PATIET INFORMATION (PLEASE PRINT) NAME ______________________________ **TODAY'S DATE** ______/______/______
STREET ADDRESS______________________________
CITY ______________________STATE______________________ ZIP ______________________
CELL#______________________DAYTIME # ______________________
EMAIL ______________________DOB ______/______/______
CIRCLE ONE: MALE FEMALE
NUMBER OF CHILDREN ______________NAMES & AGES ______________________

____

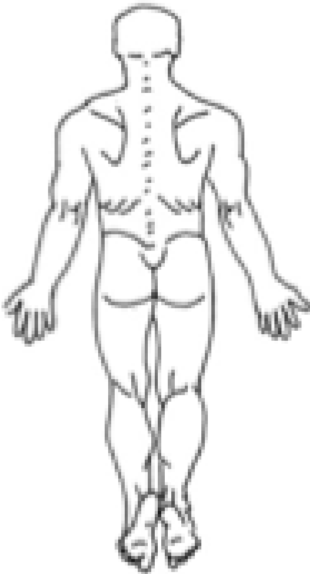
MARITAL STATUS (CIRCLE ONE): SINGLE-MARRIED-DIVORCED-WIDOWED
EMERGENCY CONTACT PERSON:______________________PHONE#______________________
EMPLOYER______________________OCCUPATION______________________
HOW DID YOU HEAR ABOUT OUR OFFICE (CIRCLE ONE): WEBSITE- GOOGLE-FACEBOOK-YELP-LOCATION-REFERRED BY:___
OTHER ____

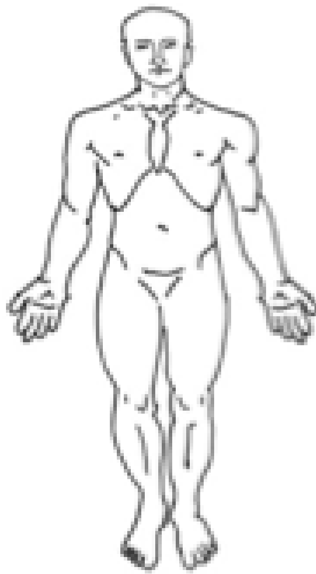
THE REASON FOR THIS VISIT IS A RESULT OF (please circle): AUTO/WORK/FALL/SPORTS/CHRONIC SPINAL PAIN/WELLNESS/CHECK UP/
OTHER______________________
PLEASE DESCRIBE YOUR **MAJOR COMPLAINT** AND HOW IT HAPPENED:______________________

____

____

OTHER COMPLAINTS:____
ON THE DIAGRAM, PLEASE PLACE AN "X" OVER THE AREA WHERE YOU EXPERIENCE PAIN/SYMPTOMS





DATE STARTED:____/________/________HAD THIS PROBLEM BEFORE? YES/NO
IS THIS INTERFERING WITH (PLEASE CIRCLE): WORK/SCHOOL/RECREATION/OTHER:______________________

AREAS OF COMPLAINT(S) PAIN SCALE **(CIRCLE ONE)**

1. ______________________________(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)
WHAT MAKES IT BETTER______________________________
WHAT MAKES IT WORSE______________________________
2. ______________________________(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)
WHAT MAKES IT BETTER______________________________
WHAT MAKES IT WORSE______________________________

3.____(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)
WHAT MAKES IT BETTER____
WHAT MAKES IT WORSE____

PAST HISTORY-PLEASE INDICATE ON THE CHART USING A CHECK MARK IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING. IF YOU CHECK YES, PLEASE PROVIDE THE DATE IN WHICH THE EVENT OCCURRED, AND A BRIEF EXPLANANTION.

	NO	YES	DATE IF YES	BRIEF EXPLANATION
HOSPITALIZATIONS				
SURGERIES				
BROKEN BONES				
SPRAIN/STRAIN				
MENTAL DISORDERS				

FAMILY HISTORY-PLEASE INDICATE IN THE CHART USING A CHECK MARK IF A FAMILY MEMBER HAS EXPERIENCED ANY OF THE FOLLOWING:

	FAMILY MEMBER (RELATIONSHIP)	FAMILY MEMBER (RELATIONSHIP)
ADD/ADHD		
ANXIETY		
AUTISM		
CANCER		
DEMENTIA		
DEPRESSION		
DIABETES		
EPILEPSY		
HEART DISEASE		
HIGH BLOOD PRESSURE		
MULTIPLE SCLEROSIS		
OSTEOPOROSIS		
PARKINSON'S DISEASE		
THYROID DISORDERS		
OTHER:		

PLEASE LIST YOUR CURRENT PRESCRIPTION MEDICATIONS AND HEALTH SUPPLEMENTS:____________________________

DO YOU HAVE ANY ALLERGIES TO:

- FOODS:____
- MEDICATIONS:____________________________________
- ENVIRONMENT:___________________________________

PRESENT HEALTH: Are you presently affected by any of the following? (Within past 3 months) Please circle best description

GENERAL HEALTH

FATIGUE
WEIGHT GAIN
WEIGHT LOSS
ALLERGIES
PAIN AT NIGHT
SENSITIVE TO SMELLS

MUSCLE & JOINT

BACK PAIN
NECK PAIN
ARM PAIN
LEG PAIN
SCOLIOSIS
ARTHRITIS

CARDIOVASCULAR

PAIN IN CHEST
SHORTNESS OF BREATH
SWELLING IN EXTREMITIES
IRREGULAR HEART BEAT
RAPID HEART BEAT
TIGHTNESS OF CHEST
BLUSHED OR RED FACE

GASTROINTESTINAL

CONSTIPATION
DIARRHEA
NAUSEA/VOMITING
GERD/HEARTBURN
FOOD ALLERGIES
GAS/BLOATING
PAIN IN ABDOMEN
WHITE TONGUE
BLOODY STOOLS

RESPIRATORY

CHRONIC COUGH

CHEST CONGESTION

DIFFICULTY BREATHING

CHEST PAIN

URINARY

PAIN IN LOW BACK

INCONTINENCE

LOW SEX DRIVE

BLOOD IN URINE

INCREASED URINATION

EARS, NOSE, THROAT

RED, ITCHY EYES

BLURRY VISION

PAIN AROUND EYE

RINGING IN EARS

EAR INFECTIONS

LOSS OF HEARING

ENLARGED LYMPH NODES

BLEEDING GUMS

WHITE TONGUE

DRY MOUTH

BAD BREATH

SORE THROAT

SKIN

OILY SKIN

DRY SKIN

ECZEMA

SKIN RASH

BODY HAIR INCREASE

BODY HAIR DECREASE

HEAD/MIND

HEADACHES/MIGRAINES

DIFFICULTY CONCENTRATING

MENTAL SLUGGISHNESS

DEPRESSION

DIZZINESS

ANXIETY

MALE ONLY

PAINFUL ERECTIONS

DECREASED FUNCTION

CLOUDY/DARK URINE

TENDER TESTIS

FEMALE ONLY

IRREGULAR MENSES

PAINFUL MENSES

EXCESSIVE FLOW

ABNORMAL DISCHARGE

CRAMPS

PAST HISTORY-PLEASE INDICATE WITH AN X IF YOU HAVE HAD THESE CONDITIONS BEFORE

	YES	NO
ADD/ADHD		
ANXIETY		
AUTISM		
CANCER		
DEMENTIA		
DEPRESSION		
DIABETES		
EPILEPSY		
HEART DISEASE		
HIGH BLOOD PRESSURE		
MULTIPLE SCLEROSIS		
OSTEOPOROSIS		
PARKINSON’S DISEASE		
THYROID DISORDERS		
OTHER:		

PLEASE LIST ANY MAJOR INJURIES, SURGERIES, ILLNESSES WITH DATE OF OCCURRENCE

INJURY	SURGERIES	ILLNESSES

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

As chiropractors we are required to advise patients of the benefits and potential risks including sprain/strain, rib fracture, disc herniation and neck problems. There have been extremely rare incidents of injury to the vertebral artery during the course of treatment. This has caused stroked or stroke like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in ten million. Orthopedic tests, without x-rays, have been performed on you to minimize these risks to yourself. Chiropractic care is considered to be one of the safest and most effective forms of therapy for neck conditions. If you have any questions about this, please ask Dr James or Dr. Scherina. Please sign below if you read the above statement and consent to treatment.

Privacy Notice

Our office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization.

Notice to Medicare/Medicaid Patients

The following is the office policy regarding Medicare Benefits. Please read carefully and sign only if you understand and agree to the terms.
We will not bill Medicare insurance for you if you have coverage with Medicare or with a secondary insurance policy; payment for the visit is due at time of service. Medicare will not reimburse you if you submit a super bill for coverage since Dr. James Butcher and Dr. Scherina Alli are non-providers. You CAN NOT submit codes and charges for coverage by Medicare/Medicaid if receiving services by Dr. James Butcher and/or Dr. Scherina Alli.
Notice of Exclusion from Medicare/Medicaid Benefit (NEMB)
The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them directly.
Please see our fee schedule for a more complete list of services offered and associated prices.
Before you make a decision, you should read this entire notice carefully.
If you have any questions, please ask us so we can clarify. By signing below, you are acknowledging that you have read, understand and agree to these terms.

Signature: ______________________________ **Date Signed:** ______________________