Jeske Chiropractic Clinic

PATIENT INFORMATION

Patient Name _____
(last)

_____
(first) *(middle initial)*

Preferred Name_____

Address _____

City _____ State _____ ZIP _____

Home Phone (___)_____ Cell Phone (___)_____

Email Address _____

SS# _____ Sex □ M □ F

Birth date _____ Age _____

Occupation _____

Employer _____

Work Phone (___)_____ Extension _____

□Married □Widowed □Single □ Minor
□Separated □Divorced □Partnered for _____ years

IN CASE OF EMERGENCY

Name _____ Relationship _____

Home Phone (___)_____ Cell Phone (___)_____

Which of the following of our marketing have you seen?

□ Direct mail □ Friend: _____
□ Internet □ Magazine (Which One _____)
□ Radio □ Talk:_____
□ Sign □ Other:_____

What specifically prompted you to choose us for your healthcare needs? _____

_____

Name of Primary Care Provider:
_____

City, State: _____

Last check up: _____

Are you under a doctor's care at the present time? □ Yes □ No

If yes, for what? _____

Name of Doctor: _____

City, State: _____

INSURANCE INFORMATION

Primary Subscriber _____

Relationship to Patient_____

Insurance Co. _____

ID # _____

Is there a Secondary Insurance? ☐ Yes ☐ No

Insurance Co. _____

ID # _____

ASSIGNMENT AND RELEASE

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Jeske Chiropractic Clinic the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of any health insurance or medical plan benefits directly to Jeske Chiropractic Clinic for medical services rendered and for any supplies, tests, or medications provided. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other legal remedies necessary in connection with same. I hereby assign directly to Jeske Chiropractic Clinic all current and prior rights, if any, to payment and benefits and all legal and other health plan rights that I (or my child, spouse, or minor dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). This assignment includes, but is not limited to, a designation that Jeske Chiropractic Clinic personnel can act on my / our behalf, as our representative or ERISA representative, as to any initial claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to Jeske Chiropractic clinic as a result of services rendered by Jeske Chiropractic Clinic and authority to pursue any and all remedies to which I / we may be entitled, including the use of legal action against the health plan or insurer. This assignment and designation remains in effect unless revoked in writing, and a photocopy is to be considered as valid and enforceable as the original.

FINANCIAL POLICY

We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, Mastercard and Care Credit. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Rep.

_____ _____
Date Relationship to Patient

MEDICAL HISTORY

Gynecologic History

Are you currently pregnant? ☐ Yes ☐ No
Pregnancies #:_____ Dates: _____
Deliveries #_____ Natural delivery or C-section? _____
Menstrual: Onset:_____ Duration: _____
Are they regular? □ Yes □ No
Pain associated? □ Yes □ No
Last menstrual period: _____

General History (Check all that apply to you)

__AIDS/HIV
__Alcoholism
__Allergy Shots
__Anemia
__Anorexia
__Appendicitis
__Arthritis
__Asthma
__Bleeding Disorders
__Blood Transfusion
__Breast Lump
__Bronchitis
__Bulimia
__Cancer
__Cataracts
__Chemical Dependency
__Chest pain
__Chicken Pox
__Cholera
__Constipation
__Diabetes
__Eating Disorder
__Emphysema
__Epilepsy
__Fractures
__Gallbladder Disorder
__Glaucoma
__Goiter
__Gonorrhea
__Gout
__Heart Attack
__Heart Disease
__Hepatitis
__Hernia
__Herniated Disk
__Herpes
__High Blood Pressure
__High Cholesterol
__Hormone Replacement Therapy
__Hypertension
__Jaundice
__Kidney Disease
__Liver Disease
__Malaria
__Measles
__Migraine Headaches
__Miscarriage
__Mononucleosis
__Multiple __ Seizures
__ Sclerosis
__Mumps
__Nervous Breakdown
__Osteoporosis
__Pacemaker
__Parkinson's Disease
__Pinched Nerve
__Pleurisy
__Pneumonia
__Polio
__Prostate Problem
__Prosthesis
__Psychiatric Care
__Rheumatoid Arthritis
__Rheumatic Fever
__Scarlet Fever
__STD
__Stroke
__Suicide Attempt
__Swelling feet
__Thyroid Problems
__Tonsillitis
__Tuberculosis
__Tumors, Growths
__Typhoid Fever
__Ulcers
__Vaginal Infections
__Whooping Cough
__Other:
_____
_____

MEDICATIONS

Medications: ***Dosages:***

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

(Use back of sheet if additional space is needed.)

Birth Control: _____

Medication Allergies: ***General Allergies:***

_____ _____
_____ _____
_____ _____

Do you have any surgical devices in your body? ***(i.e. screws, pins, plates, etc?***
If yes, where are they located?_____

ACTIVITY LEVEL

Select one of the following*:*

☐ Inactive: no regular physical activity with a sit-down job

☐ Light Activity: no organized physical activity during leisure time

☐ Moderate Activity: Occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.

☐ Heavy Activity: consistent lifting, stair climbing, heavy construction, etc. or regular participation in jogging, swimming, cycling or active sports at least three times per week.

☐ Vigorous Activity: participation in extensive physical exercise for at least 60 minutes per session, 4 or more times per week.

FAMILY HISTORY	SOCIAL HABITS
Possible Hereditary Diseases:_____ _____ _____ _____	***Habits*****:** (please select all that apply) □ Smoking Packs/day: _____ □ Alcohol Drinks/week: _____ □ Coffee/Caffeine drinks Cups/day: _____ □ High Stress level Reason: _____

SURGICAL HISTORY	NUTRITION
Past Surgical History_____ _____ _____ _____ _____ _____ _____ _____	Present Height: _____ feet _____ inches Present Weight: _____ lbs. Ideal Weight: _____lbs. Weight at age 20: _____lbs. Do you eat/snack after your evening meal? YES / NO If yes, what and how much do you eat? _____ _____ What beverages do you drink throughout a day? _____ _____

PHYSICAL MEDICINE CURRENT CONDITIONS

Reason for Visit?_____

When did your symptoms appear?_____

Is this condition getting progressively worse? □Yes □No □ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain: □Sharp □Dull □Throbbing □Numbness □Aching □Shooting

□Burning □Tingling □Cramps □Stiffness □Swelling □Other

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your □Work □Sleep □Daily Routine □Recreation

Indicate activities which are painful to perform: □ Sitting □ Standing □ Walking □ Bending □Lying Down

What treatment have you already received for your condition? □ Medication □ Surgery □ Physical Therapy

□ Chiropractic Services □ None □ Other_____

Name and address of other doctor(s) who have treated you for your condition:

_____

_____

Date of Last: Physical Exam_____ Spinal Exam/X-Ray_____ Lab work_____

Chest X-Ray_____ MRI, CT-Scan, Bone Scan_____

Is your condition due to an accident? ☐ Yes ☐ No Date of Accident: _____

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other: _____

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Work Comp. ☐ Other

REVIEW OF SYSTEMS

If you have had any of the below symptoms **in the last 1-2 months**, place a check in the box to the left

General-
□ Weight loss or gain
□ Fatigue
□ Fever or chills
□ Weakness
□ Trouble sleeping

Skin-
□ Rashes
□ Lumps
□ Itching
□ Dryness
□ Color changes
□ Hair and nail changes

Ears-
□ Decreased hearing
□ Drainage
□ Ringing in ears
□ Earache

Head-
□ Headache
□ Head injury

Nose-
□ Stuffiness
□ Nosebleeds
□ Discharge
□ Hay fever
□ Itching

Eyes-
□ Vision
□ Glasses or contacts
□ Pain
□ Hay fever
□ Blurry or double vision
□ Cataracts
□ Redness

Throat-
□ Teeth problems
□ Hoarseness
□ Bleeding gums
□ Sore throat
□ Dentures

Neurologic-
□ Dizziness
□ Fainting
□ Seizures
□ Numbness
□ Weakness
□ Tremor
□ Tingling

Respiratory-
□ Cough
□ Sputum
□ Coughing up blood
□ Shortness of breath
□ Wheezing
□ Painful breathing

Cardiovascular-
□ Chest pain or discomfort
□ Tightness
□ Palpitations
□ Swelling
□ Shortness of breath with activity
□ Difficulty breathing lying down
□ Pacemaker/Defibrillator
□ Coronary Artery Disease
□ Congestive heart Failure

Gastrointestinal-
□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Change in bowel habits
□ Rectal bleeding
□ Constipation
□ Diarrhea
□ Chrohn's Disease
□ Nausea
□ Diverticulitis
□ Other _____

Urinary-
□ Frequency
□ Urgency
□ Burning or pain
□ Blood in urine
□ Incontinence
□ Kidney Stones

Genital-Male-
□ Pain with sex
□ Hernia
□ Discharge
□ STD's
□ Masses or pain
□ Erectile dysfunction

Genital-Female
□ Pain with sex
□ Hot flashes
□ Vaginal discharge
□ STD's
□ Itching or rash

Hematologic-
□ Bruising □ Ease of bleeding
□ Cancer- Where_____

Endocrine-
□ Hot or cold intolerance
□ Sweating
□ Frequent urination
□ Change in appetite
□ Thirst

Psychiatric-
□Anxiety □ Stress
□ Depression □ Memory loss

*Reviewed By*_____ *Patient Name*_____ *Date* _____

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