Welcome to Durham Chiropractic Wellness Center

Confidential Health Questionnaire

Name ______________________ **Date** ______________________
Address ______________________________________

____

Home Phone: ____________ **Cell:** _________ **Work:** ______________
Email: ____________________________(for appointment confirmation)
Emergency Contact: ______________________ **Phone** ___________
Sex: ☐ M ☐ F **Age** ____ **Date of Birth** __________ **SSN** ______________
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Occupation_________________________ Full Time or Part Time?
Employer_________________________ Retired from:____________
General Physician: ______________________________
Permission to consult with them if necessary Y N
Prior Chiropractic Care? Dr_______________ Last date seen ___________

Who may we thank for referring you? ______________________
We are proud to say 95% of our patients are referred!

Circle 1-10 severity of pain and shade problem areas on figures to the right
No pain 1 2 3 4 5 6 7 8 9 10 Excruciating

Case Type:
___ Personal Health Insurance
___ Medicare ___ Auto Accident
___ Workers Comp ___ Self Pay

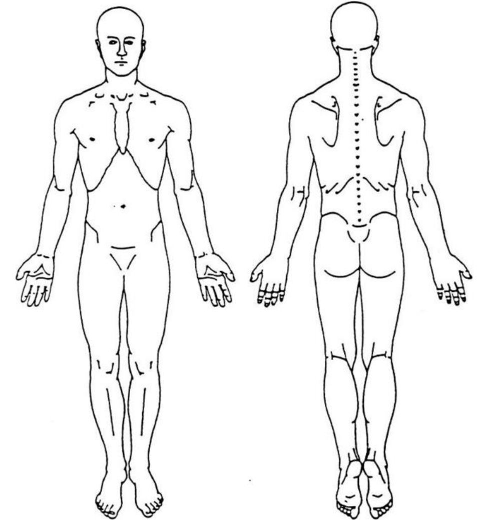
Insured's Name (if not you)
____
Insured's Date of Birth ___________

If condition is due to an accident, please list responsible contact persons:
____
Phone _____________

*** Please present any insurance cards, auto accident, worker's comp. or attorney info to receptionist**

Tell us why you're here today:

Chief Complaint: ______________________________
Complaint #2: ______________________________
Complaint #3: ______________________________
When it started: ______________________________
What caused or aggravated it: ______________________________
Is it changing? ☐ Worse ☐ Same ☐ Better
Have you had this condition before? ☐ Yes ☐ No: When? ______________
How often do you have the symptoms? ☐ Constant (75-100% of day)
☐ Frequent (50-75% of day)
☐ Intermittent (25-50% of day)
☐ Occasional (> 25% of day)



Describe the discomfort: ☐ Aching ☐ Burning ☐ Cramping ☐ Dull ☐ Numbness
☐ Sharp ☐ Shooting ☐ Stiffness ☐ Swelling ☐ Throbbing ☐ Tingling
Other:__________

Any pain, numbness, tingling, or weakness radiating to the arms? ☐ No ☐ Left ☐ Right ☐ Both
legs? ☐ No ☐ Left ☐ Right ☐ Both
Treatments attempted for condition? ☐ None ☐ Acupuncture ☐ Anti-inflammatories ☐ Chiropractic ☐ Heat ☐ Ice ☐ MRI
☐ Muscle Relaxers ☐ Nerve Block ☐ OTC Meds ☐ Physical Therapy ☐ Pain Medications ☐ Surgery ☐ Topical Ointments
Other Doctors seen: (treatment, tests, results) ______________________________
What makes it better? ______________________
What makes it worse? ______________________ **Worse to cough or sneeze?** Yes or No

List the 3 most affected activities that you are unable to do or are having difficulty with as a result of your complaint:
(be specific: work activities, taking meds to get through, hobbies, sleeping, personal care, household chores, etc.)

1. ______________________________ No Effect 0 1 2 3 4 5 6 7 8 9 10 Unable to perform

2. ______________________________ No Effect 0 1 2 3 4 5 6 7 8 9 10 Unable to perform

3. ______________________________ No Effect 0 1 2 3 4 5 6 7 8 9 10 Unable to perform

Family History

(Please tell us **which** of your immediate family members have had any of the following diseases.)

Cancer (what type?) ____________________
Diabetes (type 1 or type 2?) ____________________
Arthritis (Rheumatoid or Osteoarthritis?) ____________________
Heart Disease ____________________

Adopted ____________________
Died under the age of 50 ____________________
Other ____________________

Personal Health History

Please note any conditions or problems you currently have or have had.

General	☐ Cancer: (what type) ____________________				☐ Unexplained weight loss
	☐ HIV	☐ Fatigue-weak	☐ Chronic fever	☐ Night sweats	☐ Chronic infections
EENT	☐ Allergy-Sinus	☐ Vertigo	☐ Vision	☐ Hearing	☐ Speech
MS	☐ Neck pain	☐ Mid back	☐ Low back pain	☐ Osteoporosis	☐ Arthritis-Rheumatoid
	☐ Scoliosis	☐ Prosthesis	☐ Fibromyalgia	☐ Disc herniations	☐ Plantar Fasciitis
	☐ Dislocations	☐ Fractures (list here: ____________________)			
CRS	☐ High BP	☐ Heart attack	☐ Blockage/clots	☐ High cholesterol	☐ Anemia
	☐ TB	☐ Breathing	☐ Chronic cough	☐ Heart surgery	☐ Vascular surgery
GI	☐ Colon- IBS	☐ Ulcers	☐ Hernia	☐ Appetite-Anorexia	☐ Reflux-GERD
GU	☐ Breast	☐ Abn. periods	☐ Abn. pap smear	☐ Urination problems	☐ Pregnant
	☐ Kidney	☐ Prostate	☐ Testicular	☐ Bladder	☐ Sexual Dysfunction
CNS/PNS	☐ Headache	☐ Seizures	☐ Fainting	☐ Dizziness/Balance	☐ Epilepsy
	☐ Neuropathy	☐ Paralysis	☐ Memory	☐ Parkinson's	☐ Multiple Sclerosis
Endocrine	☐ Diabetes I, II	☐ Thyroid	☐ Liver	☐ Hepatitis A, B, C	☐ Excess thirst-urine-sweat
Vascular	☐ Stroke	☐ Clots	☐ Bleeding disorder	☐ Lymph edema	☐ Extremity coldness
Psych	☐ Anxiety	☐ Depression	☐ Insomnia	☐ Suicidal	☐ Psych counseling-meds
Skin	☐ Rash	☐ Itching	☐ Sores	☐ Excess bruising	☐ Skin Cancer

Please list ANY significant accident, surgery, or test no matter how long ago. It could relate to your present complaints.

	Approximate Dates
Surgeries ____________________	____________
Significant Falls or Trauma ____________________	____________
Extended hospital stays ____________________	____________
MRI, CT, Bone scans & results ____________________	____________
Motor Vehicle Accidents ____________________	____________

Tobacco/Vape? Y or N If yes, ☐ 1/2 pack-day ☐ 1 pack-day ☐ 1-2 pack-day ☐ Oral tobacco ☐ Vape
Do you drink: (circle and fill out all that apply) **Alcohol**? If yes, how many drinks ___ /day or ___/ week
Coffee Tea Sodas? ___/day or ___/week
High Stress due to: ☐ Career ☐ Family ☐ Marriage ☐ Relationship ☐ Drug abuse
Sleep habits : ☐ Hours (Side – back – stomach –all over) (Good -- fair – restless leg syndrome-- insomnia)

Medications/ Supplements

☐ None	☐ OTC	☐ Pain meds	☐ Muscle relaxer	☐ Anti-inflammatory
☐ Heart	☐ HBP	☐ Blood thinner(s)	☐ Cholesterol	☐ Thyroid
☐ Hormones	☐ Birth control	☐ Anti-depressant	☐ Multivitamin	☐ Calcium
☐ Magnesium	☐ Fish Oil	☐ Glucosamine	☐ Other:____________________	

Other Hobbies/Activities: (such as golf, fishing, hunting, taking care of elderly parent, etc.)

Caregiving: ____________________ Hobbies: ____________________
Sports: ____________________ Volunteering: ____________________
Yardwork: ____________________ Housework: ____________________

Exercise (mark all that apply) ☐ None ☐ Minimal ☐ Moderate or ☐ Daily If exercise, low or high intensity?
☐ Aerobics ☐ Weights ☐ Yoga ☐ Other Specify:____________________

Patient or guardian signature____________________ **Date** ____________

Durham Chiropractic Consent, Authorization, and Financial Policy

Read these terms carefully and please present the receptionist your current insurance cards and photo ID to copy.

Treatment Authorization: I consent to treatment for myself or on behalf of the minor to which this pertains. I give permission for the doctor/s and assistants of Durham Chiropractic to examine, x-ray, diagnose, and initiate treatment including manipulation and physiotherapy as deemed appropriate and considered necessary by typical standards of care. I further attest that I am the Legal Guardian of the minor or have the authority to authorize care and treatment. I understand the office policy in the case of separated or divorced parents: the parent bringing the child into the office is financially responsible for all charges incurred if not noted otherwise. This serves as a long-term authorization that applies until revoked.

Initial: _______________

Payment Authorization: I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance, worker's comp, auto insurance, third party, my adjustor or attorney directly to the appropriate physicians of Durham Chiropractic. This assignment will remain in effect until revoked by me in writing. See TCA 56-7-120 (a) (1&2)

Initial: _______________

Financial Policy: At Durham Chiropractic and Wellness, we are committed to providing you with the best possible care regardless of whether you have insurance coverage or not. We are glad to assist you in receiving your maximum allowable benefits through insurance; otherwise, we have many affordable options for you. Discussing your treatment options, alternatives, financing, and any other questions to the best of our ability up front allows everyone to focus on what is most important: **your health**.

In order to help achieve your health goals, we need you to understand our payment policies and general insurance's laws. Your insurance is a contract between you and your insurance company only; we are not a party in that contract. Each insurance company's policy is unique in services covered, amounts allowed for services, and the amount you are contracted to pay. We attempt to contact your insurance carrier to verify your coverage, but until we receive an actual EOB, we can only estimate what they may pay. If you feel your insurance coverage is different than what we are quoted, please investigate, and let us know ASAP. Per our contract with insurance companies and state law, it is considered fraudulent and illegal for us to waive deductibles or co-payments.

Although we file claims as a courtesy for our patients, we are health care providers, not a billing company. It is not our responsibility to coerce the responsible parties to pay the full benefits to which you may be entitled. YOU are ultimately responsible for charges on the date services are rendered, and may also be responsible for what your insurance company or attorney does not pay in accordance with timely payment laws, or procedures that are routinely covered but rejected as not medically necessary by your policy. **Remember, insurance is a method of assistance in paying your doctor but is not a substitute for payment.**

We DO NOT carry delinquent accounts over 90 days. Balances past 90 days (without prior arrangements or notice of circumstances) will be considered in default and are subject to additional collection fees and interest charges. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Otherwise, I am aware in the event my account becomes delinquent; I am responsible for all the collection and/or legal fees incurred in the collection process. In addition, if I make prior payment arrangements and lapse in payment for 90 days, the arrangement is void and the outstanding balance is due in full. Declined CC/ auto draft /returned checks fee is $20.00 per occurrence.

Name of Patient printed: ____ Date: ______________________

Signature of Patient/Parent/Legal Guardian:____

Witness: ____ Date:________________________

Notice of Privacy Practices Acknowledgement
Durham Chiropractic

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

____ Date ______________________

Patient Name or Legal Guardian (print)

____

Signature

Office Use Only

Staff Name ____

We have made the following attempt(s) to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date ____________ Attempt ______________________________________

Date ____________ Attempt ______________________________________

Date ____________ Attempt ______________________________________

Date ____________ Attempt ______________________________________