MESA FAMILY CHIROPRACTIC

Date: _____

PATIENT CASE HISTORY

Full Name: _____

Birthdate: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Phone: _____ Email: _____

Occupation: _____

Relationship status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Spouse: _____

Children: _____

Emergency Contact: _____

Phone Number: _____ Relationship: _____

REFERRAL

Who can we thank for referring you into our clinic?

☐ Signage ☐ Google ☐ Instagram ☐ Yelp ☐ Attorney ☐ Other (explain) _____

☐ Word of mouth (Please provide name) _____

INSURANCE

Who besides yourself Is responsible for this bill:

☐ Self-pay ☐ Health Insurance ☐ Medicare ☐ Medicaid ☐ Auto Insurance ☐ Workers Comp

☐ Other *(be specific)* _____

Personal Health Insurance Carrier: _____ Health ID Card #:_____

Insured Person's Name: _____ Group #: _____

Insured Person's DOB:___/___/_____ Insured Person's Social Security Number: _____

ACCIDENT INFORMATION

Is the conditions that brought you here today due to an accident? ☐ Yes ☐ No

Date of Accident: _____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

Auto or Workers' Comp Insurance Carrier & Claim #: _____

Attorney Name (If applicable): _____

PURPOSE FOR SEEKING CHIROPRACTIC CARE

☐ I have no special problem, I understand the role of Chiropractic care in my general health care and wellness.

☐ I have a problem/symptom, and I am interested in the role of chiropractic to help with this specific issue.

☐ I have a problem/symptom, and I am interested in help with this specific Issue. I am also interested in learning how to prevent it in the future.

☐ I have a problem/symptom, and I am interested in help with this specific issue.

PREVIOUS CHIROPRACTIC CARE

Have you ever had Chiropractic care: ☐ Yes ☐ No

Name of Chiropractor: _____

Why did you seek chiropractic care: _____

Did the Chiropractor take X-Rays? ☐ Yes ☐ No

What were the results of your care: ☐ Didn't help ☐ Poor ☐ Satisfactory ☐ Excellent

PATIENT HEALTH CONDITION

As a full spectrum chiropractic clinic, we focus on your ability to be healthy. Throughout life, stresses occur (physically, emotionally, chemically), which damage our health expressions. Our goals are to first address the issues that brought you in to chiropractic, and second, to offer you the opportunity of improved health potential and wellness in the future.

Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, especially to your nervous system. This will allow us to serve you better on your health journey.

Reason for visit: _____

_____

When did the symptom appear: _____

If you are experiencing pain, is it:

☐ Sharp ☐ Dull ☐ Comes & goes ☐ Constant
☐ Tingling ☐ Tingling ☐ Numbing ☐ Shooting
☐ Stiffness ☐ Throbbing ☐ Aching ☐ Cramps

Since the problem started, is it:

☐ Same ☐ Getting better ☐ Getting worse

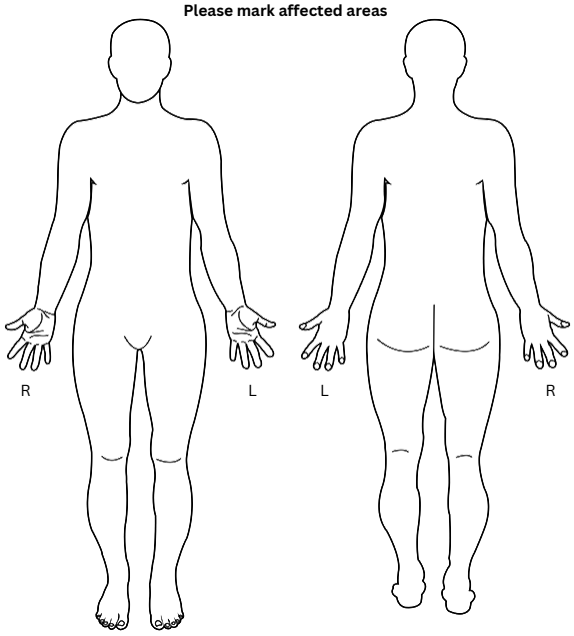
Does it interfere with:

☐ Work ☐ Sleep ☐ Hobbies ☐ Leisure ☐ Daily routine

Currently, your symptoms are aggravated by:

☐ Bending ☐ Coughing ☐ Neck movement ☐ Reaching
☐ Lifting ☐ Sitting ☐ Sneezing ☐ Standing
☐ Walking ☐ Straining at stool

Please mark affected areas



HEALTH HISTORY

	Never	Occasionally	Moderately	Excessive
Alcohol	☐	☐	☐	☐
Smoking	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Sodas	☐	☐	☐	☐

Diet	1	2	3	4	5
Exercise	1	2	3	4	5
Sleep	1	2	3	4	5
General Health	1	2	3	4	5
Personal Stress	1	2	3	4	5
Job Stress	1	2	3	4	5

Do you have any serious health problems? ☐ Yes ☐ No *If yes, please explain*

_____

_____

_____

Have you had any falls, head injuries, broken bones or surgeries? ☐ Yes ☐ No *If yes, please explain*

_____

_____

_____

_____

GUT HEALTH

Do you currently experience any gastro-intestinal (gut) Issues? ☐ Yes ☐ No

iI yes, how often? _____

Do you have regulary daily bowel movements? ☐ Yes ☐ No

if so, once before noon? ☐ Yes ☐ NO

MEDICATIONS

_____

_____

_____

_____

_____

VITAMINS/SUPPLEMENTS/HERBS

_____

_____

_____

_____

_____

FOR WOMEN

Are you pregnant? ☐ Yes ☐ No ☐ Unsure

Do you experience any of the following:

☐ Irregular Periods ☐ Painful or tender breasts ☐ Lumps In breast ☐ Period pain

☐ Vaginal discharge ☐ Hot flushes ☐ Painful Intercourse ☐ Bleeding between periods

☐ Excessive menstrual flow

PERMISSION TO X-RAY

X-ray's are diagnostic tools used to determine the underlying cause of spinal and postural Issues. By using X-rays, the chiropractor has a clear view of your spinal health, which is vital for patients to receive optimal care.
We kindly ask for you permission for the chiropractor to take X-Rays of your spine.

I, (name)_____, grant permission for X-Rays to be taken of:

☐ Myself

☐ (If female) and further certify that, to the best of my knowledge, I am not pregnant.

By: Dr Sam Pourian DC

Signature: _____

ACKNOWLEDGEMENTS

AUTHORIZATION FOR RELEASE OF INFORMATION:
I authorize the release of any medical information necessary to process my insurance claims.

REIMBURSEMENT POLICY:
We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

ACCEPTANCE AS A PATIENT:
I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins, or terminate my care as a patient if in the course of treatment if I am not following the treatment plan for my condition, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

_____ _____

PATIENT PRINTED NAME PATIENT SIGNATURE

MESA FAMILY CHIROPRACTIC

GENERAL CLINIC POLICY

The purpose of this patient office policy is to allow us to better serve you and to get the best results in the shortest period of time. It is our experience that those who adhere to the following policies get the best results.

Appointments & Cancellations
After your visit, please see the front desk to make or confirm your next appointment. I n the event that you cannot make your appointment, please notify the clinic at least 24 hours prior to your scheduled appointment. Failure to do so, may result in a $25 rebooking fee.

Sign-in
When you arrive, please sign in at the front desk. You will be called and assigned a treatment room in the order you signed in. Other patients may be called before you because of the particular services being received that day or their doctor may be available before yours.

New Injuries
In the event you sustain a new injury, please let us know as soon as possible. There may be additional paper work to be filled out.

Payment of Bills
We will expect that you honor all financial agreements made with our office. If you find that you cannot fulfill your financial obligation, notify our office manager immediately so that new arrangements can be made. Our policy is that patients maintain a zero personal balance. Insurance companies are expected to pay their portion within 45 days of claim submission.If they do not, we expect you to call your insurance company and help get the claim paid. If an insurance company sends a check to your home, it should be brought or sent to our office as soon as possible. Please also bring in the attached explanation of benefits.

Progress Evaluations & Re-examinations
Progress evaluations & re-examinations will be performed periodically to determine your rate of progress and future course of care. There is a $30 fee for re-evaluations. A special time will be set up for these appointments.

Media & Text Consent
You will automatically be setup to receive text messages for appointment reminders and information about the clinic, but you will not receive text messages about promotions or other services we offer. If you wish to decline receiving text messages, please Inform the front desk.

I, _____ (print name) have read, understand and agree to the above patient office policy.

_____ _____
Patient Signature Date