

DATE _____	I.D. NO. _____
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PERSONAL HISTORY

Name: _____ Address: _____
City: _____ State _____ Zip Code: _____
Home Phone: _____ Birth Date: _____ Age: _____ Sex: M F
Cell Phone: _____ E-mail Address: _____
Social Security # _____ Driver's License Number: _____
Check One: Married Single Widowed Divorced Separated
Business Employer: _____ Type of Work: _____
Business Phone: _____
Name of Spouse _____ Spouse's Social Security # _____
Spouse's Employer _____ Business Phone _____
Type of Work _____ Name and Ages of Children _____
Referred To This Office By: _____
Name and Number of Emergency Contact: _____ Relationship: _____
Who Is Responsible For Your Bill, You and Spouse Workers' Comp. Auto Insurance Medicare Medicaid
 Personal Health Insurance (Name) _____ Health Card # _____
Insured Person's Name _____ Date of Birth _____

CURRENT HEALTH CONDITION

Unwanted Health Condition _____
Other Doctors Seen For This Condition: Yes No _____ Who? _____
Type of Treatment: _____ Results: _____
When Did This Condition Begin? _____ Has This Condition Occurred Before? Yes No
Is Condition: Job Related Auto Accident Home Injury Fall Other: _____
Date of Accident: _____ Time of Accident: _____
Have You Made A Report of Your Accident To Your Employer: Yes No
Drugs You Now Take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine
 Insulin Other _____
Do You Wear A Shoe Lift? Yes No
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Please Check and Describe:
Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery
 Broken Bones Other _____
Major Accident or Falls: _____
Hospitalization (Other Than Above): _____
Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | INTAKE |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema | |

Have you been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

FEMALES ONLY:

When was your last period? _____

Are you pregnant?

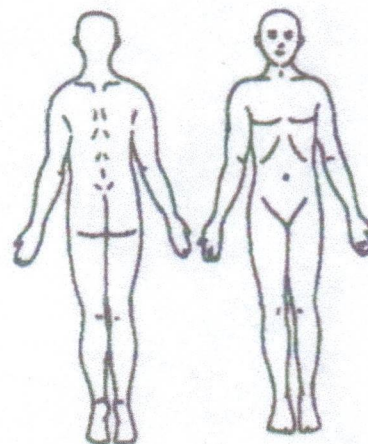
- Yes No Not Sure

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke



Please outline on the diagram the area of your discomfort

NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____

FAMILY HISTORY

The following members have a same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: Yes No Referred

Doctor's Signature

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.

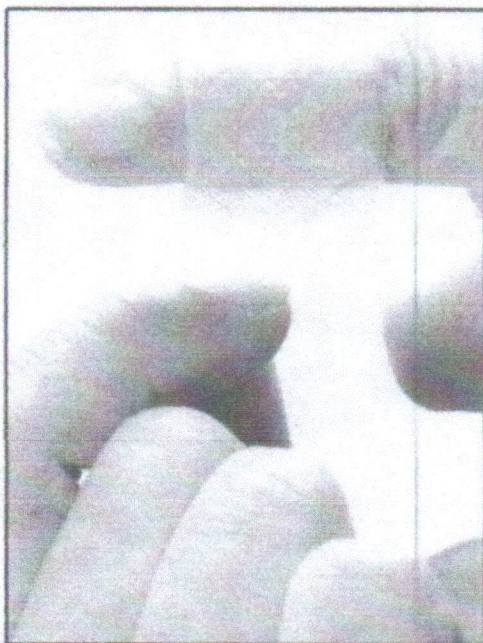
Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care
 Corrective Care
 Check here if you want the Doctor to select the type of care appropriate for your condition

_____ Date

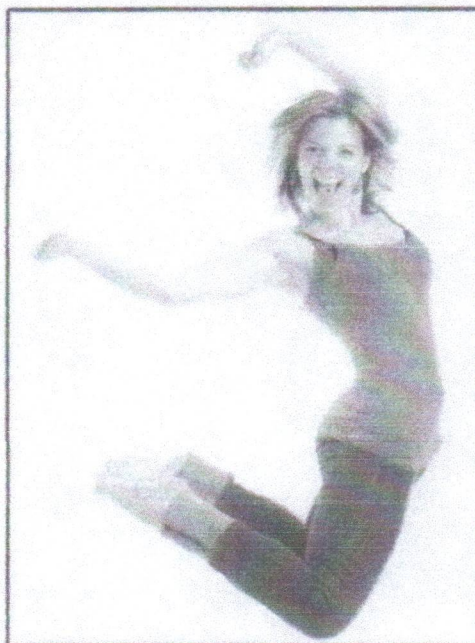
_____ Patient's Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!



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.

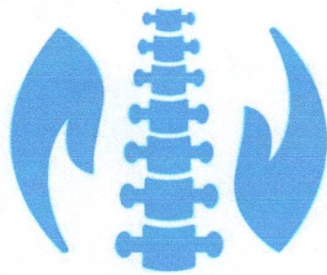
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature _____ Date _____

Consent to Treat a Minor _____ Date _____

Guardian or Spouse's Signature of Authorizing Care _____ Date _____



PEARSON

CHIROPRACTIC

- ◆ 5707 ABERCORN STREET SAVANNAH, , GA 31405
- ◆ (912) 354-5073 (P) ◆ (912) 354-4221 (F)
- ◆ PEARSONCHIROPRACTICGA@GMAIL.COM

INFORMED CONSENT FOR CHIROPRACTIC CARE

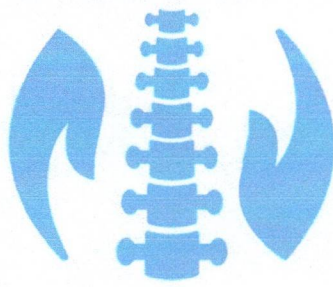
Chiropractic care, like all forms of health care, while offering benefits may also provide some level of risk. This level of risk is most often minimal, yet in rare cases injuries have been associated with Chiropractic care. The types of complications that have been reported secondary to Chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely fractures. One of the rarest complications associated with Chiropractic care, occurring at a rate between one instance per one million to one instance per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke.

Prior to receiving Chiropractic care at this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health, and your spine. These procedures will assist us in determining if Chiropractic care is needed or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.



I understand and accept that there are risks associated with Chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the Chiropractic care, including spinal adjustments, as reported following my assessment.

PATIENT NAME: _____
DATE: _____
PATIENT SIGNATURE: _____
PARENT/LEGAL GUARDIAN SIGNATURE: _____
WITNESS: _____
DATE: _____



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PATIENT HEALTH INFORMATION CONSENT FORM

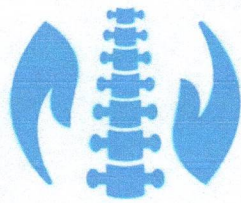
We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any healthcare operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this contract.

1. The patient understands and agrees to allow Pearson Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow Pearson Chiropractic to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request correction. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.
5. For your security and the right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all known precautions to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and healthcare operations, our office has the right to refuse to give care.

I have read and understood how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature

Date



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OUR FINANCIAL POLICY

Please understand that payment to your account is considered part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to, and sign prior to treatment.

- ◆ Full payment of balance or co-pay, whichever should apply, is due at the time of service.
- ◆ We accept cash, check, or credit cards: Visa, MasterCard, American Express, Discover, and Apple Pay.
- ◆ In the event we receive a returned check, there will be a \$35.00 fee charged to your account, thereafter cash and credit cards will ONLY be accepted.

REGARDING INSURED PATIENTS

Your first office visit must be paid in full at the time of service. However, we will be happy to accept assignment of your insurance benefits upon verification of Chiropractic coverage. We will file your insurance, and you will be required to pay your co-pay, or portion of insurance if applicable, at the time of each office visit. In the event your insurance company has not paid on your account in full within 60 days, the balance then becomes the patient's responsibility. Please be aware some and perhaps all of the services provided have a chance of being "non-covered" services per your insurance policy. If that would be the case, it then becomes the patient's responsibility to pay in full. Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. In the event you discontinue your care without the Doctor's authorization, you are responsible for payment in full of any outstanding balance, even if your insurance has been filed.

REGARDING SELF-PAY PATIENTS

Patients that are without insurance or whose insurance does not cover Chiropractic care, will personally be responsible for payment. Payments must be made at the time of service. Arrangements can be made with our staff to ensure an accurate account. We offer a special rate for our self-pay patients or those whose insurance does not cover Chiropractic care, as we want to help make Chiropractic care affordable for all of our patients.

PERSONAL INJURY/ AUTO INJURY/ THIRD PARTY AUTHORIZATION

Please advise our office on your first visit if you have one of the above claims, so that we can ensure we have all the information to bill correctly.

Please let us know if you have any questions or concerns regarding this policy.

I have read and understand the financial policy set forth by Pearson Chiropractic, and I agree to be bound by its terms. I also understand and agree that such terms may be amended periodically by the practice.

Patient Signature

Date

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unskilled extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

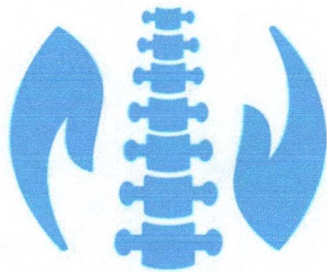
10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ ID#/SS# _____ Plan ID _____ Total Score _____

PRINTED Signature

Date



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AUTHORIZATION TO RELEASE INFORMATION

I authorize Pearson Chiropractic to release or receive any information deemed appropriate concerning my physical condition to or from any physician, the insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred during care, as well as to develop and execute a treatment plan. I hereby release him/her of any consequence thereof. I agree that a Photostat copy of this agreement shall serve as the original.

Signature	Date	Witness	Date
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