43 N 300 W Ste B
Washington, Ut 84780
(435) 986-1021

Name: ______________________________ Date: ______________
Address: ______________________________ State: _______ Zip: _________
H. Phone: ______________________ C. Phone: ______________________
Date of Birth: ______________ Age: __________ Height: __________ Weight: ___________
Referred by: ______________________________
Occupation: ______________________ Employer: ______________________
Marital Status S M D W Spouse Name______________________________
Insurance Company______________________ Please give card to the front desk so it can be copied.
Have you ever received Chiropractic Care? Yes No

Insurance Patients:
Allen Chiropractic Care offers insurance billing as a service to our patients. We are providers for a number of insurance companies. Each insurance company is different and offers their members a variety of plans. All plans are diverse with different benefits for each plan. Your insurance card is not a guarantee of benefits or payment, and some chiropractic services may be denied payment by your Insurance Company. All agreements made are between you (the beneficiary) and the Insurance Company. Allen Chiropractic Care will do everything in its power to ensure you receive your maximum chiropractic benefits from your Insurance company, but please understand that we are a third party in your insurance agreement, and as such, are limited.

Cash Patients:
Allen Chiropractic Care offers low rates to our Cash patients. The first visit (consultation, exam, adjustment and report of findings) is $55 and each visit thereafter is only $55. We are providers for a Discount Medical Plan. If you are able to join this Discount Medical Plan it allows us to reduce our fee to $35. We are able to offer these low rates because you are a member of that Discount Medical Plan.
If at any time, you need to defer payment and wish to be billed for the visit, a $5 billing fee will be added to the full balance for each bill sent (bills will be sent out once a month).

Past Health History:
A. Previous major illnesses you've had in your life: ______________________________
B. Previous accidents, injury or trauma: ______________________________
Have you ever broken any bones? Which? ______________________________
C. Allergies: ______________________________
D. Medications: ______________________________
____
E. Vitamins or supplement: ______________________________
F. Surgeries: ______________________________

Family Health History:
Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other__________
Father's side:	☐	☐	☐	☐	☐
Mother's side:	☐	☐	☐	☐	☐

Family History: Health conditions, age of death and cause of death.
Father: ______________________________
Mother: ______________________________
Brother/s & Sister/s: ______________________________

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Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Numbness
__ Wheezing
__ Fatigue
__ Depression
__ Sleeping Problems
__ Diabetes
__ Osteoporosis
__ Arthritis

MUSCLES & JOINTS
__ Low Back Problems
__ Upper Back Pain
__ Shoulder Pain
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Loss of Smell or Taste
__ Pain behind Eyes
__ Lights Bother Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis
__ Jaw/TMJ Problems

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Heartburn/Reflux
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy

FOR WOMEN ONLY
__ Birth Control
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain

Symptoms and Present State of Health

Present condition due to an injury? ☐ Yes ☐ No ☐ On the Job ☐ Auto Accident ☐ Other ________________________
Has the accident been reported? ☐ Yes ☐ No ☐ To Employer ☐ Auto Carrier ☐ Other ________________________

Present Complaint or Reason for Seeking Care in Our Office:
Complaint: ____
Started on: ____
Pains are: ☐ Sharp ☐ Burning ☐ Throbbing ☐ Dull/ Ache ☐ Deep ☐ Nagging ☐ Other____________________________
☐ Constant 76-100% ☐ Frequently 51-75% ☐ Occasionally 26-50% ☐ Intermittent 0-25%
Does this pain shoot, radiate, or travel in your body? Where? ____
Are you experiencing numbness or tingling in any area of your body? Where? _________________________________
Since it began, is it: ☐ Same ☐ Better ☐ Worse
How much does it interfere with your daily activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a Bit ☐ Extremely
What aggravate your condition/pain? ____
What lessen your condition/pain? ____
Is this condition worse during certain times of the day? ____
Other Doctors seen for this condition: ____
Any home remedies? ☐ Ice ☐ Heat ☐ Aspirin ☐ Tylenol ☐ Ibuprofen ☐ Other________________________
Please Circle
Current level: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Last 24 hours: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

ALLEN CHIROPRACTIC CARE

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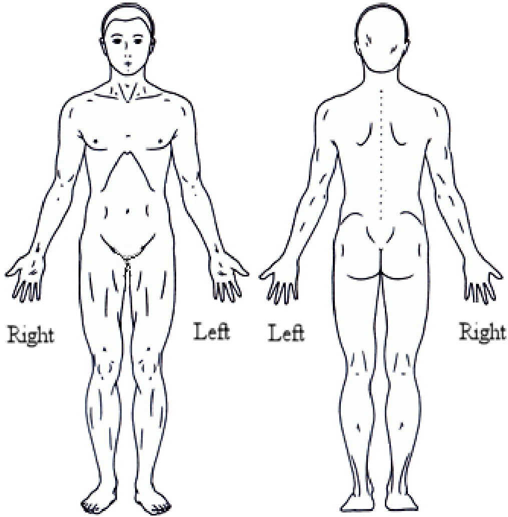

Using the symbols below, mark on the pictures where you feel pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other ______	^ ^ ^

Please score all of the following on a scale of 1-10, based on your current condition.
0- Can perform without pain or condition   10- Cannot perform due to pain or condition

Neck and Upper Back

1- Personal care: _____
2- Lifting: _____
3- Reading: _____
4- Headaches: _____
5- Concentration: _____
6- Work: _____
7- Driving: _____
8- Sleeping: _____
9- Recreation _____

Low Back and Pelvis

1- Personal care: _____
2- Lifting: _____
3- Sitting: _____
4- Changing Degree: _____
5- Standing: _____
6- Walking: _____
7- Traveling: _____
8- Sleeping: _____
9- Social Life: _____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Patient Signature____Date___________________________

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CHIROPRATIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on (or on the patient named below, or for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctor of chiropractic who now or in the future treat me while employed by, working, or associated with, or serving as a back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustment and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. Therefore, I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels is in my best interest, based upon the facts then known.

Under HIPPA guidelines, I consent to the procedures of this office including my name being visible on the daily sign in sheet.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

____ ____

Patient/Guardian Signature (if minor) *Date*

Arbitration Agreement

Arbitration is a way to decide health care complaints without going to court. By signing this agreement, my doctor(s) and I are choosing arbitration rather than going to court as a way of resolving any future claim about my chiropractic care. This agreement only applies to the care that I receive in this office from the undersigned chiropractor, or any office assistants or, employed assigned to my care by my chiropractor immediately following the execution of this form during the time when this form is in effect.

This agreement does not apply to disagreements over the fees charged. State law gives me a choice of two ways to decide claims; either a trial by a judge or jury, or arbitration. I have a right to a lawyer for a trial or arbitration. If I select arbitration, my case will be decided by a panel of three people instead of a judge or jury. The arbitration panel will contain a lawyer, a member of the public, and a Doctor of Chiropractic. My doctor and I will take part in choosing the panel members who will decide the case. If the parties involved in the case cannot agree on the panel members, the American Arbitration Association and my doctor's state or national association representative may appoint the panel members. State laws and rules of the American Arbitration Association will apply to all arbitration hearings, and may vary from state to state. All parties are delegated to investigate on their own and/or seek counsel. I am choosing arbitration of my own free will. This agreement applies to me, my heirs, and my legal representatives.

If I want to change my mind and cancel this agreement, I must notify my doctor in writing within 60 days after I sign. After 60 days, I cannot change my decision unless mutually agreed upon by all parties. In most cases, a decision by an arbitration panel is final and cannot be appealed.

This agreement to arbitrate is not a prerequisite to health care or treatment and may be revoked within 60 days after execution by notification in writing to:

____ ____

Signature of Chiropractic Representative *Patient Signature* *Date*

I CERTIFY THAT I AM THE PARENT OF THE MINOR CHILD, THE GUARDIAN, OR OTHER LEGAL REPRESENTATIVE OF THE PATIENT INVOLVED.

____

Parent/Guardian/Legal Representative *Date*