Manchester Chiropractic & Wellness Clinic
231 E. Gray St. Norman, OK 73069.
Phone: 405.579.9844, Fax: 405.364.4611

First Name: _____ M.I.: _____ Last Name: _____ Date:_____

Address: _____ City: _____

State: _____ Zip:_____ Email: _____

Home #:_____ Cell #: _____ Work #: _____

SS#:_____-_____-_____ Age:_____ DOB: __ __ /__ __ /__ __ Male / Female / Other

Primary Care Physician:_____

Do we have permission to contact your doctor regarding your care in our office? ____Yes ____No

Occupation:_____ Employer:_____

Marital Status: ▢ Single ▢ Married ▢ Divorced ▢ Widowed ▢ Separated ▢ Minor

Spouse's Name:_____ # of Children?_____

Emergency Contact Name:_____ Relation: _____ Phone #:_____

Smoking Status: Never smoked / Former Smoker / Occasional Smoker / Daily Smoker

Have you had an auto accident? (X if applies): ▢ 0-6mo ▢ 6 mo-1 yr ▢ 1-3yrs ▢ 3+yrs ▢ Never

Had a recent fall/other accident? (X if applies): ▢ 0-6mo ▢ 6 mo-1 yr ▢ 1-3yrs ▢ 3+yrs ▢ Never

Have You Ever Received Physical Therapy ▢ Chiropractic Care ▢ or Pain Management ▢? Last Visit:_____

How Did You Hear About This Office?

▢ Existing Patient: _____ ▢ Walk-In/Drive-By

▢ Ad:_____ ▢ Massage Therapist :_____ ▢

Other: _____ ▢ Internet: _____

Do you have health insurance? ▢ Yes ▢ No Name of Carrier: _____

Do you have secondary insurance? ▢ Yes ▢ No Name of Carrier: _____

**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)**

***Assignment and Release*** **Method of payment for today's charges: ___Cash ___Check ___Visa / MC**

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.
I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of care.)

**SIGNATURE (X)**_____ **DATE:**_____

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**PRIMARY COMPLAINTS: Please list in order of most severe (#1) to least severe (#4).** *Sample complaints: Low Back, Left Knee, Right Shoulder, Neck, etc.*

| | MOST SEVERE | | | LEAST SEVERE |
|---|---|---|---|---|
| **You have the following complaints (WRITE-IN)** | **1.** | **2.** | **3.** | **4.** |
| **Circle the word that best describes this complaint.** | Sharp dull achy throbbing numb shooting other | Sharp dull achy throbbing numb shooting other | Sharp dull achy throbbing numb shooting other | Sharp dull achy throbbing numb shooting other |
| **How often do you feel this complaint?** | Constant Daily Weekly "Off and On" | Constant Daily Weekly "Off and On" | Constant Daily Weekly "Off and On" | Constant Daily Weekly "Off and On" |
| **How long have you had this complaint?** | ____ Days / Weeks / Months / Years | ____ Days / Weeks / Months / Years | ____ Days / Weeks / Months / Years | ____ Days / Weeks / Months / Years |
| **Is it getting better, worse, or staying the same?** | Better Worse Same | Better Worse Same | Better Worse Same | Better Worse Same |
| **What makes it better, if anything?** | | | | |
| **What makes it worse, if anything?** | | | | |
| **On a scale of 0 – 10, rate your discomfort. *(0 = no pain, 10 = excruciating)*** | **Circle response** 0 1 2 3 4 5 6 7 8 9 10 | **Circle response** 0 1 2 3 4 5 6 7 8 9 10 | **Circle response** 0 1 2 3 4 5 6 7 8 9 10 | **Circle response** 0 1 2 3 4 5 6 7 8 9 10 |
| **How have you taken care of this in the past? Has that worked for you?** | | | | |
| **Circle the ways this issue is affecting your life.** *(all that apply)* | job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity | job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity | job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity | job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity |
| **Improving this issue in my life would improve my quality of life by:** *(Circle best response)* | 10-20% 30-40% 50-60% 70-80% 90% 100% | 10-20% 30-40% 50-60% 70-80% 90% 100% | 10-20% 30-40% 50-60% 70-80% 90% 100% | 10-20% 30-40% 50-60% 70-80% 90% 100% |

Date Problem Began?_____ How the Problem Began?_____

Are you pregnant?_____ If yes what is your due date:_____

Have you taken any of the following for the above complaints in the last 6 months? ❑ Tylenol ❑ Ibuprofen/NSAIDs ❑ Aspirin

Have you tried any of the following? ❑ Physical Therapy/Rehab ❑ Occupational Therapy ❑ Chiropractic ❑ Ice/Heat

❑ Pain Management

How long ago or how often did you attempt the selected therapies? _____

_____ _____ _____

***Name (Print)*** ***Signature*** ***Date***

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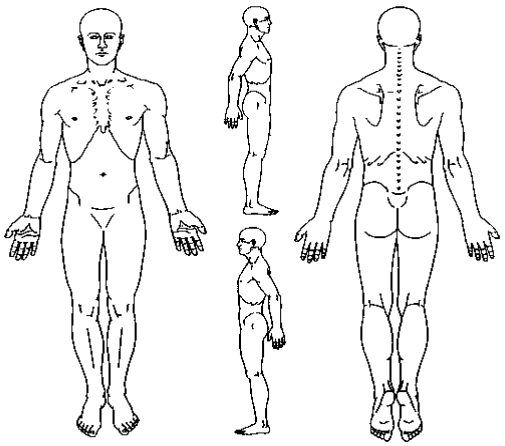
# PATIENT HEALTH HISTORY

***Please check if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:***

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Loss of Taste
- ❑ Nervousness
- ❑ Jaw Problems
- ❑ Dizziness/Fainting
- ❑ Blurred/Double Vision
- ❑ Mood Changes
- ❑ Stomach Problems
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Light Bothers Eyes
- ❑ Recent Weight Change
- ❑ Loss of Memory
- ❑ Cold Extremities
- ❑ Sleeping Difficulties
- ❑ Bowel/Bladder Changes
- ❑ Constipation/Diarrhea
- ❑ Loss of Balance
- ❑ Trouble Concentrating
- ❑ Shortness of Breath
- ❑ Nausea
- ❑ Night Pain
- ❑ Fatigue
- ❑ Fever
- ❑ Tension
- ❑ Chest Pain
- ❑ Asthma
- ❑ Cold Sweats
- ❑ Loss of Smell
- ❑ Swollen Joints
- ❑ Foot Trouble

Mark the body where pain is.



**ALLERGIES: (Please place a checkmark next to any known allergies that you have.)**

___ Milk ___Eggs ___Peanuts ___Almonds ___Cashews ___Walnuts ___ Fish ___ Shellfish ___Soy ___Wheat
___ Gluten ___Penicillin ___Sulfa Drugs ___Tetracycline ___Codeine ___NSAIDS ___Phenytoin ___Carbamazepine ___Mildew
___Mold ___ Dust ___Fungus ___Mites ___Tree Pollen ___Grass Pollen ___Weed Pollen ___Insects ___Dog Dander ___Cat Dander ___Latex ___Other Animal Dander ___ OTHER: _____ *(please fill in)*

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

_____

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain

_____

Please list any and all medications you are currently taking: _____

_____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

_____

**Is there a family history of any of the following conditions? *(indicate family members including parents, grandparents & siblings)***

- ❑ Heart Problems/Stroke_____
- ❑ Diabetes
- ❑ High Blood Pressure __
- ❑ Cancer _____
- ❑ Arthritis
- ❑ Other

_____

Do you exercise: ❑ 5-7x/week ❑ 3-4x/week ❑ 1-2x/week ❑ Occasionally ❑ None

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach

What is your daily/weekly intake of the following: Caffeine ____ cups/day Alcohol ____ drinks/week Cigarettes _____ pks/day

**I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will give complete & accurate information during my exam.**

**Signature (X) _____ Date_____**

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# Allergy, Food & Chemical Sensitivity Survey

***Please complete the following allergy, food and chemical sensitivity questionnaire. Score each symptom based upon your experiences over the last 90 days. Circle appropriate number 0-5 according to severity.***

***0=No Problem at All***
***1=Extremely Mild Symptoms***
***2=Mild to Moderate Symptoms Occasionally***
***3=Moderate Symptoms Frequently***
***4=Moderate to Severe Symptoms***
***5=Very Severe Symptoms***

**Patient Name:** **DOB:** **Date:**

**Digestive Symptoms**
0 1 2 3 4 5 Stomach Pains or Cramping
0 1 2 3 4 5 Constipation
0 1 2 3 4 5 Diarrhea
0 1 2 3 4 5 Reflux or Heartburn
0 1 2 3 4 5 Bloating
0 1 2 3 4 5 Gas
0 1 2 3 4 5 Nausea or Vomiting

**Weight**
0 1 2 3 4 5 Inability to Lose Weight
0 1 2 3 4 5 Food Cravings
0 1 2 3 4 5 Binge Eating
0 1 2 3 4 5 Water Retention

**Sinus/Respiratory**
0 1 2 3 4 5 Stuffy or Runny Nose
0 1 2 3 4 5 Asthma
0 1 2 3 4 5 Chest Congestion
0 1 2 3 4 5 Chronic Cough
0 1 2 3 4 5 Wheezing
0 1 2 3 4 5 Frequent Sneezing or Nasal Discharge

**Head/Ears**
0 1 2 3 4 5 Migraines
0 1 2 3 4 5 Headaches
0 1 2 3 4 5 Earaches
0 1 2 3 4 5 Sinus or Ear Infections
0 1 2 3 4 5 Ringing in Ears

**Eyes/Throat**
0 1 2 3 4 5 Itchy Eyes
0 1 2 3 4 5 Watery Eyes
0 1 2 3 4 5 Sore Throats or Colds
0 1 2 3 4 5 Persistent Canker Sores

**Emotional/Mental**
0 1 2 3 4 5 Depression
0 1 2 3 4 5 Anxiety
0 1 2 3 4 5 Mood Swings
0 1 2 3 4 5 Irritability
0 1 2 3 4 5 Poor Concentration/Memory

**Energy**
0 1 2 3 4 5 Fatigue
0 1 2 3 4 5 Hyperactivity
0 1 2 3 4 5 Lethargy
0 1 2 3 4 5 Restlessness
0 1 2 3 4 5 Insomnia

**Skin Disorders**
0 1 2 3 4 5 Eczema
0 1 2 3 4 5 Dermatitis
0 1 2 3 4 5 Excessive Sweating
0 1 2 3 4 5 Rashes
0 1 2 3 4 5 Hives

**Other Symptoms:**
0 1 2 3 4 5 Joint Pain
0 1 2 3 4 5 Arthritis
0 1 2 3 4 5 Irregular Heartbeat
0 1 2 3 4 5 Chest Pains
0 1 2 3 4 5 Muscle Aches

Please list any symptoms not mentioned above:
_____
_____
_____

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## TERMS OF ACCEPTANCE AND CONSENT FOR CARE

The clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific health care, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc).

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also understand that the fee paid for treatment x-rays is for analysis only. The file itself is the property of this office. Once films are taken, they cannot be released, but may be checked out.

I have read and I accept the terms above and understand them fully. I hereby give consent to the clinic to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

*I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.*

I, _____ have read and fully understand the above statements.

**(PRINT NAME)**

_____ _____

**(SIGNATURE)** **(DATE)**

**FOR MINORS:** I, _____ being the parent or legal guardian of

*(Print Guardian Name)*

_____,

*(Print Minor's Name)*

have read and fully understand the above terms of acceptance & grant permission for my child to receive treatment.

_____ _____

**X-ray Questionnaire: For women only** Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____ Date of last menstrual period: _____

There is a possibility that I may be pregnant at this time? ____Yes, I am definitely pregnant.
____ No, I am definitely not pregnant at this time. ____ I request that x-ray films not be taken because:

_____

_____

Patient's Signature: Date:

**(SIGNATURE)** **(DATE)**

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# PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient Manchester Chiropractic & Wellness Clinic, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the
Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Jackie Henry Office Manager. If you would like further information about our privacy policies and practices please contact: Jackie Henry Office Manager.

This notice is effective as of January 1, 2021, and any alterations or amendments made herein will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

***Name (Print)*** ***Signature*** ***Date***

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WE ARE HONORED YOU HAVE CHOSEN US FOR YOUR CHIROPRACTIC CARE. IN ORDER TO KEEP A COMPLETELY PROFESSIONAL AND UP FRONT BUSINESS RELATIONSHIP WITH OUR PATIENTS, WE ASK THAT YOU READ AND STATE THAT YOU UNDERSTAND OUR PAYMENT POLICY AND OUR INSURANCE POLICY. IF YOU DO NOT HAVE MEDICAL INSURANCE PLEASE SKIP DOWN TO THE LOWER HALF OF THE PAGE.

# PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

I understand that my insurance policy is a contract between my insurance company and myself. The contract is not between Dr. Manchester and my insurance company. I know that I am fully responsible for all charges resulting from services rendered to me.

In instances where pre-determinations are approved you may pay your co-payment and we will file for the remaining balance. However, if payment from your insurance company is not received within 120 days we will notify you of the balance due and your payment is expected in full at that time.

**If Insured**
If your insurance does not pay, i.e. due to the deductible not being met, referral needed, or out-of-network, you will be billed the difference of $50 and your co-pay. (Example: If you paid a co-pay of $35 on the date of service, you will be billed the difference of $15.00.)

Print Name: _____ Signature: _____ Date: _____

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**If Not Insured**
All co-pays and payments are due at the time of services. If any payment arrangements need to be made, please speak with our office manager (Jackie Henry).

Please sign and date that you understand and agree to our policy. If there are any questions please ask us before signing.

Thank You!!!

Print Name: _____ Signature: _____ Date: _____