DEMOULIN CHIROPRACTIC CENTER, LLC

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PATIENT HEALTH ASSESSMENT FORM

GENERAL INFORMATION

Patient Name:________________________ Patient Sex: M F Date:______________

Date of Birth__________________ Social Security #: __________________ Height _____feet ______in Weight ______

Patient Address:______________________________ City:________________________State:________Zip:__________

Phone:______________________ Referred for Treatment by:__________________ Preferred Language ______________

RACE:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ African American
- ☐ Native Hawaiin/Pacific Islander
- ☐ Caucasian
- ☐ Not willing to provide

ETHNICITY:

- ☐ Hispanic/latino
- ☐ Non Hispanic/latino
- ☐ Not willing to provide

COMPLAINT HISTORY

Describe your current compliant(s)____

____

How long have you had this condition? ________________________ Date of onset:________________________

Spine Pain Radiation:
- ❑ Level I: Pain localized to Spine
- ❑ Level II: Pain radiating to the elbow or knee
- ❑ Level III: Pain radiating below the elbow or knee

How would describe pain?

☐ Sharp ☐ Spasm ☐ Burning ☐ Ache ☐ Weakness ☐ Numbness
☐ Soreness ☐ Throbbing ☐ Tingling ☐ Dull ☐ Stiffness ☐ Shooting

Pain Intensity: 0 1 2 3 4 5 6 7 8 9 10 (0 = No Pain 10 = Unbearable Pain)

What makes it worse?____

What makes it better?____

Since your problem began is the pain: Getting worse? Getting better? Staying the same?

How did your problem begin? ☐ An auto accident ☐ Work related accident ☐ Other type of accident
☐ Gradual ☐ Sudden ☐ No specific reason

Explain:____

Medications? ____

Medication Allergies (if yes, what type)?____

Were you previously treated for an earlier occurrence of this same condition? YES NO

What were the approximate dates, type of treatment and the results?____________________________

____

What is your physical activity at work? ☐ Mostly sitting ☐ Light manual labor ☐ Moderate manual Labor ☐ Heavy manual labor

Do you exercise? ☐ No regular exercise ☐ 1-2 times a week ☐ 3-4 times a week ☐ 5-7 times a week ☐ Cardiovascular ☐ Stretching ☐ Weight machine ☐ Free weights ☐ Sports ____________________________ (Type)

PAST OR PRESENT SYMPTOMS, CONDITONS OR HABITS

- ☐ Swelling/stiffness of joint
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting spells
- ☐ Convulsions
- ☐ General prolonged fatigue
- ☐ Condition of uterus/ovaries
- ☐ High blood pressure
- ☐ Heart condition
- ☐ Respiratory condition
- ☐ Digestive problems
- ☐ Prostrate conditions
- ☐ Kidney/bladder problem
- ☐ Menstrual problems
- ☐ Breast soreness/lump
- ☐ Sinus conditions
- ☐ Allergies/asthma
- ☐ Cancer
- ☐ Stroke
- ☐ Excessive weight gain/loss
- ☐ Skin condition
- ☐ Arthritis
- ☐ Diabetes

Comments:____

____

Major Accidents/Falls?____

Tobacco use:
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Alcohol use:
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Caffeine use: (coffee, tea, soft drinks)
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Pregnancy: ☐ Past ☐ Present

Surgical Procedure: ☐ Past ☐ Present

Please list: ____________________________

Any treatment for any health conditions in the past year?____

Family History:____

THE FOLLOWING IS OUR POLICY FOR PAYMENT OF MEDICAL SERVICES RENDERED:

1. You are responsible for the payment of any deductible and co-pay/ co-insurance at the time the services are rendered.
2. It is your responsibility to know the details concerning the coverage of your particular insurance plan, including if referral is required and to obtain and maintain referral authority.
3. As a courtesy, we will submit billing to your insurance company. If payment is not received within 60 days, it is your responsibility to intervene with your insurance company to get your bills paid. **PLEASE NOTE: YOU ARE ULTIMATELY RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED**, regardless of insurance coverage, or the amount of payment made by the insurance company.
4. Any insurances checks received by you for services rendered here, must be endorsed and brought into this office immediately to be applied to your account.

MONTHLY STATEMENTS: All monthly statements are due and payable, in full, upon receipt, unless prior arrangements have been made with this office. If the bill remains unpaid for 30 days, and no satisfactory arrangements have been made, then collection proceedings may be instituted, without further warning. **Any and all costs associated with any collection proceedings, including reasonable attorneys' fees and costs will be added to the outstanding amount, and sall be your responsibility to pay.**

I HAVE READ AND UNDERSTOOD THE ABOVE:

SIGNATURE:____ **DATE:**____________________