CHEELEY CHIROPRACTIC INC.

NEW PATIENT PAPERWORK FOR PERSONSAL INJURY

THAT IS DUE TO AN MOTOR VEHICLE ACCIDENT

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remove obstacles • restore function • improve performance • maximize potential

Welcome to Our Office

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

Our Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your health information to:

- Treat you
- Collect payment
- Run our office
- Inform you about other services
- Discuss your case with family
- Do research
- Include you in care classes
- Thank you for referring other patients

We may use your health information for:

- Health and safety reasons
- Reporting to law officials
- Reporting victims of abuse
- Court hearings and filings
- Reporting to worker's compensation

You have the right to:

- Request a copy of your health record
- Request a list of whom we share your health information with
- Ask us to limit the information we share
- Advise our management if you believe your privacy rights have been violated
- Request confidential communications
- Amend your protected health information

These privacy practices are effective: _____

For further information please contact: _____

Consultation & Exam

To begin today's visit, we will collect some confidential health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests.

If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition.

We will always inform you of associated fees before we perform any procedure or service.

Report of Findings

Patients who are examined will receive a report of our findings from the recorded history, consultation, and examination.

If we believe we can help, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan may be created to address your short and/or long-term goals.

As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy
- I understand the purpose of today's visit
- The doctor(s) may use my confidential health information in the manner previously described

_____
patient or guardian signature

_____
date

PATIENT INFORMATION FORM

(Office use only)

1)New patient_____ Previous Patient (New Case) _____

Patient Code#_____ 2) Date: ___/___/_____ 3) Time ___:___ __m 4) Claim#_____

5) First Name: _____M.I. ____ Last Name: _____ 6)Sex: 1) Male 2) Female

7)Birthdate_____/_____/_____ Age_____ Marital Status (S M W D) Spouse's Name_____

8) Social Security # _____/____/_____ 9) Home Phone ( ) ____ - _____ Cell Phone( ) ____ - _____

10) Address _____ City _____ State _____Zip _____

11) Employer _____ 12) Job Title _____ Work Phone ( ) _____- _____

Driver's License No. _____ State: _____

Person Responsible for this account _____

Referred By _____

Primary Insurance: (Group___ Work/Comp ____ Automobile ___ Other ___) 13) Policy # _____

Insurance Co. _____ 14) Group# _____

Address _____ City _____State _____ Zip _____ Phone ( )____-_____

15) Primary name of Insured: _____DOB:____/____/_____ Relationship to Patient _____ SS#_____

16) Employer _____ Employee # _____ Work Phone ( )_____-_____

Work Address_____ City _____ State: _____ Zip_____

Secondary Insurance: (Group___ Work/Comp ____ Automobile ___ Other ___) Policy # _____

Insurance Co. _____ Group# _____

Address _____ City _____State _____ Zip _____ Phone ( )____-_____

Primary name of Insured: _____DOB:____/____/_____ Relationship to Patient _____ SS#_____

Employer _____ Employee # _____ Work Phone ( )_____-_____

Work Address_____ City _____ State: _____ Zip_____

Other Insurance: (Group___ Work/Comp ____ Automobile ___ Other ___) Policy # _____

Insurance Co. _____ Group# _____

Address _____ City _____State _____ Zip _____ Phone ( )____-_____

Primary name of Insured: _____DOB:____/____/_____ Relationship to Patient _____ SS#_____

Employer _____ Employee # _____ Work Phone ( )_____-_____

Work Address_____ City _____ State: _____ Zip_____

Are you or do you think you might be pregnant? 1) Yes 2) No

17) Cause of complaint: (circle) 1) Auto Accident 2) Work Injury 3) Other Accident 4) Illness 5) Congenital 6) Unknown

I Understand and agree that health and accident insurances polices are an arrangement between an insurance carrier and me. I authorize payment for my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney's fees as may be required to effect collection.

Patient Signature _____ Date_____/_____/_____

PATIENT HEALTH HISTORY

Name: _____ **Family Physician:** _____

1) FAMILY HISTORY: (Circle as many as apply)

MOTHER: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

If deceased- Age at death: _____

FATHER: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

If deceased- Age at death: _____

SIBLINGS: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

2) SOCIAL HISTORY:

MARITAL STATUS:	1) Single 2) Married 3) Divorced 4) Widowed
NUMBER OF CHILDREN:	(1) (2) (3) (4) (5) (6) (7) (8) (None)
DO YOU:	1) Exercise regularly 2) Eat a balanced diet 3) Obtain sufficient rest
DO YOU SMOKE?	1) No 2) Less than 1 3) 1-2 4) 2-3 5) 3-4 6) More than 5 (packs / day)
DO YOU DRINK COFFEE/TEA?	1) No 2) Occasionally 3) 1-2 4) 2-3 5) 3-4 6) More than 5 (cups / day)
DO YOU DRINK ALCOHOL?	1) No 2) Occasionally 3) 1-2 4) 2-3 5) 3-4 6) More than 5 (drinks / day)

3) MEDICAL HISTORY:

CHILDHOOD ILLNESSES: 1) Measles 2) Mumps 3) Chickenpox 4) Tuberculosis 5) Rheumatic fever 6) Diabetes

LIST ANY SERIOUS CHILDHOOD ILLNESSES NOT RECORDED ABOVE.

_____ Age: [ ]

_____ Age: [ ]

_____ Age: [ ]

LIST ANY BIRTH DEFECTS:

_____

HOSPITALIZATIONS & SURGERIES: If you have ever been hospitalized, list reason and dates.

_____ M/D/Y_____/_____/_____

_____ M/D/Y_____/_____/_____

_____ M/D/Y_____/_____/_____

ADULT ILLNESSES/INJURIES: List all serious diseases & injuries for which you have not been hospitalized; include approximate dates.

_____ M/D/Y_____/_____/_____

_____ M/D/Y_____/_____/_____

_____ M/D/Y_____/_____/_____

4) MEDICATIONS:

List all medications that you are currently taking or have taken on a regular basis in the last 6 months (include home remedies).

A) _____ B) _____

C) _____ D) _____

MEDICATIONS IN WHICH YOU ARE ALLERGIC:

A) _____ B) _____

C) _____ D) _____

VEHICLE ACCIDENT QUESTIONNAIRE

Name : _____

*If you are represented by an Attorney for this accident, complete the following:
Attorney Name:_____ Phone ( ) _____-_____
Address_____ City_____ State_____ Zip_____

(PLEASE NOTE:) If you were at work when the accident occurred you must also complete the INDUSTRIAL INJURY FORM!

1) Date of Accident: _____/_____/_____ **2) Time :**_____:_____ **(AM/PM)** **3) Last day worked** ____/____/____
4) Date returned to *modified* work: ____/____/____ **5)** Date returned to regular work ____/____/____
6) Are you working now? 1) Yes, part time 2) Yes, full time 3) No
7) Your vehicle: 1) Auto 2) Light Truck 3) Truck 4) Van 5) Bus 6) Motorhome 7) Motorcycle 8) Motorscooter 9) Bicycle
8) Other vehicle: 1) Auto 2) Light Truck 3) Truck 4) Van 5) Bus 6) Motorhome 7) Motorcycle 8) Motorscooter 9) Bicycle
9) Were you: 1) Driver 2) Pass (front middle) 3) Pass.(front right) 4) Pass.(rear middle) 5) Pass.(rear left) 6) Pass.(rear right)
10) Wearing your seat belt? 1) Yes 2) No **11) Your vehicle moving?** 1) Yes 2) No **12) Other vehicle moving?** 1) Yes 2) No
13) Cause of accident: 1) Hit by a vehicle 2) Hit another vehicle 3) Hit a stationary object 4) Other
14) Where was your vehicle hit? 1) Front 2) Rear 3) Lt. Front 4) Rt. Front 5) Lt. Side 6) Rt. Side 7) Lt. Rear 8) Rt. Rear
15) Where was the other vehicle hit? 1) Front 2) Rear 3) Lt. Front 4) Rt. Front 5) Lt. Side 6) Rt. Side 7) Lt. Rear 8) Rt. Rear
16) Describe any Pre-existing Conditions or disabilities:
A) _____ **Date of Onset:** ____/____/____
Cause: 1) Auto Accident 2) Work Injury 3) Sports Injury 4) Injury at home 5) Other Injury 6) Illness 7) Congenital 8) Unknown
B) _____ **Date of Onset:** ____/____/____
Cause: 1) Auto Accident 2) Work Injury 3) Sports Injury 4) Injury at home 5) Other Injury 6) Illness 7) Congenital 8) Unknown
C) _____ **Date of Onset:** ____/____/____
Cause: 1) Auto Accident 2) Work Injury 3) Sports Injury 4) Injury at home 5) Other Injury 6) Illness 7) Congenital 8) Unknown

17) In your own words, describe how the accident happened (give details):

_____

_____

_____

18) What happened at the moment of impact? (Circle as many as apply)
1) Tensed body 2) Neck whiplashed 3) Back bent & twisted 4) Thrown over seat 5) Cut
6) Bruised 7) Thrown from vehicle 8) Pinned in vehicle 9) Thrown from side to side

19) For each injured part of your body, circle the number(s) representing the part(s) of the vehicle that it struck during the accident

[1] DASH [2] WINDSHIELD [3] STEERING WHEEL [4] DOOR [5] HEAD REST [6] ROOF [7] UNKNOWN PART

Head:	[1]	[2]	[3]	[4]	[5]	[6]	[7]	Chest:	[1]	[2]	[3]	[4]	[5]	[6]	[7]
Face:	[1]	[2]	[3]	[4]	[5]	[6]	[7]	Upper Back:	[1]	[2]	[3]	[4]	[5]	[6]	[7]
Lt. Shoulder:	[1]	[2]	[3]	[4]	[5]	[6]	[7]	Lower Back:	[1]	[2]	[3]	[4]	[5]	[6]	[7]
Rt. Shoulder	[1]	[2]	[3]	[4]	[5]	[6]	[7]	Lt. Hip:	[1]	[2]	[3]	[4]	[5]	[6]	[7]
Lt. Upper Arm:	[1]	[2]	[3]	[4]	[5]	[6]	[7]	Rt. Hip:	[1]	[2]	[3]	[4]	[5]	[6]	[7]
Rt. Upper Arm:	[1]	[2]	[3]	[4]	[5]	[6]	[7]	Lt. Thigh:	[1]	[2]	[3]	[4]	[5]	[6]	[7]
Lt. Elbow:	[1]	[2]	[3]	[4]	[5]	[6]	[7]	Rt. Thigh:	[1]	[2]	[3]	[4]	[5]	[6]	[7]
Rt. Elbow:	[1]	[2]	[3]	[4]	[5]	[6]	[7]	Lt. Knee:	[1]	[2]	[3]	[4]	[5]	[6]	[7]
Lt. Forearm:	[1]	[2]	[3]	[4]	[5]	[6]	[7]	Rt. Knee:	[1]	[2]	[3]	[4]	[5]	[6]	[7]
Rt. Forearm:	[1]	[2]	[3]	[4]	[5]	[6]	[7]	Lt. Shin:	[1]	[2]	[3]	[4]	[5]	[6]	[7]
Lt. Wrist:	[1]	[2]	[3]	[4]	[5]	[6]	[7]	Rt. Shin:	[1]	[2]	[3]	[4]	[5]	[6]	[7]
Rt. Wrist:	[1]	[2]	[3]	[4]	[5]	[6]	[7]	Lt. Ankle:	[1]	[2]	[3]	[4]	[5]	[6]	[7]
Lt. Hand:	[1]	[2]	[3]	[4]	[5]	[6]	[7]	Rt. Ankle:	[1]	[2]	[3]	[4]	[5]	[6]	[7]
Rt. Hand:	[1]	[2]	[3]	[4]	[5]	[6]	[7]	Lt. Foot:	[1]	[2]	[3]	[4]	[5]	[6]	[7]
Ribcage:	[1]	[2]	[3]	[4]	[5]	[6]	[7]	Rt. Foot:	[1]	[2]	[3]	[4]	[5]	[6]	[7]

20) Were you unconscious? 1) No 2) Not 3) A few seconds 4) A few minutes 5) An hour 6) A few hours

21) Immediately after the accident, did you feel? (circle as many as apply)
1) Stunned 2) Frightened 3) Confused 4) Dazed 5) Dizzy 6) Shocked 7) Shaken 8) Nauseous

22) **Did you receive medical aid at accident site?** 1) Yes 2) No

23) **Where did you go right after the accident?**
1) Hospital 2) Emergency Treatment Center 3) Home 4) Family physician 5) To this office 6) Resumed activities 7) Work

24) **How did you get there?** 1) Ambulance 2) Drove myself 3) Someone drove me 4) Walked

25) **Hospital Name:** _____ 26) **Hospital City / State:** _____

27) **When did your symptoms develop?**
1) Immediately 2) Hours later 3) The next day 4) Over the first few days
5) During the first week 6) Over the next few weeks 7) Over next few months

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If you were treated by *another* Doctor or Therapist for this condition, answer questions 28 - 30:

28A) **Name:** _____ 1) CA 2) DC 3) DDS 4) DO 5) DPM 6) MD 7) OD 8) PT *
B) **Tests Performed:** 1) Examination 2) X-Ray 3) Cat Scan 4) EMG 5) Thermography
6) MRI 7) EEG 8) Lab 9) Psychological
C) **Prescription given:** 1) Pain Killers 2) Muscle relaxants 3) Antibiotics 4) Sedatives 5) Anti-Inflammatory 6) Other
D) **Treatment frequency:** 1) Daily 2) 1x a week 3) 2x a week 4) 3x a wk 5) 4x a week
6) 1x a month 7) 2x a month 8) 3x a month
E) **Treatment duration:** _____ 1) Days 2) Weeks 3) Months (circle)
F) **Date first appointment:** _____/_____/_____
G) **Date last appointment:** _____/_____/_____
H) **Did the treatment help?** 1) No, Aggravated the condition 2) No 3) Yes, a little 4) Yes, a lot 5) Cured the condition

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29A) **Name:** _____ 1) CA 2) DC 3) DDS 4) DO 5) DPM 6) MD 7) OD 8) PT *
B) **Tests Performed:** 1) Examination 2) X-Ray 3) Cat Scan 4) EMG 5) Thermography
6) MRI 7) EEG 8) Lab 9) Psychological
C) **Prescription given:** 1) Pain Killers 2) Muscle relaxants 3) Antibiotics 4) Sedatives 5) Anti-Inflammatory 6) Other
D) **Treatment frequency:** 1) Daily 2) 1x a week 3) 2x a week 4) 3x a wk 5) 4x a week
6) 1x a month 7) 2x a month 8) 3x a month
E) **Treatment duration:** _____ 1) Days 2) Weeks 3) Months (circle)
F) **Date first appointment:** _____/_____/_____
G) **Date last appointment:** _____/_____/_____
H) **Did the treatment help?** 1) No, Aggravated the condition 2) No 3) Yes, a little 4) Yes, a lot 5) Cured the condition

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30A) **Name:** _____ 1) CA 2) DC 3) DDS 4) DO 5) DPM 6) MD 7) OD 8) PT *
B) **Tests Performed:** 1) Examination 2) X-Ray 3) Cat Scan 4) EMG 5) Thermography
6) MRI 7) EEG 8) Lab 9) Psychological
C) **Prescription given:** 1) Pain Killers 2) Muscle relaxants 3) Antibiotics 4) Sedatives 5) Anti-Inflammatory 6) Other
D) **Treatment frequency:** 1) Daily 2) 1x a week 3) 2x a week 4) 3x a wk 5) 4x a week
6) 1x a month 7) 2x a month 8) 3x a month
E) **Treatment duration:** _____ 1) Days 2) Weeks 3) Months (circle)
F) **Date first appointment:** _____/_____/_____
G) **Date last appointment:** _____/_____/_____
H) **Did the treatment help?** 1) No, Aggravated the condition 2) No 3) Yes, a little 4) Yes, a lot 5) Cured the condition

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* C.A. =Acupuncturist, D.C =Chiropractor, D.D.S. =Dentist, D.O. = Osteopath, D.P.M. =Podiatrist, M.D. =Physician, O.D. = Optometrist, P.T. = Physical Therapist

Patient Signature: _____ **Date:** _____/_____/_____

PATIENT COMPLAINTS

NAME:_____ A) DATE:_____/_____/_____

B) GENERAL:	Frequency Const/Intermit		Intensity Mild/Moderate/Severe			Pain Type Sharp/Dull	
Anxiety	1	2	1	2	3		
Cannot concentrate	1	2	1	2	3		
Nervousness	1	2	1	2	3		
Irritability	1	2	1	2	3		
Fatigue	1	2	1	2	3		
Depression	1	2	1	2	3		
Memory loss	1	2	1	2	3		
Loss of sleep	1	2	1	2	3		
Tension	1	2	1	2	3		
Fainting spells	1	2	1	2	3		
Dizzy spells	1	2	1	2	3		
PMS	1	2	1	2	3		

C) HEAD:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Headaches		1	2	1	2	3	1	2
Jaw pain		1	2	1	2	3	1	2
Jaw tension		1	2	1	2	3		
Pain in ears	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Ringing in ears		1	2	1	2	3		
Ear discharge	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Hearing loss	Lt.			1	2	3		
	Rt.			1	2	3		
Eye pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Decreased acuity				1	2	3		
Light sensitivity				1	2	3		
Floating lights				1	2	3		
Nose bleeds				1	2	3		
Nasal obstruction				1	2	3		

D) NECK/THROAT:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Neck pain	Lt.	1	2	1	2	3	1	2
	Diffuse	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Pain radiates to	Lt.	1)Shldr	2)Arm	3)Elbw	4)Wrist	5)Fingers		
	Rt.	1)Shldr	2)Arm	3)Elbw	4)Wrist	5)Fingers		
Stiffness		1	2	1	2	3		
Grinding sounds		1	2	1	2	3		
Popping sounds		1	2	1	2	3		
Hoarseness		1	2	1	2	3		

E) SHOULDERS:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Pain with motion	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Pain at rest	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Muscle spasm	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Limited motion	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Muscle weakness	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		

F) ARMS:		Frequency Const/Intermit		Intensity Mild/Moderate/Severe			Pain Type Sharp/Dull	
UPPER ARM pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Pins & Needles	Lt.	1	2	1	2	3		
(upper arm)	Rt.	1	2	1	2	3		
Numbness	Lt.	1	2	1	2	3		
(upper arm)	Rt.	1	2	1	2	3		
Muscle weakness	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
ELBOW pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
FOREARM pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Pins & Needles	Lt.	1	2	1	2	3		
(forearm)	Rt.	1	2	1	2	3		
Numbness	Lt.	1	2	1	2	3		
(forearm)	Rt.	1	2	1	2	3		
Muscle weakness	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		

G) HANDS:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Wrist pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Hand pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Pins & Needles	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Numbness - hand	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Thumb pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Index finger pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Middle finger pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Ring finger pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Little finger pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Numbness - fngr	Lt.	1)Index	2)Middle	3)Ring	4)Little	5)Thumb		
	Rt.	1)Index	2)Middle	3)Ring	4)Little	5)Thumb		
Muscle weakness	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		

H) MIDBACK:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Pain	Lt.	1	2	1	2	3	1	2
	MIDLINE	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Muscle spasm	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		

I) LOWBACK:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Pain	Lt.	1	2	1	2	3	1	2
	MIDLINE	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Stiffness		1	2	1	2	3		
Muscle spasm	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Pain radiates to	Lt.	1)Buttocks	2)Hip	3)Side of Leg	4)Back of Leg			
	Rt.	1)Buttocks	2)Hip	3)Side of Leg	4)Back of Leg			

J) PELVIS:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Hip joint pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Sacroiliac pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Buttock pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Groin pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Tail bone pain		1	2	1	2	3	1	2

K) THIGH:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Pain radiates to	Lt.	1)Knee___		2)Calf___		3)Ankle___		
	Rt.	1)Knee___		2)Calf___		3)Ankle___		
Numbness	Lt.	1	2	1	2	3		
Pins and Needles	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Knee pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Swollen knee	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Muscle weakness	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		

L) CALVES		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Calf Pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Pain radiates to	Lt.	1)Ankle___		2)Foot___		3)Toes___		
	Rt.	1)Ankle___		2)Foot___		3)Toes___		
Numbness	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Pins and Needles	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Cramps	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Muscle weakness	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		

M) ANKLES:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Swelling	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		

N) FEET:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Numbness	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Pin and Needles	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Swelling	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Cramps	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Big toe pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
2nd toe pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Mid toe pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
4th toe pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Small toe pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2

O) CHEST:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Deep chest pain		1	2	1	2	3	1	2
Pain around ribs	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Pain with exertion		1	2	1	2	3	1	2
Shortness of breath		1	2	1	2	3		
Difficult breathing		1	2	1	2	3		
Irregular heartbeat		1	2	1	2	3		
Rapid heart beat		1	2	1	2	3		
Night sweats		1	2	1	2	3		
Chronic cough		1	2	1	2	3		

P) DIGESTIVE TRACT:	Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Stomach pain	1	2	1	2	3	1	2
Indigestion	1	2	1	2	3		
Nausea	1	2	1	2	3		
Gas	1	2	1	2	3		
Clay colored stool	1	2	1	2	3		
Black tarry stool	1	2	1	2	3		
Hemorrhoids	1	2	1	2	3		
Bleeding from rectum	1	2	1	2	3		
Abnormal weight loss			1	2	3		
Diarrhea	1	2	1	2	3		
Constipation	1	2	1	2	3		

Q) URINARY TRACT:	Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Painful urination	1	2	1	2	3	1	2
Frequent urination	1	2	1	2	3		
Unable to urinate	1	2	1	2	3		
Leakage of urine	1	2	1	2	3		
Blood in urine	1	2	1	2	3		
Bedwetting	1	2	1	2	3		

R) WOMEN ONLY:	Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Painful menstruation	1	2	1	2	3	1	2
Excess menstruation	1	2	1	2	3		
Missed periods	1	2	1	2	3		

S) SUMMARY:

You have identified general complaints and complaints in different parts of your body. Enter the letter (B thru R) to tell us where:

1) Is your most serious complaint. _____

2) Is your next most serious complaint. _____

3) Approximate date of onset (if known): ____/____/____

4) Onset was: 1) Sudden 2) Gradual

5) Are the complaints? (circle one)
1) Improving 2) Getting worse
3) About the same 4) Intermittent (Comes & Goes)

6) When are the complaints most noticeable?
1) Morning 2) Afternoon 3) Evening 4) Night

7) What aggravates the complaint(s)?
1) Standing 2) Walking 3) Sitting 4) Bending
5) Lying 6) Lifting 7) Twisting 8) Coughing

8) What relieves the complaint(s)?
1) Rest 2) Sitting 3) Lying 4) Bending
5) Stretching 6) Exercise 7) Lying knees bent

Authorization to Use or Disclose Protected Health Information

Cheeley Chiropractic, Inc.
900 East Washington St., Ste 300
Colton, CA 92324
Phone: (909) 533-4591 Fax: (909) 533-4597

Patient Name:_____

Address:_____

Date of Birth:_____ **Date Requested:**_____

As required by the Privacy Regulations, Cheeley Chiropractic, Inc. may not use or disclose your protected health information except as provided in or Notice of Privacy Practices without your authorization.

I hereby authorize Cheeley Chiropractic, Inc. and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), and/or business associates of this office:

_____

Patient Health Information authorized to be disclosed:

_____

For specific purpose of (describe in detail):

_____

Effective dates for this authorization: _____ through_____
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond the control of Cheeley Chiropractic, Inc.

I understand I have the right to:

1. Revoke this authorization by sending written notice to Cheeley Chiropractic, Inc. and previous reliance on the used or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under Federal Law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not affect my condition, my treatment, payment, enrollment in a health plan, or eligibility for benefits, whether or not I provide authorization to use or disclose protected patient health information.

_____ _____
Signature of Patient or Patient's Authorized Representative **Date**

_____ _____
Authorized Signature of Facility **Date**

Assignment and Instruction for Direct Payment to Doctor
Private and Group Accident and Health Insurance

Patient Name:_____

Name of Employer:_____

Claim/Group #:_____

SS#/ID#:_____

I hereby instruct and direct the _____ insurance Company

to issue check made out and mailed directly to:

Cheeley Chiropractic, Inc.

900 East Washington St., Ste 300
Colton, CA 92324

If my current policy prohibits direct payment to doctor, I hereby instruct and direct you to make out the check to me and mail it as follows:

C/O Cheeley Chiropractic, Inc.

900 East Washington St., Ste 300
Colton, CA 92324

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner and any balance of said professional service charges over and above the insurance payment.

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.

Dated at _____ this _____ day of _____20 _____

_____ _____
Signature of Patient or Patient's Authorized Representative **Date**

_____ _____
Authorized Signature of Facility **Date**