

INNER HEALTH CHIROPRACTIC INC.

Confidential Patient Information

Patient Name: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell #: _____ Work #: _____

Social Security #: _____ DOB: ____/____/____ Age: ____ Sex: M / F Marital Status: _____

Patients Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone#: _____ Relationship to Patient: _____

Referred By: _____

Insurance Information: (Insurance Holder Information)

Insured Name: _____ Insured DOB ____/____/____ SS #: _____

Relationship to the patient: _____ Insured ID #: _____ Group #: _____

Insurance Company: _____ Address: _____

Auto Accident Information:

Date of Accident: ____/____/____ Was the accident reported to the at fault or not at fault insurance company? Yes No

At Fault Information: Insurance Company: _____ Phone #: _____ Claim #: _____

Attorney Name: _____ Address: _____ Phone #: _____

Work Related Accident:

Was this accident reported to your employer? Yes No Date of Injury ____/____/____ BWC Claim #: _____

Attorney Name: _____ Address: _____ Phone #: _____

Appointment Cancellation Policy

Our office policy is to charge \$20.00 for appointments that are not called and canceled/re-scheduled. You may call up until the time of your appointment. Initial _____

Treatment of a Minor

I, _____, give my permission to Inner Health Chiropractic, Inc. and its representatives to render the necessary treatment to my child, _____. I authorize payment of medical insurance benefits to Inner Health Chiropractic, Inc. for any services furnished to him/her. I also authorize you to release medical information concerning his/her health care to any attorney, insurance company, or third-party payors, and/or their respective agent(s). This information will be used for the purpose of evaluating and administering claims of benefits.

Parent/Guardian Signature: _____ Social Security #: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell #: _____ Work #: _____

Authorization for Assignment of Benefits/Information Release:

I authorize payment of medical insurance benefits to Inner Health Chiropractic, Inc. for any services furnished to me. I also authorize you to release medical information concerning my health care to any attorney, insurance company, or third-party payors, and/or their respective agent(s). This information will be used for the purpose of evaluating and administering claims of benefits.

Patient Signature: _____ Date: _____

MUSCULO-SKELETAL

Low Back Pain

Joint Pain/Stiffness

Pain Between Shoulders

Walking Problems

Neck Pain

Difficult Chewing

Arm Pain

General Stiffness

NERVOUS SYSTEM

Nervous

Confusion/Depression

Numbness

Fainting

Dizziness

Cold Tingling Extremities

Forgetfulness

Stress

GENERAL

Fatigue

Allergies

Loss of Sleep

Headaches

GASTRO-INTESTINAL

Weight Trouble

Diarrhea

Gall Bladder Problems

Gas/Bloating After Meals

Poor/Excessive Appetite

Constipation

Vomiting

Black/Bloody Stool

Excessive Thirst

Hemorrhoids

Abdominal Cramps

Colitis

Frequent Nausea

Liver Problems

Heartburn

GENITO-URINARY

Bladder Trouble

Discolored Urine

Painful/Excessive Urination

C-V-R

Chest Pain

Heart Problems

Short Breath

Lung Problems/Congestion

Blood Pressure Problems

Stroke

Irregular Heartbeat

Ankle Swelling

EENT

Vision Problems

Hearing Difficulty

Dental Problems

Stuffy Nose

Sore Throat

Ear Aches

MALE/FEMALE

Menstrual Irregularity

Prostate Problems

Menstrual Cramps

Sexual Dysfunction

Vaginal Pain/Infection

Other Problems

Breast Pain/Lumps

FAMILY HISTORY: The following members have the same or similar problem as I do:

Father

Mother

Brother

Sister

Spouse

Child

DO YOU INTAKE:

Coffee

Tea

Alcohol

Cigarettes

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (**Corrective Care**). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care

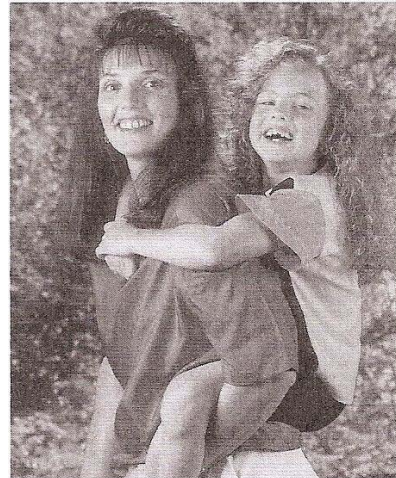
OR

Corrective Care



Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.