or more consecutively scheduled appointments, without notice (no show), you may be discharged from your needed care.

"I have read and understand this policy."

Patient/Guardian Signature _____ **Date**_____

CONSENT TO DISCLOSE PATIENT INFORMATION/HIPAA

"I understand this center's Notice of Privacy Practices and give permission for my protected heath information to be disclosed for purposes of communicating results, findings, care decisions, and appointments to the persons listed below:"

Name _____

Name _____

Name _____

Patient Name (please print) _____

Parent/Guardian Signature _____ **Date**_____

INSURANCE ASSIGNMENT AGREEMENT AND

AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION I, the below named patient, hereby authorize Riverwalk Chiropractic to release to any third party payer (such as insurance company or governmental agency, example: Anthem BC/BS, UHC, or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

PRIVACY PRACTICES I, the below named patient, understand that I am entitled to certain privacy rights regarding protected health information according the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I also understand that this information can and will be used to convey treatment plan, payments, and administrative activities. I understand and have been given the opportunity to receive a copy of the entire Notice of Privacy Practices prior to signing this consent and understand that I may revoke this authorization in writing, except to the extent that action has already been taken.

INSURANCE ASSIGNMENT I, the below named patient, hereby authorize payment directly to the Riverwalk Chiropractic Group for any group and/or individual medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services. I understand and agree that the clinic providing services is based on a treatment team approach to care. The treatment team consists of chiropractors, and massage therapists working under the direction and supervision of the treating Chiropractor.

MY RESPONSIBILITY I, the below named patient, understand that it is my responsibility to pay at time of service and deductible amount, co-payment, co-insurance, or any other balance not paid for by my insurance. All major credit cards and debit cards, checks, and cash are accepted. If you anticipate difficulty in paying, please call our office to arrange a meeting with one of our billing specialists so that a payment plan may be established. Please be aware that insurance policies have different plans covering chiropractic services. We will assist you in any way we can, **but ultimately it is your responsibility to understand your coverage**. To obtain information about your specific plan we encourage you to contact your insurance company's customer service department. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT RIVERWALK CHIROPRACTIC. This assignment will remain in effect until revoked by me in writing.

Patient Name (print) _____

Parent/Guardian Signature _____ Date_____