



Chart Number: _____

Health History and Insurance Information Form

Name _____ Sex: M F

Address _____

City _____ State _____ Zip Code _____

Home # _____ E-mail Address _____

Work # _____ Occupation _____

Cell # _____ Date of Birth _____

Referred By: _____

Status: Married Single Divorced Widowed Spouse's Name: _____

Children _____

Employer _____

Have you ever had chiropractic care before? Yes No

For what did you receive care for? _____

Where the results satisfactory? Yes No N/A

Primary Insurance Information

Insurance Company Name _____

Primary Policy Holder's Name _____

Policy Holder's Date of Birth _____ Relation to You _____

Primary Policy Holder's Employer _____

Secondary Insurance Information

Insurance Company Name _____

Primary Policy Holder's Name _____

Policy Holder's Date of Birth _____ Relation to You _____

Primary Policy Holder's Employer _____



Chart Number: _____

Major Complaints and Symptoms (Please be as specific as possible.)

How do you believe your problem/pain first began?

Is this issue related to an auto accident? Yes No If yes, please give date of accident _____

When did you first notice this problem/pain? _____

Have you lost any work? Yes No Date you last worked: _____

Have you ever had this or a similar condition before? Yes No When? _____

What positions or activities aggravate your condition? _____

What positions or activities relieve your condition? _____

Have you ever been treated by a medical physician for this ailment? Yes No

Where? _____

Describe the type of treatment:

Diagnosis, if known, by previous physician:

Length of time under care: _____

Results: _____

Are you currently on any medications? Yes No

If yes, please list

Do you have any allergies to medications, food, seasonal, etc.? Yes No

If yes, please list

Family Physician's Name:

Phone Number: _____

Would you like a report sent? Yes No

Do you take vitamins? Yes No

If yes, please give a complete list:



Chart Number: _____

Have you ever been in any accidents (*Include childhood injuries*)? Yes No

Please list and give year:

Have you ever broken/fractured any bones? Yes No Any dislocations? Yes No

If yes, please list:

Have you ever had cosmetic surgery (breast implants, etc.)? Yes No

Have you had any replacement surgery (hip, knee, etc.)? Yes No

Please list all surgeries and give year:

Have you had any of the following done within the last 6 months? Please circle all that apply.

Blood Test Urinalysis MRI CT Scan

Ultrasound Radiation Treatment X-Ray

Please list any other treatments/test performed within the last 6 months not listed above.

Do you have any other health problems/issues that have not been covered? Yes No

If yes, please list and explain:

Women Only

Date of last menstrual period: _____

Do you have any reason to believe that you may be pregnant? Yes No

Type of birth control: _____

Is there any unusual periods/bleeding/discharge?

Have you had any unusual breast tenderness/pain?

 Yes No

If yes, please explain

Habits (Please circle all that apply)

Cigarettes Quantity _____ Tea Quantity _____

Alcohol Quantity _____ Coffee Quantity _____



Chart Number: _____

Have you had or do you now have any of the following symptoms which are/have been of significant distress to you?
Please indicate with the letter **N** if you have these conditions **NOW** (within the past **12** months).

Please indicate with the letter **P** if you ever had these conditions in the **PAST** (prior to the past **12** months).

Weakness in Legs	Irritability	Fatigue	Arthritis	Belching
Neck Pain	Diabetes	Fainting	Shortness of Breath	Muscle Spasms
Weakness in Arms	Knee Pain	Allergies	Leg Cramps	Fever
Colitis	Hay fever	Tension	Hands Cold	Feet Cold
Cold Sweats	Indigestion	Back Pain	Diarrhea	High Blood Pressure
Upset Stomach	Constipation	Loss of Smell	Loss of Taste	Gall Bladder
Loss of Memory	Frequent Colds	Sinus Issues	Face Flushed	Swelling Joints
Depression	Hemorrhoids	Issues Sleeping	Loss of Balance	Nervousness
Ringling/Buzzing in Ears	Jaw/Face/Shoulder/Neck/Arm Pain			

Additional Comments: _____

Do you have chest pain?	Yes	No
Do you have vertigo (dizziness)?	Yes	No
Do you have blurred vision?	Yes	No
Do you have double vision?	Yes	No
Do you have any other visual issues?	Yes	No
Do you have night sweats?	Yes	No
Do you faint easily?	Yes	No
Do you have nausea or vomiting?	Yes	No
Do you have slurred speech?	Yes	No
Have you ever had cancer?	Yes	No
Do you have cough/hoarseness?	Yes	No

Do you have any change in bowel/bladder habits (loss of control, blood, difficulty, etc.)?	Yes	No
Do you have any sores that will not heal or other type of skin issues?	Yes	No
Do you have any indigestion/trouble swallowing/reflux issues?	Yes	No
Do you have headaches that last for hours or days?	Yes	No
Do you have a drooping eyelid or any change in your pupils?	Yes	No
Do you have any changes in the breast (lumps, thickening, pain, etc.)?	Yes	No

Do you exercise regularly? Yes No

If yes, please list:



Family History

Has your mother or father had any of the following: Put an **M=MOTHER, F=FATHER, B=BOTH**.

High Blood Pressure	Thyroid Disease	Ulcer/Stomach Problems
Asthma	Heart Attack	Circulation Problems
Stroke	Diabetes	Emphysema
Cancer	Arthritis/Rheumatism	Kidney Disease
Seizures/Convulsions	Osteoporosis	Mental Illness
Pacemaker	HIV Positive	

Additional Comments:

Pain Levels

Please mark on the pain scale from 0 to 10 the pain you feel with this condition ten being the worst pain you have felt and 0 being no pain at all. Also, circle one of the descriptions as to the type of pain.

Neck-Shoulder-Arm Pain

1 2 3 4 5 6 7 8 9 10

Dull/achy Sharp Numb Tingling Burning Cold

Low Back and Leg Pain

1 2 3 4 5 6 7 8 9 10

Dull/achy Sharp Numb Tingling Burning Cold

Mid Back Pain

1 2 3 4 5 6 7 8 9 10

Dull/achy Sharp Numb Tingling Burning Cold

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting whatever services the doctor deems necessary.
- It is my responsibility to complete the clinic's forms accurately.
- It is my responsibility to notify the doctor if any of my information has changed or requires updating.
- Original x-rays are the clinic's property and copies of the original film(s) and report(s) will be released to me upon written request.

Patient or Guardian Signature

Date _____



Chart Number: _____

TO INSURE THAT WE HAVE ALL YOUR INFORMATION, THIS PAGE SHOWING AREAS OF PAIN/DISCOMFORT MUST BE COMPLETED PRIOR TO YOUR FIRST TREATMENT.

MARK THE AREAS ON THE BODY DIAGRAM BELOW WHERE YOU FEEL THE DESCRIBED SENSATIONS: USE THE APPROPRIATE SYMBOL FOR NUMBNESS, PINS AND NEEDLES, BURNING, ACHING, AND STABBING PAIN. MARK AREAS ON THE DIAGRAM FROM WHERE PAIN RADIATES. INCLUDE ALL AFFECTED AREAS.

Numbness

Pins & Needles

000000000000
000000000000
000000000000

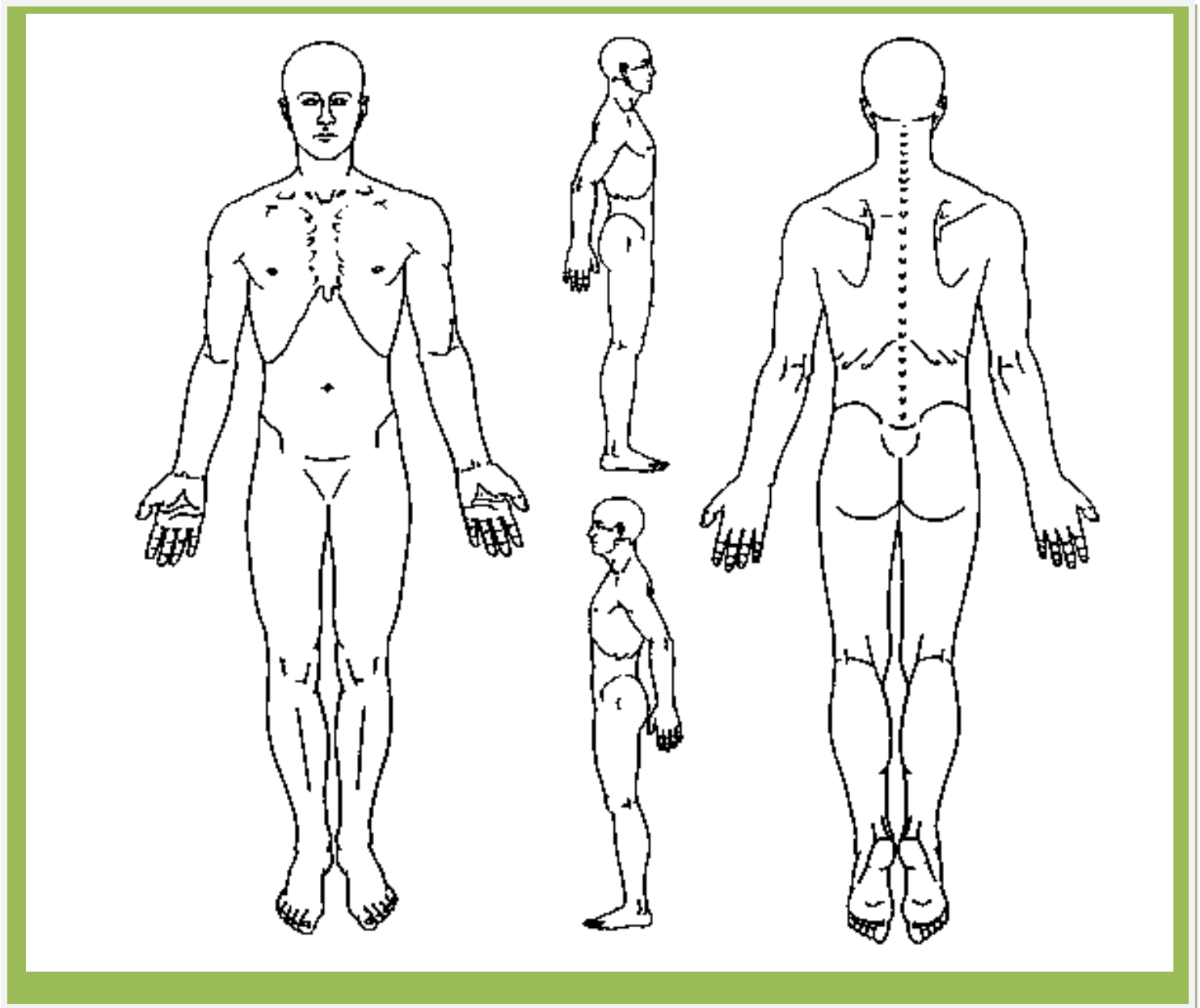
Burning

XXXXXXXXXX
XXXXXXXXXX
XXXXXXXXXX

Aching

Stabbing

//////////
//////////
//////////



ASSIGNMENT OF BENEFITS

As a courtesy, we accept insurance on assignment, upon verification of your benefits & coverage. We gladly file all claims for service, according to our policies, directly to your insurance carrier.

- You will be responsible for all deductibles, co-insurance/payments, and non-covered services. We will gladly provide several options to help you take care of these out of pocket expenses.
- We will do our best to accurately file your claims; however, we cannot be responsible for how your insurance chooses to reimburse for your care, even if it is different than the benefits they quoted to us.
- Should your carrier deny any claims, we will provide the necessary documents for reconsideration or for an appeal. You will be responsible for your account balance and for the pursuit of reimbursement from your insurance.
- If your care requires an authorization from your primary care doctor or insurance carrier, it is your responsibility to take care of this prior to your first visit with our office. We will not assume responsibility for any unauthorized treatment.
- Most insurance plans do not cover the following: rehabilitative, maintenance or wellness care, supports, braces, cervical pillows, supplements and most supplies. If any of the services/supplies listed above are rendered, they are required to be paid up front. We will gladly supply you with a statement to submit to your insurance carrier. We will submit all other services, but should your insurance company deem them non-covered benefit(s), you will be responsible for the full, unpaid amount submitted services.
- It is important that you inform us of ALL insurance changes. This allows us to file claims in a timely manner and prevents billing errors.
- If for **ANY** reason your insurance company does not cover a visit, you will be responsible for payment of that service. Our billing department sends monthly statements. A \$25.00 "returned check fee" will be charged for all returned checks, and payment to cover that check must be paid by cash, credit card or money order.
- Neglected patient accounts are sent to a collection agency. Patients sent to the collection agency or filing for bankruptcy, causing our office to write-off any debt, are subsequently dismissed from the practice as well as all family members for whom the patient is responsible.
- **SOME INSURANCE COMPANIES TAKE SEVERAL WEEKS/MONTHS TO PAY. IF YOU DO NOT RECEIVE A BILL, IT IS BECAUSE WE ARE WAITING ON YOUR INSURANCE TO PAY. AS SOON AS ALL PAYMENTS ARE RECEIVED FROM YOUR INSURANCE COMPANY, YOU WILL RECEIVE A BILL FOR ANY PORTION THAT YOU OWE.**

With my signature below, I confirm that I have been informed and understand the above policy. I agree to be responsible for payment and to make payment arrangements if needed.

PATIENT _____

DATE _____

SIGNATURE _____

Privacy Policy

With my signature below, I confirm that Seay Chiropractic is willing to provide a written copy of the office privacy policy at anytime upon request.

PATIENT _____

DATE _____

SIGNATURE _____