(Place Patient label here)

A Plus Chiropractic Care, PC
Howard D. Fern, DC
3048 E. Baseline Rd #130 Mesa, AZ 85204
(480)-649-5868 (fax) (480) 649-5870
www.APlusChiroCare.com

CONFIDENTIAL PATIENT INFORMATION

The information requested below is strictly confidential. Please supply us with complete and accurate information. If you need assistance, please ask the front office staff.

PLEASE PRINT!

Last Name: M.I:	Birth Date: _____/_____/_____ Age_____
First Name:	Sex: Male Female
Address:	Social Security # - -
Apt. #	Marriage Status: Single Married Divorced Widowed
City	Drivers License # State
State: Zip:	E-mail Address:
Home Phone # ( )	Cell Phone # ( )

Employment Information

Employer	Occupation
Address	Work Phone# ( ) Ext.
City	Yrs. Employed
State Zip	Status: Full time / Part time / Retired

Insurance Information

Are you seeking care due to an automobile accident?	☐ Yes ☐ No
Are you seeking care due to an injury at work?	☐ Yes ☐ No

Do you have health insurance? ☐ Yes ☐ No

At this time, please bring Your Insurance Card to the front desk so a copy may be made for your file.

Insured Party? ☐Self ☐Spouse ☐Parent ☐Other_____

Primary Insured Name _____ *Primary DOB:* _____/_____/_____

*Primary Insured Address*_____

*Primary Insured Place of Employment*_____

Demographics

Which category best describes your race? (Check One)

☐ White ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander
☐ Asian ☐ American Indian/Alaska Native ☐ I choose not to specify

Do you consider yourself Hispanic or Latino? (Check One) ☐ Yes ☐ No ☐ I choose not to specify

Preferred Language? ☐ English ☐ Spanish ☐ Other_____

Emergency Contact

Emergency Contact Name	Telephone # ( )
Relationship To You	

Whom may we thank for referring you? Or How did you hear about us?

(Place Patient label here)

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List your reason(s) for this visit. Put in order of importance: **"what hurts the most"**	**When did your problem start?**	**On a scale of 1 to 10,"1"being no pain/discomfort and "10" being severe pain/discomfort, circle the number that best reflects your condition(s):** **↓ none . . . . .to . . . .severe ↓**	**Circle that best represents how much time of your day you feel the pain/discomfort for the listed reason(s).** **↓Occasional…….to……Constant↓**
1)		1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%
2)		1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%
3)		1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%
4)		1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%

For each reason stated above, how did this problem begin?
Reason 1
Reason 2
Reason 3
Reason 4

For the reasons listed above, please CIRCLE the one(s) that best describes your current pain/symptom(s)

Reason 1**:** Sharp, Stabbing, Dull, Throbbing, Numbness, Burning, Aching, Shooting, Tingling, Gripping, Weakness, Other_____

Reason 2**:** Sharp, Stabbing, Dull, Throbbing, Numbness, Burning, Aching, Shooting, Tingling, Gripping, Weakness, Other_____

Reason 3**:** Sharp, Stabbing, Dull, Throbbing, Numbness, Burning, Aching, Shooting, Tingling, Gripping, Weakness, Other_____

Reason 4**:** Sharp, Stabbing, Dull, Throbbing, Numbness, Burning, Aching, Shooting, Tingling, Gripping, Weakness, Other_____

For each reason listed above, What makes it feel better?

Place a "X" in the box that best describes whether your pain or symptom(s) limit normal activities

Activity	**Normal**	**Somewhat Limited**	**Severely Limited**	**Activity**	**Normal**	**Somewhat Limited**	**Severely Limited**
Lifting				**Running**			
Bending				**Sleeping**			
Standing				**Intercourse**			
Walking				**Computer Work**			
Sitting				**Normal work**			
Climbing Stairs				**Household activities**			
Twisting				**Recreational activities**			

Primary Care Physician (PCP) Name PCP Telephone #: ( ) -

Have you sought care form your PCP for this problem? ☐ Yes ☐ No

What previous treatment have you received for this condition(s)?
None Medicine Chiropractic Physical Therapy Massage Other_____

Have you sought care from anybody else? ☐ Yes ☐ No Who?

Have you had any tests for this problem?
X-Ray MRI CT Scan Bone Density Body Scan Blood Testing Other: _____

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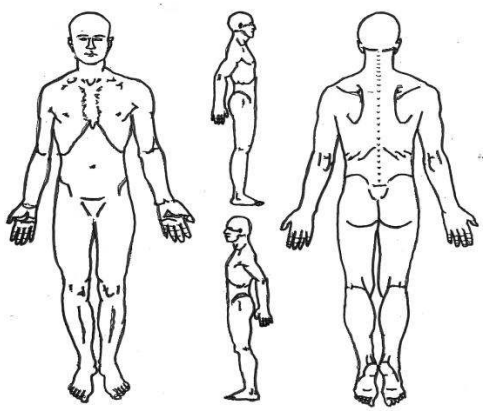
CIRCLE: *P = Past History, C = Current History, F = Family History* to all that applies to your health history!			
P C F Abdominal Pain	**P C F** Depression	**P C F** Kidney Disorders	**P C F** Pain in Upper Leg
P C F Angina	**P C F** Dizziness	**P C F** Kidney Stones	**P C F** Pain in Hip
P C F Anorexia	**P C F** Emphysema	**P C F** Liver Problems	**P C F** Painful Urination
P C F Aortic Aneurysm	**P C F** Endometriosis	**P C F** Gallbladder problems	**P C F** PMS
P C F Arthritis	**P C F** Epilepsy	**P C F** Ulcer	**P C F** Prostate Problems
P C F Blood Disorder	**P C F** Excessive Thirst	**P C F** Low Back Pain	**P C F** Rapid Heat Beat
P C F Breast Soreness	**P C F** Frequent Urination	**P C F** Mid back Pain	**P C F** Rheumatoid Arthritis
P C F Cancer	**P C F** General Fatigue	**P C F** Neck Pain	**P C F** Scoliosis
P C F Chest Pain	**P C F** Headache	**P C F** Pain in Foot	**P C F** Shoulder Pain
P C F Chronic Cough	**P C F** Heart Attack	**P C F** Pain in Ankle	**P C F** Stroke
P C F Colitis	**P C F** Hepatitis	**P C F** Pain Knee	**P C F** Tumor
P C F Constipation	**P C F** High Blood Pressure	**P C F** Pain in Lower Leg	**P C F** Loss of Bladder Control
P C F Convulsions	**P C F** HIV	**P C F** Pain in Arm	**P C F** Wrist Pain
P C F Diabetes I or II	**P C F** Jaw Pain	**P C F** Pain in Elbow	**Other:**

Please list all of your allergies: (include medication, foods, materials etc.)
Height _____Feet _____Inches **Weight** _____lbs
List all vitamins and supplements that you currently take?
List all current prescription (include dosage) and over the counter medication? (Let us copy your list)
List all operations, hospitalization and fractures (include dates) (Let us copy your list)
Do you smoke? Yes No ☐ **Every day** ☐ **Some Days** ☐ **Former smoker** ☐ **Never smoked** **Do you use tobacco?** Yes No **Do you want to quit?** Yes No
Are you wearing? ☐ Custom Foot Orthotics ☐Shoe Lifts ☐Arch Support ☐Gel/heel insert
Do You exercise? Yes No **How Often?** _____ **Do you have pain when exercising?** Yes No
Do You feel healthy? Yes No **Do you want to learn how to obtain Optimal Health?** Yes No

Pain Drawing

On the drawings below, please indicate where you are experiencing pain by placing the abbreviations that most accurately reflect the type of discomfort that you have been experiencing, at the proper location(s).

A = Dull ache B = Burning D = Dull pain T= Tingling
N = Numbness P = Sharp pain S = Stiffness O = Other



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Consent to Treat

The information I have given to this office is complete to the best of my knowledge. I hold harmless, release and indemnify this clinic, its principals and employees from any liability from injury or harm that my errors or omissions within this document may have caused me or my dependents. I authorize the doctors and staff of this clinic to administer an examination and treatment as they deem necessary. They have implied no guarantees of a cure.

Patient's signature: _____ Date: _____

Consent to Treat Minor Child:

The information I have given this office pertaining to _____is truthful and complete to the best of my knowledge. I authorize the doctors and staff to administer such procedures and treatment as they deem necessary to my child/ward in my legal custody. The doctors have implied no guarantee of cure.
Parent or Guardian's Signature: _____ Date: _____
Relationship to Minor Child: _____
Witness: _____ Date: _____

Permission to use photograph and/or testimonial, or article written by patient

I consent to having my likeness and/or name reproduced for use, in a newsletter, testimonials or on the bulletin boards of this clinic. I agree that any original articles, writings, or recipes submitted can be used without compensation. I agree that for this purpose I waive the rights of privacy under the HIPAA laws.
Patient signature: _____ Date: _____

Authorization to Pay Directly to Doctor

TO _____
(Name of attorney and/ or insurance company)
My signature at the end of this page will act as an endorsement for this authorization. In consideration of the chiropractic services rendered, I authorize and direct my insurance company and/or my attorney to pay Howard D. Fern, DC/ A Plus Chiropractic Care, PC of any sum I now or hereafter owe to A Plus Chiropractic Care. If my current policy prohibits direct payments to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/O A Plus Chiropractic Care
745 N. Gilbert Rd Ste 124 PMB 266
Gilbert, AZ 85234

Assignments of Benefits

I hereby authorize Howard D. Fern, DC/ A Plus Chiropractic Care, PC to furnish to the insurance company(s) listed on this form or to designated attorney, all information which said insurance company(s) or attorney may request. I hereby assign Howard D. Fern, DC/ A Plus Chiropractic Care, PC all money to which I am entitled for medical/chiropractic expenses related to the services rendered. It is understood that money received from the above named insurance company(s) over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am fully responsible to Howard D. Fern DC/A Plus Chiropractic Care, PC for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection, and/or the court cost and reasonable legal fees should this be required. I understand that 14% annual interest fee will be added to any charges not paid after 120days. I fully understand that I am directly and fully responsible to Howard D. Fern/ A Plus Chiropractic Care, PC for all medical/chiropractic bills submitted by him for services rendered to me that this agreement is made solely for his additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Patient Signature: _____ Date: _____