# WEBSTER CHIROPRACTIC CARE

Name:_____

Address:_____

City:_____ Zip Code:_____ ___ Marital Status: M S

Phone:_____ Cell:_____

Age_____ Date of Birth_____

Email:_____

Are you interested in hearing about our ChiroThin Weight Loss Program ? Yes or No

Would you like E-mail reminders for your appointment. Yes or No

Text reminders? Yes or No If yes, cell carrier:_____

How did you hear about our office?_____

## Workers Compensation/No Fault :

Claim#_____Soc. Security#_____

Insurance Company:_____

Insurance Phone:_____

Insurance Address:_____

Adjuster Name:_____

Employer when injured:_____

Date of Injury:_____

Dates of Missed Work:_____

Names of other treating doctors:_____

**NAME**:_____

How did your pain start?_____

Date pain started? _____How long have you had this pain?_____

What do you think is causing your pain? _____

What makes the pain better?_____

What makes the pain worse?_____

Can you describe the way your pain feels?
_____

What have you done to treat the pain?
_____

What current activities would you like to do, that your pain inhibits you from doing? (please list)(ex. Golfing, biking, vacuuming, gardening, walking etc.)
_____
_____

How is most of your day spent? Standing Sitting Other_____

Please Circle:

Is the pain: Intermittent Continuous Positional W/Activities

Is this condition getting progressively worse? Yes No

Does this interfere with Sleep? Yes No

Have you gained or lost weight unexpectedly? Yes No

Have you ever had a similar condition? Yes No

Bowel or bladder problems from pain? Yes No

Do you currently wear shoe inserts? Yes No

**NAME:**_____

Primary Physician:_____

Phone:_____

Date of last: (Circle all that apply)

Physical exam: 1-4months 5-9mths 12mths or greater never

Blood Work: 1-4months 5-9mths 12mths or greater never

Urine: 1-3months 5-9mths 12mths or greater never

Bone Density: 1-3months 5-9mths 12mths or greater never

Current Height:_____ Current Weight _____

List surgical operations and year performed:

_____

_____

_____

Medications/Supplements/Herbs:_____

_____

_____

Have you undergone: (Circle all that apply)

Physical Therapy Massage Therapy Acupuncture Injections

Have you had Chiropractic Care before? Yes No

Date of Last Treatment: _____

Do you have a chiropractic physician preference in this office?

Female Male No Preference

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**In case of an Emergency Contact:**_____

Relation_____Phone_____

**NAME:**_____

Have you ever had any of the following?
Circle all that apply:

| | | |
|---|---|---|
| Anxiety | Osteoporosis | Tremors/Shakes |
| Aneurysm | Stroke/Blood Clots | Sensory Processing Disorder |
| Heart Attack | Heart Disease | Atrial Fibrillation |
| Chest Pain | Jaw Pain | Sweating/Night Sweats |
| High Blood Pressure | High Cholesterol | Acid Reflux |
| Hernia | Blood Thinners | Rib Disorder |
| Pregnancy | Hormone Replacement | Birth Control |
| Multiple Sclerosis | Rheumatoid Arthritis | Diabetes |
| Dizziness | Headaches | Migraines |
| Sinus Trouble | Cancer | Prostate Disorder |
| Joint Replacement | Pacemaker/ Heart Surgery | Sexual Assault |
| Ulcerative Colitis/Crohns | Autoimmune Dz | Allergies |
| Autism | Gallbladder Trouble | Gout |
| Skin Ulcerations | HIV/AIDS | Shingles |

Life Style:
Exercise: _____ times a week - month - year.

Tobacco: _____ packs per day - week - month - year.

Alcohol: _____ drinks a day - week - month - year.

Occupation:_____

Family Medical History (first degree relatives only): Circle all that apply:

Heart attack Diabetes Stroke Cancer
Multiple Sclerosis Rheumatoid Arthritis Autoimmune Dz

Signature_____ Date_____ 

# AUTHORIZATION OF INSURANCE PAYMENT
# Webster Chiropractic Care, P.C.

I hereby instruct and direct my insurance company to pay by check made out and mailed to: **Webster Chiropractic Care**
**Dr. Alaina Keem & Dr. Matthew Keem**
**1205 Ridge Road**
**Webster, New York 14580**

or If my current policy prohibits direct payment to the doctors, I acknowledge that I will make payment to the above mentioned health care provider.

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This insurance payment along with any required deductible, co-insurance, or co-payment will be accepted as payment in full. A photocopy of this Assignment shall be considered as effective and valid as the original.
I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
I authorize the doctors to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____

**Signature of Policyholder or Patient** **Date**

_____ _____

**Name of Policyholder or Patient (Print)** **Date**

_____ _____

**Witness** **Date**

# HIPAA Release
# Webster Chiropractic Care, P.C.

*Patient consent for use and disclosure of protected health information **(HIPAA)** for*
***Webster Chiropractic Care***

I hereby give my consent for Alaina Keem DC, Matthew Keem DC, or any other personnel of **Webster Chiropractic Care** to use and disclose protected health information (PHI) about me in order to carry out treatment, payment and healthcare operations (TPO).

With this consent, Alaina Keem DC, Matthew Keem DC, or other personnel of **Webster Chiropractic Care** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, **Webster Chiropractic Care** may mail to my home or other alternative location any item that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, **Webster Chiropractic Care** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Webster Chiropractic Care** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Webster Chiropractic Care** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Webster Chiropractic Care** may decline to provide treatment to me.

_____ _____
Patient's Name (PRINT) Date

_____ _____
Patient's Signature Date

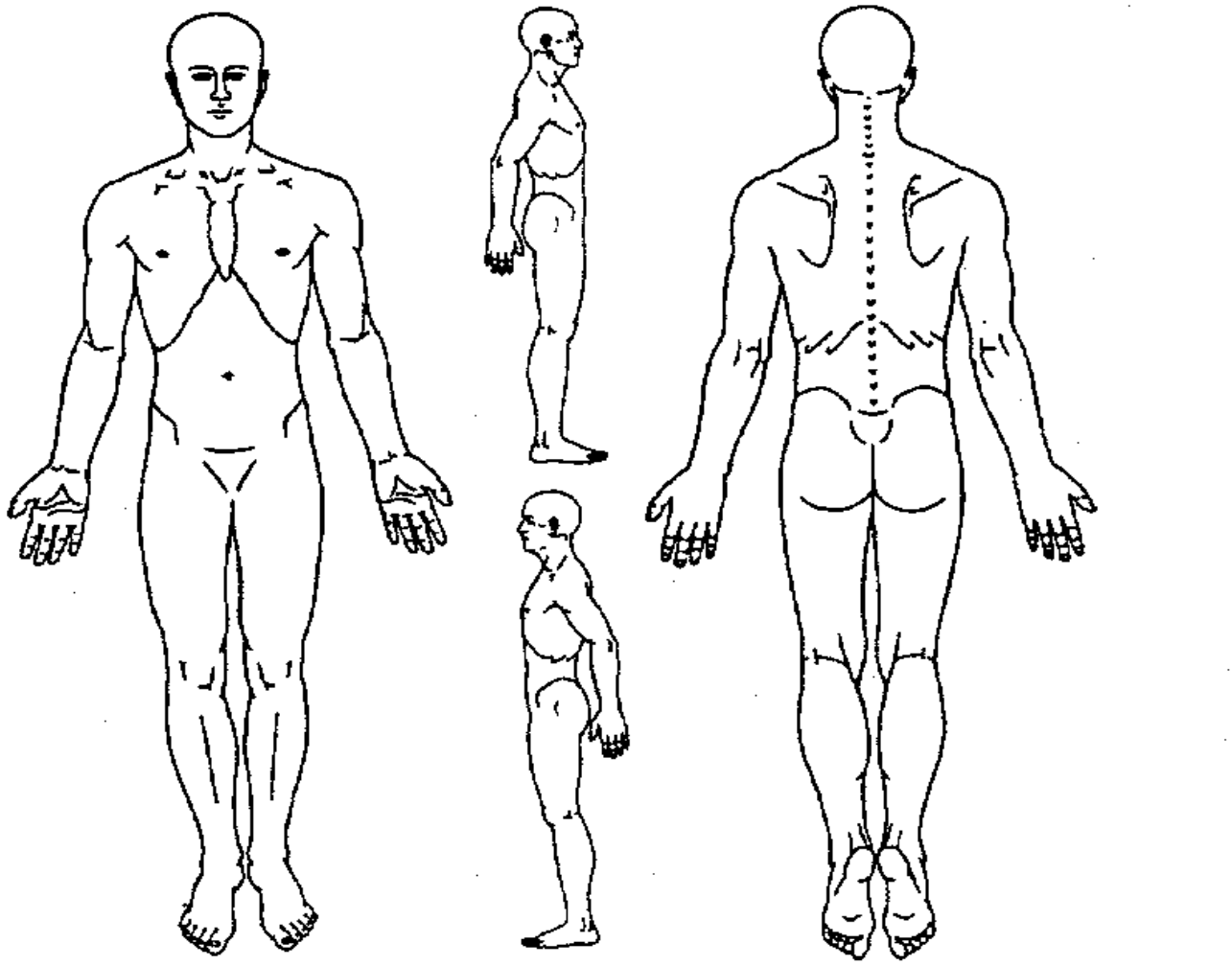
Pain Diagram and Pain Rating

**Name: _____Date: _____**

**INSTRUCTIONS:** Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Use the key to indicate the type of symptoms.

**KEY: Pins and Needles = 000000 Stabbing = / / / / / /**

**Burning = xxxxxx Deep Ache =zzzzzz**



Please rate your current level of pain on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst imaginable pain)

Please rate your **worst** level of pain in the last 24 hours on the following scale:

0 1 2 3 4 5 6 7 8 9 10

Please rate your **best** level of pain in the last 24 hours on the following scale:

0 1 2 3 4 5 6 7 8 9 10