CHIROFIT

3326 Aspen Grove Dr. Ste. 502 Franklin, TN 37067 Phone (615) 771-0722 Fax (615) 771-0734 Website: www.chirofitcoolsprings.com

Confidential Patient Information

Patient Information:

Date:____/____/____

Patient's Full Name _____

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

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Date of Birth:____/___/_____ ☐ Male ☐ Female Spouse's Name:_____

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced Number of Children/Ages_____

Social Security # _____ - _____ - _____ Referred by (Friend, Relative, Physician or Newspaper) :_____

Emergency Contact:_____ Relationship:_____ Phone: _____

Family Physician: _____ City: _____ State:_____ Phone_____

Primary Insurance Company_____ ID#_____ Group#_____

Phone:_____ Insured's Name_____ Date of Birth: ____/____/_____ Relation to Insured:_____

Auto Insurance Company:_____ Address:_____

Phone Number:_____ Adjustor/Agent:_____ Claim Number:_____

Is Today's visit due to an automobile injury: ☐ Yes ☐ No Date Of Injury:_____

Responsible Party Information:

Responsible Party's Name:_____ Address:_____

Responsible Party's Insurance Company:_____ Adjustor:_____

Phone Number:_____ Claim Number:_____

Attorney Information:

I have retained an attorney: ☐ Yes ☐ No Attorney's Name:_____ Phone:_____

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

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, **I personally owe to you.**
4. I understand that I may choose to submit medical bills to my health insurance company and that any monies received will be applied towards my balance. *I also understand that should my health insurance company request reimbursement once a settlement through the automobile insurance is made, then I will be responsible for said reimbursement.*
5. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you (CHIROFIT) are **paid in full.**

Patient Signature_____ Date_____/_____/_____

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Date:_____/_____/_____

Patient's Name: _____

Date of Accident: ____/____/_____ Time of Day:_____ Were there witnesses ☐ Yes ☐ No Names:_____

Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat Number of People in your vehicle:_____ Were you wearing seatbelt:_____

What direction were you headed ☐ North ☐ South ☐ East ☐ West On what street:_____

What direction was the other vehicle headed ☐ North ☐ South ☐ East ☐ West On what street:_____

Were you struck from: ☐ Front ☐ Behind ☐ Left ☐ Right Approximate Speed of you car____ mph Other car's approx speed_____ mph

Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long?_____ Were the police notified? ☐ Yes ☐ No

In your own words, please describe the accident:_____

_____

_____

Did you have any physical complaints BEFORE THE ACCIDENT? ☐ Yes ☐ No If yes, please describe in detail:_____

_____

_____

Please describe how you felt:

A. DURING the accident:_____

B. IMMEDIATELY AFTER the accident:_____

C. LATER THAT DAY: _____

D. THE NEXT DAY:_____

Do you have any congenital (from birth) factors which relate to this problem? ☐ Yes ☐ No If yes, please describe_____

_____

Do you have any previous illness which relate to this case? ☐ Yes ☐ No If yes, please describe_____

_____

Have you ever been involved in an accident before? ☐ Yes ☐ No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received: _____

_____

Where were you taken after the accident?_____ Have you had X-rays/MRIs since the accident? ☐ Yes ☐ No Specify_____

Have you been treated by another doctor since the accident? ☐ Yes ☐ No Doctor's Name(s):_____

Have you lost time from work due to of this accident? ☐ Yes ☐ No If yes, please complete this question. Last Day Worked:____/____/_____

Type of Employment:_____ Present Salary:_____ Are you being compensated for lost work: ☐ Yes ☐ No

Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No If yes, please describe in detail:_____

_____

Other pertinent information:_____

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Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Date:_____/_____/_____

Patient's Name: _____

Chief complaint_____

Secondary or related complaint(s) if any:_____

Was the onset of your symptoms: ☐ Gradual ☐ Sudden Since accident, has it gotten: ☐ Worse ☐ Better

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP EXPLAIN YOUR **CHIEF COMPLAINT:**

Describe the quality of the complaint/pain:
- ☐ sharp
- ☐ dull/ache
- ☐ throbbing
- ☐ tingling/numbness
- ☐ other:_____

Does any of the following make the pain worse:
- ☐ lifting/bending/pushing/pulling
- ☐ cough/sneeze/bowel movement
- ☐ driving/riding/sitting
- ☐ walking/running/standing
- ☐ other:_____

Describe if pain is in a single spot or does is spread out:
- ☐ radiating dull, deep ache
- ☐ pin point
- ☐ burning, sharp stabbing, tingling, numb
- ☐ other:_____

Does any of the following make it better:
- ☐ rest/laying down
- ☐ sitting
- ☐ walking/exercise
- ☐ other:_____

How often are you aware of the pain:
- ☐ intermittent (less than 25% of time when awake)
- ☐ occasional (25-50% of time when awake)
- ☐ frequent (50-75% of time when awake)
- ☐ constant (75-100% of time when awake)

Does it interfere with your daily activities:
- ☐ minimal (annoyance, no impairment)
- ☐ slight (tolerated, some impairment)
- ☐ moderate (marked impairment)
- ☐ marked (preclude any activity)

Have you detected any possible relationship of your current complaint with any of the following:

☐ Muscle Weakness ☐ Bowel/Bladder problems ☐ Digestion ☐ Cardiac/Respiratory ☐ Other:_____

Have you tried any self-treatment or taken any medication (over the counter or prescription): ☐ Yes ☐ No

If yes, explain;_____Results:_____

Are you currently pregnant? ☐ Yes ☐ No Are you currently taking anti-coagulant or blood thinning medication? ☐ Yes ☐ No

What type of care are you interested in: ☐ Pain relief only ☐ Healing of current condition ☐ Optimizing your health ☐ All three

---

NP1 NP2 NP3 NP4 OV1 OV2 A1 A2 A3 EM MED1 TE NMED ES M15 M30 MT XC3 XC5 XC7 XT2 XL2

_____

_____

_____

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_____

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OFFICE NOTES

CHIROFIT

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Date:_____/_____/_____

Patient's Name: _____

In general, would you say your health is (check one): ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

PAST HEALTH HISTORY:

1. Have you ever experienced your present problem before for which you are consulting us: ☐ Yes ☐ No If yes, When: _____

   Was treatment provided: ☐ Yes ☐ No If yes, By whom:_____ Outcome: _____

2. Have you **ever** had a **stroke** or issues with **blood clotting**? ☐ Yes ☐ No If yes, explain_____
3. Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? ☐ Yes ☐ No If yes, explain:_____
4. Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries?** ☐ Yes ☐ No

Date	Injury/Fracture/Illness/Surgeries	Treatment	Results

Are you presently taking any **prescription drugs**, over-the-counter drugs, vitamins, or supplements? ☐ Yes ☐ No

Product/Drug	Reason	Dosage	Frequency

SYSTEMS REVIEW QUESTIONS:

Do you or have you ever had any problems with the following areas? (Please mark **Y** for yes or **N** for no in each of the following:)

1. _____ Eyes
2. _____ Ears, Nose, Mouth, Throat
3. _____ Heart
4. _____ Lungs/ Breathing
5. _____ Intestines/Bowels
6. _____ Urinary
7. _____ Muscles
8. _____ Nerves
9. _____ Joints/Bones
10. _____ Skin
11. _____ Internal Organs
12. _____ Blood
13. _____ Allergies
14. _____ Psychological/Emotional

Females only:

15. _____ Gynecological/Menstrual/Breast

Males Only:

17. _____ Prostate/Testicular/Penile

Please explain any above **Yes** answers: _____

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SOCIAL HISTORY:

Recreational Activities (Hobbies):_____

_____

Your education level: ☐ Highschool ☐ Some college ☐ College Graduate ☐ Post Graduate ☐ Other: _____

Yes	No		
☐	☐	Do you exercise? _____	times per week Type of Exercise:_____
☐	☐	Do you smoke? _____	packs per day If you have quit smoking, when did you quit?_____
☐	☐	Do you use other forms of tobacco?	What/How much per day? _____
☐	☐	Do you consume alcohol?	How many drinks per week? _____
☐	☐	Do you eat a balanced low fat diet?	If no, explain: _____
☐	☐	Do you get adequate sleep?	If no, explain: _____
☐	☐	Is work stressful to you?	If yes, explain: _____
☐	☐	Is family life stressful to you?	If yes, explain: _____
☐	☐	Do you use recreational drugs?	If yes, explain: _____

FAMILY HISTORY AND HEALTH STATUS: list any diseases, disorders, or major illnesses. If deceased, from what?

1. Mother: _____
2. Father: _____
3. Sisters: _____ How many? _____
4. Brothers:_____ How many? _____
5. Other: _____

OTHER INFORMATION:

How do you sleep ☐ Back ☐ Side ☐ Stomach Do you use a pillow : ☐ Yes ☐ No

Do you wear orthotics or arch supports ☐ Yes ☐ No

Females: Date of last gynecological and breast exam:_____

For Purposes of X-Ray: Possible pregnancy? ☐ Yes ☐ No

Date of last menstrual cycle: _____

Please read and sign:
I hereby state that all information that I have provided CHIROFIT is complete and truthful and that I fully disclosed my health history.

SIGNED: _____ Date_____

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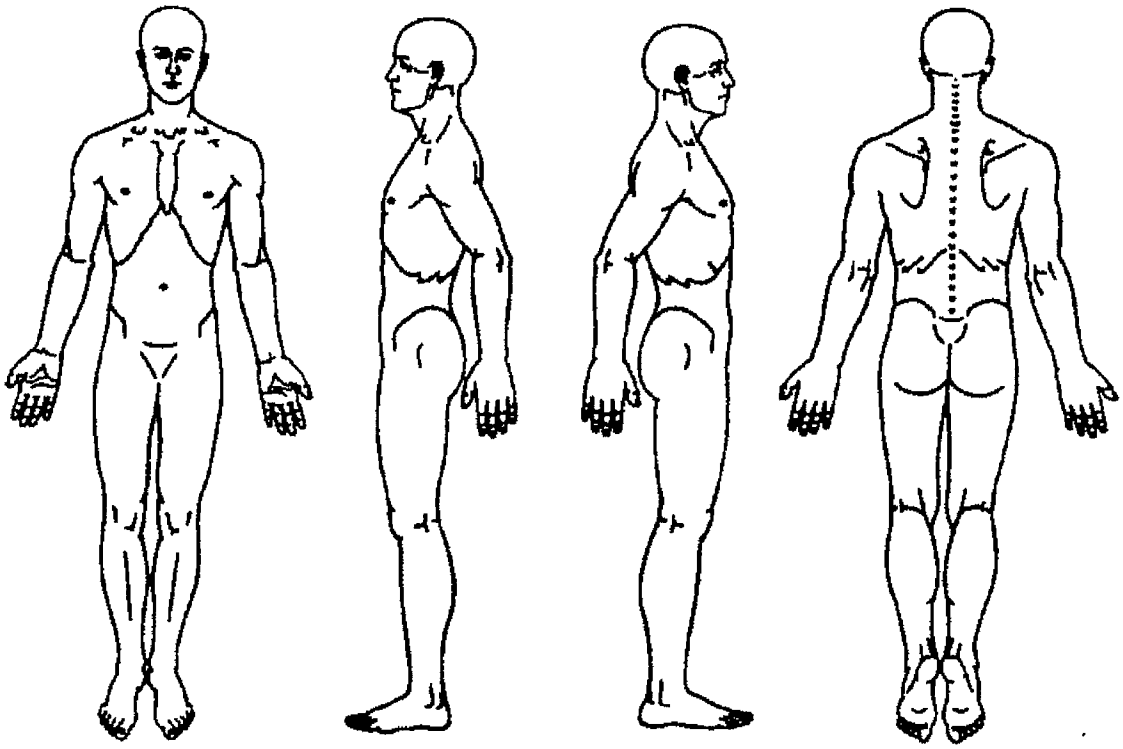
Please Mark Area Of Pain on the Drawing Using The Codes Listed Be-

+++	Burning
###	Dull/Ache
***	Numbness/Tingling
===	Throbbing
000	Stabbing/Sharp



SEVERITY OF PAIN

List region of pain and circle the number which represents the intensity of your pain

Example:
Ex.Complaint:_____low back pain_____

1. Complaint:_____
2. Complaint:_____
3. Complaint:_____
4. Complaint:_____

0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware the there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of Patient Date_____

_____ Signature of Parent or Guardian (if a minor) Date_____

_____ Signature of Witness Date_____

To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously because it can make a difference between responding to treatment or not. Usually your referring doctor and/or therapist have prescribed a set frequency of treatment. If you show up for treatment, it will enable you to get better. Other than that all you need to do is follow your doctor's instructions, and you should achieve your treatment goals.

We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get the full number of prescribed treatments that week whenever possible.

There is a **$20 charge for a cancellation or no-show without proper notice.** This charge will not be covered by you insurance, but will have to be paid by you personally.

For **Workmen's Compensation and Personal Injury patients,** documentation of any missed appointments is forwarded to your case manager and primary physician. This could jeopardize your claim.

You may occasionally need to see another physician other than the one who normally sees you if you do need to re-arrange your appointment. All of our physicians are experienced professional and they will study your chart. You may return to your original physician at the next appointment.

Please understand that your pain will probably increase and decreases as your course of treatment progresses and before it is finally eliminated. Either condition should not be a reason not to come in: 1) Your pain is gone or 2) Your pain is worse. If the pain is gone, now is the time to really begin rehabilitating the injured area to prevent recurrence. If your pain is worse, we can do something to help.

When you don't show as scheduled, three people are hurt. 1) You, because you didn't get the treatment you need as prescribed by your doctor; 2) The doctor who now has a hole in their schedule; 3) The person that couldn't get in when you had your appointment scheduled.

Thank you for cooperating with us on this matter. We are looking forward to working with you.

_____ _____

patient signature **date**

Please sign, date and return to the doctor's office as well as keep a copy for your records

Doctor's Lien

Patient Name_____ Date of Accident_____

I am authorizing Dr. Hunter Evans (hereafter referred to in this document as "the doctor") to furnish all my accident/injury treatment records, reports and billing information to my attorney.

I am authorizing my attorney to pay the doctor directly any and all monies due on my account in regards to said accident/injury, and for any other bills which are outstanding in my name on his records. I direct that my attorney withhold these amounts from any settlement due me to completely pay my account in full with the doctor. This is a notice of a lien on my case to this doctor against all monies awarded me, paid to my attorney or me in this accident/injury case.

I will notify the doctor within three business days of any change in my legal representation. My attorney is instructed to make available a copy of this lien to any other legal counsel working on my behalf.

I agree that I am financially responsible to the doctor for any and all fees for treatment rendered to me by him or provided under his direction. The purpose of this lien is to protect the doctor in his consideration of waiting for payment. I also realize that such payment to the doctor is not contingent upon my settlement or judgment, and the doctor may choose to make the full balance due if my legal counsel chooses not to sign this lien.

Patient Signature_____ Today's Date_____

By signing below, I state that I am the legal counsel representing the above signed patient; and I agree to comply with the terms as stated in the Doctor's Lien above. If this lien becomes involved in litigation, I agree to award attorney fees and costs to the prevailing party.

Attorney Signature_____ Today's Date_____

Dr. Hunter Evans
Chirofit, PLLC
3326 Aspen Grove Dr.
Suite 502
Franklin, TN 37067
(615) 771-0722

Patient Acknowledgement Form for Personal Injury Cases

- **It is our office policy that Med-pay from the patient's auto insurance policy be the primary source of payment, if available. Med-pay is purchased for bodily injury sustained while in your automobile. If this portion of your insurance is used there should not be an increase in your premium.**

- **Second source of payment should come from the at fault drivers auto insurance. The insurance information exchanged at the incident is the information you need.**

- **The third source is from your attorney settlement.**

- **Your health insurance is our last option, and most likely not an option.**
  - Your health insurance requires you to be responsible for co-payments, co-insurance and deductibles for covered services as well as those services that exceed benefit limits. Those payments are always expected at the time of service.
  - Your health insurance limits you to a certain number of visits per year. If you exceed that limit you will then be responsible for the total bill for each visit and will not have chiropractic benefits left to use for any other reason the remainder of the policy term.
  - Most insurance companies will not cover personal injury claims. If claims are submitted and denied you will be responsible for your total bill.

- ** **The above policy insures not only the protection of this office, but will also insure that the patient's financial responsibility be kept at a minimum.**

Patient Acknowledgement:

I, _____ (patient name), acknowledge that I have been told in advance, by this office, of it's policy pertaining to personal injury claims. I agree that I am ultimately responsible for payment or directing payment to this office.

_____	_____	_____
Patient Name (Print)	**Patient Signature**	**Date**