WELCOME TO OUR OFFICE!

We are committed to providing you with the best care possible and are pleased to discuss our professional fees with you at any time. Your clear understanding of our policies is important of our professional relationship. Our office adheres to a strict "payment is due when services are rendered" policy. Thank you so much for your patronage.

- **Limited Release of Medical Information:** I authorize this Chiropractic office to make inquiries and to release any pertinent information to any insurance company, adjuster, attorney, or government agency to facilitate collections/reimbursements under these assignments.
- **Insurance Patients:** I understand that my health insurance is a contract between the insurance carrier and myself. I understand that I am ultimately responsible for any fees for services rendered that are not covered by my insurance company. I agree to pay my portion of fees at the time of treatment is rendered. I authorize my insurance benefits be paid directly to the physician. I also authorize this office or my insurance company to release any information required to process my claims. I understand that this office accepts billing for individual or group policies, personal injury cases, authorized worker's compensation and Medicare.
- **Missed Appointments:** In the event I am accepted for care in this office, I understand that it is vital to adhere to the recommended treatment plan. As a courtesy to others and to improve your results, our office has the following missed appointment policy: 1st offense: warning, 2nd offense: $10 fee. **Massage appointments require a 24 hour notice of cancellation**
- **Nonpayment:** Please be aware if your account becomes delinquent we may refer you to a collection agency. In this event, all collection agency fees and/or legal fees and any unpaid balance would be your responsibility.
- **No Guarantee of Results:** I recognize that this office can not guarantee the results of my health and that it is based upon my cooperation and my body's ability to recover.
- **Promotions and Discounts:** I understand that this office may attempt to assist me in my financial obligations for care needed by offering a promotion or discounted program if I prepay for my care. In the event I decide to not follow the recommendation for this care, I agree and understand that I would be liable for whatever services were rendered at the office's normal fee.
- **HIPPA Acknowledgement:** I have had the opportunity to read the HIPPA policies of this office.

I have read and understand the payment policies listed above and agree to abide by its guidelines:

Patient Name (please print): _____ Date: _____

Signature of Patient or Responsible Party_____ Date:_____

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.

PATIENT APPLICATION FOR TREATMENT

Last name:	First:	MI:	Gender ☐ M ☐ F		
How would you like to be addressed?		Date of Birth:	Age:		
Your address:		City:	State:		
Zip:	SS#:	Home #	Cell #		
Your Occupation?		EMAIL:			
Marital status? Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er) ☐					
Emergency Contact?		Emergency Phone #			
How many children do you have? What are their ages?					
Have you ever had chiropractic care? ☐ Yes ☐ No How long has it been?					
Has anyone else in your family ever had chiropractic care? ☐ Yes ☐ No					
Do you smoke: ☐ Yes ☐ No How much?		Do you exercise: ☐ Yes ☐ No How much?			
What is the purpose or reason for this appointment?					
When do you notice it most? ☐ AM ☐ PM		Have you ever had this in the past? ☐ Yes ☐ No			
What makes it feel better?		What makes it feel worse?			
(Females only) Are you pregnant? ☐ Yes ☐ No					

Using the scale below, indicate the **severity** of your **main complaint** (when at its worst)

None		**Slight**		**Mild**		**Moderate**			**Severe**
1	2	3	4	5	6	7	8	9	10

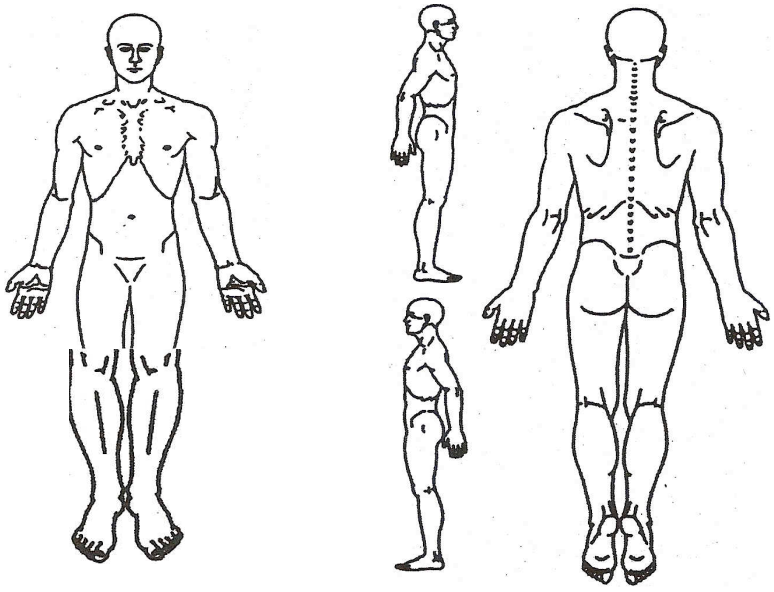
Using the scale below, indicate the **percentage of time** you experience your **main complaint**:

		Occasional		**Intermittent**		**FREQUENT**		**CONSTANT**	
0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

How long have you been experiencing your **main complaint**?

On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ACHE **B:** BURNING PAIN **C:** CRAMPING **D:** DULL PAIN **R:** THROBBING PAIN **N:** NUMBNESS **T:** TINGLING



AFC Chiropractic of Chandler 2100 W Chandler Blvd. Ste. 34 Chandler, Arizona 85224 Ph: 480.899.9855 Fax: 480.899.4655

FAMILY HEALTH HISTORY

Patient: _____ Date: _____

Please check all that apply. Dr.: _____

	DAD	MOM	SPOUSE	BROTHER(S)		SISTER(S)			CHILDREN	
CONDITION	AGE___	AGE___	AGE___	AGE___	AGE___	AGE___	AGE___	AGE___	AGE___	AGE___
Example: Pain		X			X			X	X	
Arthritis										
Asthma-Hay Fever										
Back Pain										
Bursitis										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Headaches										
High Blood Pressure										
Insomnia										
Migraine										
Nervousness										
Neuritis										
Pinched Nerves										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										
Other:										
Other:										
Add. Notes:										
Add. Notes:										
Add. Notes:										

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SYSTEMS REVIEW

In the left-hand column, please indicate with a (C) all conditions you are currently experiencing, or with a (P) the conditions you have had in the past. If neither apply, mark (NA). Please complete all lines without leaving any blanks.

High Blood Pressure	☐C ☐P ☐NA
Stroke	☐C ☐P ☐NA
Cancer	☐C ☐P ☐NA
Dizziness/Fainting	☐C ☐P ☐NA
Insomnia	☐C ☐P ☐NA
Low Resistance	☐C ☐P ☐NA
Rheumatoid / Osteoarthritis	☐C ☐P ☐NA
Confusion	☐C ☐P ☐NA
Fatigue	☐C ☐P ☐NA
Ulcers	☐C ☐P ☐NA
Eye/Vision Problems	☐C ☐P ☐NA
Ear/Hearing Problems	☐C ☐P ☐NA
Difficulty Breathing	☐C ☐P ☐NA
Heart Probs. / Pacemaker	☐C ☐P ☐NA
Loss of Bladder Control	☐C ☐P ☐NA
Constipation	☐C ☐P ☐NA
Diarrhea	☐C ☐P ☐NA
Digestive Problems	☐C ☐P ☐NA
Gall Bladder Problems	☐C ☐P ☐NA
Nausea	☐C ☐P ☐NA
Female Problems	☐C ☐P ☐NA
Prostate Problems	☐C ☐P ☐NA
Diabetes	☐C ☐P ☐NA
Cold Hands/Feet	☐C ☐P ☐NA
Hand Tremors	☐C ☐P ☐NA
Loss of Memory	☐C ☐P ☐NA
Nervousness	☐C ☐P ☐NA
Broken or Fractured Bones	☐C ☐P ☐NA
Speech Difficulty	☐C ☐P ☐NA
Anxiety	☐C ☐P ☐NA
Depression	☐C ☐P ☐NA
Irritability	☐C ☐P ☐NA

FOR DOCTOR USE ONLY: **DR: _____**

DR. REVIEWED	SYSTEMS	SYMPTOMS
____	General	Weight changes, fatigue, anorexia, weakness, fever, chill, changes in activity
____	Skin	Rashes, eruptions, changes in warts or moles, pigmentation changes, bruising, itching, hair loss, nail changes
____	Head	Trauma, headaches, dizziness, light headed.
____	Eyes	Change in acuity of vision, use of corrective lenses, loss of diplopia, photophobia, blurred vision, cortomata, pain, excessive lacrimation, redness, discharge
____	Nose	Rhinorrhea, epistaxis, allergies, alrway obstruction
____	Mouth & Throat	Ulcers, tooth pain/extractions, tempormanbibular joint (TMJ), pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat
____	Neck	Stiffness, lumps/swelling/masses, pain
____	Lungs	Cough (productive/nonproductive), hemopysis, dyspnea, pain with respiration, wheezing, night sweats.
____	Cardiac	Palpitations, chest pain, orhopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope
____	Vascular	Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever.
____	Breasts	Self-examination, frequency/results, pain, nipple discharge, lumps/masses, skin dimpling.
____	Gastrointestinal	Unusual diet, sysphagia, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematemasis, stool color changes, diarrhea, constipation, change in bowel habits, jaundice, abdominal swelling.
____	Genitourinary	Polyuria, nocturia, oliguria, dysuria, urgency, incontinence, urine color changes, hematurea, sexually transmitted disease, dyspareunia, scrotal mass (male), hernia
____	Endocrine	Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsuitsm, menstruation history, pregnancy history, dysmonorrhea, premenstrual syndrome, climacteric
____	Hematopoletic	Anemia, abdominal bleeding, lymph node enlargement/pain.
____	Musculoskeletal	Bone/Joint pain, selling, joint deformity, trauma, restricted range of motion, weakness, atrophy
____	Neurological	Cranial nerve deficits, seizures, loss of consciousness, paraly-sis, tremors, staxis, loss of balance, numbness, parenthesia
____	Psychological	Mood swings, depression, anxiety, phobias

Please identify all facilities/providers you have seen for these conditions and those you are currently seeing, if any, for your presenting problem(s)

DR NAME/ FACILITY	PROBLEM	TYPE OF TREATMENT REC'D	From when to when:

All information is true to the best of my knowledge. I consent to allow the doctor to treat my condition as he/she deems appropriate.

Email Address: _____

Patient / Guardian Signature: _____ Date: _____

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