Patient Name: _____ *Doctor:* _____ *Date:* _____

PLEASE FILL OUT COMPLETELY + LEGIBLY - CASE HISTORY / PATIENT INFORMATION / INTAKE FORM

*WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

How did you FIND our PHONE NUMBER? ___Friend told me ___Business Card ___Internet ___Phone Book:.....

Last Name .....First Name ..... Nick Name..... Middle Initial..... **Sex**: M / F

Date of Birth (DOB) ...../...../..... **SSN #** .....-.....-..... **Status**: Married / Partnered / Single / Widowed / Divorced

Address .....City .....State..... Zip .....

Home Phone:_____
Cell Phone: _____
Work Phone: _____
**Preferred Method of Contact:*
__Home __Cell __Work

E-mail address: ..... (for appointment reminder)

Occupation ..... Since ...../..... Employer .....

Spouse's Name ..... Phone#.....

Emergency Contact: ..... Relationship:..... Phone: .....

Previous Chiropractor..... Last Treatment ...../..... to ...../.....

City .....State..... For the same problems? YES / NO If yes, did it help? YES / NO

Family Medical Doctor..... City .....State .....

When doctors work together, it benefits you. May we contact your doctor(s) ? YES / NO.

(WOMEN Initial ____) I realize X-ray may be hazardous to an unborn child and I certify that I am not pregnant. Date last period:...../...../.....

The following person(s) have my PERMISSION TO ACCESS / RECEIVE my health information: (PLEASE PRINT CLEARLY)

Name..... Relationship..... Name..... Relationship.....

Name..... Relationship..... Name..... Relationship.....

Payment for Services will be by: ❑Cash/Credit Card ❑Health Insurance (enter below) ❑Automobile Ins. Claim#.....
Primary Insurance Company .....Plan Type ..... ID # .....

Who carries this policy? __Self __Spouse __Parent Insured's First, Last Name..... DOB...../...../.....
Supplementary / Secondary Insurance Company .....Plan Type ..... ID # .....

CREDIT GUARANTEE FOR CASH PATIENTS – Patients who are uninsured or whose insurance does not cover chiropractic care because of high deductibles or other limitations are personally responsible for payment. Payments may be paid at the time of service or on the last visit of the week. Weekly payments require a credit card guarantee. As a service to you (patient) and to keep your account current, any balance not paid by Friday will be automatically charged to your designated card below. This procedure will enable you to spread out your payments if you wish and make them smaller while keeping your account current. I agree to the above terms and authorize Pangemanan Chiropractic to charge any payment not paid by the end of each week to the above credit card.

CREDIT GUARANTEE FOR INSURANCE ASSIGNMENT - Your (patient's) insurance policy is an agreement between you and your insurance company. As a courtesy to you, the patient, we will bill your health insurance carrier on your behalf and wait up to 30 days for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you leave a credit card to guarantee payment. Any payments made on these claims thereafter will be refunded to you. By signing below you, the patient, agree and understand that should payment not be received within 30 days after submission of my claim, or should you terminate your scheduled care prematurely, you will be charged the amount due on the designated card below.

CREDIT CARD: ❑ VISA ❑ MASTERCARD ❑ DISCOVER ❑ AMEX

CARDHOLDER NAME: _____ CARD # _____EXP. DATE_____

ACKNOWLEDGEMENTS: (1) All of the health and personal information I entered on all forms from this office is complete and truthful and I understand that it is my responsibility to inform Pangemanan Chiropractic of any changes in my medical status or personal information. (2) If there is anyone I do not want access to my records or health information, I will inform Pangemanan Chiropractic in writing. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I authorize payment of benefits directly to Pangemanan Chiropractic. (3) I acknowledge that any insurance I may have is an agreement between the insurance company and me, and that I am responsible for the payment of any covered or non-covered services I receive. (4) I grant permission to be called to confirm or reschedule appointments and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office. (5) I may choose not to follow the doctors' advice and/or terminate my care at any time and take full responsibility of the consequences, such as relapse and/or worsening of my symptoms. (6) I have read, understood, accepted, and hereby consent to the terms on Pangemanan Chiropractic's Care Agreement, the Consent for Chiropractic Care, Financial Policy, Notice of Privacy Practices Pursuant To HIPAA and Consent for Use or Disclosure of Protected Health Information for the Purposes of Treatment, Payment and Healthcare Operations (HIPAA 2013). (7) I understand that there are no warranties, express or implied. I have had the opportunity to ask questions regarding anything that I do not understand. I hereby request chiropractic care and adjunctive services by *Pangemanan Chiropractic*.

Patient's Legal Signature: **X**_____ Guardian's Signature Authorizing Care _____ Date:_____

Pangemanan Chiropractic, 1004 Dewey Dr, Suite C, Lawrenceburg KY. Ph. 502-839-7171. www.839-7171.com

Patient Name: _____ *Doctor:* _____ *Date:* _____

(Signature must match Signature on Driver's License or Passport)

REVIEW OF SYSTEMS Have you had, or do you now have any of the following symptoms/conditions? **Mark N = Now P=Past**

CONSTITUTIONAL:	___Fainting	___Fast weight gain/loss	___Poor appetite	___Low libido	___Weakness
MUSCULOSKELETAL:	___Osteoporosis	___Scoliosis	___Neck Pain	___Back Problems	___Poor Posture
	___TMJ Issues	___Feet/ankle/knee pain	___Elbow/wrist pain	___Shoulder Problems	
NEUROLOGICAL:	___Dizziness	___Depression/Anxiety	___Headache	___Pins/Needles	___Numbness
CARDIOVASCULAR:	___Heart attack	___High / Low BP	___Stroke	___High Cholesterol	___Easy bruising
RESPIRATORY:	___Asthma	___Apnea	___Emphysema	___Difficult breathing	___Pneumonia
DIGESTIVE:	___Ulcer	___Diarrhea recurrent	___Food Allergy	___Heartburn	___Constipation
SENSORY:	___Blurred vision	___Ringing in ears	___Hearing Loss	___Loss of Smell	___Loss of Taste
INTEGUMENTARY:	___Skin cancer	___Psoriasis	___Eczema/ Rash	___Acne	___Hair Loss
ENDOCRINE:	___Hypoglycemia	___Thyroid disorder	___Immune disorder	___Swollen glands	___Low energy
GENITOURINARY:	___Infertility	___ Erectile dysfunction	___Bedwetting	___ Kidney stones	___PMS symptoms

FAMILY / MEDICAL HISTORY Please mark **S (self), or M (Mother), F (Father), B (Brother), S (Sister)** on any of these conditions:

___AIDS/HIV positive	___Bladder Trouble	___Depression	___Insomnia	___Neck Pain
___Anemia	___Cancer	___Dislocated Joints	___Kidney Disorders	___Poor Circulation
___Arthritis	___Chest Pain	___Epilepsy	___Bowel Control Loss	___Polio
___Asthma/Hay Fever	___Concussions	___Headache/Migraine	___Mental Illness	___Reproductive Disorders
___Back Pain	___Convulsions	___Heart Trouble	___Muscular Dystrophy	___Scoliosis
___Bone Fracture	___Diabetes	___Hepatitis	___Multiple Sclerosis	___Sinus Trouble
___Bursitis	___Emphysema	___High Blood Pressure	___Neuritis/Neuralgia	___Spinal Surgery

Any congenital / hereditary / genetic health issues you know about? .....

Any health condition you've been treated by a physician in the last year: .....

MEDICATIONS / SUPPLEMENTS *(name, what for)* .....

SURGICAL HISTORY:*(What kind, month/year)*.....

*For women, please include information on *childbirth(s)* + dates: .....

ACCIDENT / INJURY HISTORY: *(Month/year)* ❑Job ❑Auto ❑Other .....

__Bone(s) fractured:..... __Spine/Nerve Disorder __Knocked Unconscious __Used crutch/ neck/back brace

.....

SOCIAL HISTORY Tell us about your **health habits** and **stress levels**:

Alcohol use:	__Daily	__Weekly	How much? _____	Prayer / Meditation:	❑Yes / ❑No
Coffee use:	__Daily	__Weekly	How much? _____	Job Pressure / Stress:	❑Yes / ❑No
Tobacco use:	__Daily	__Weekly	How much? _____	Financial Peace:	❑Yes / ❑No
Exercising:	__Daily	__Weekly	How much? _____	Breakfast:	❑Yes / ❑No
Painkillers:	__Daily	__Weekly	How much? _____	Recreational drugs:	❑Yes / ❑No

IN REGARDS TO YOUR **PRESENT** CHIEF COMPLAINTS:

Have you ever had the same or a similar condition in the past? ❑ Yes ❑ No

If yes, when and describe.....

.....

Name and Location of Doctors Recently / Previously Seen for these condition(s):.....

.....

Have you had any **X-rays, CT or MRI** or any tests taken for this problem(s) in the last 2 years?

❑Yes / ❑No *(If yes, our doctors need to have the written radiology reports. Ask to fax to 502-517-4754)*

What were the results: .....

#Days lost from work.....

What is the major stressor in your life? .....

What additional health goals do you have? .....

*In a scale of zero (0=No Interest) to ten (10=Fully Committed), **how serious and committed** are you in correcting your problems? CIRCLE A NUMBER: **0 1 2 3 4 5 6 7 8 9 10**

ADL. Rate ZERO (0) to FIVE (5) on how your symptoms interfere with your life and ability to function:

___Sitting ___Standing

___Driving ___Shower/Bath

___Yardwork ___Dressing

___Sleeping ___Love life

___Reaching overhead

___Computer Use

___Grocery shopping

___Exercising

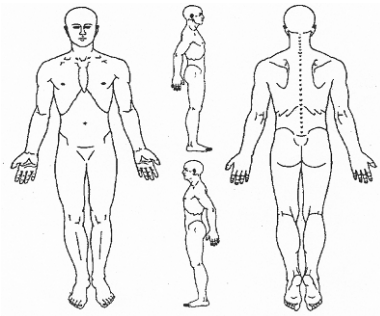
___Household Chores

___Caring for family

Patient Name: _____ Doctor: _____ Date: _____

Please mark accordingly:

Numbness	- - - - -
Tingling	O O O
Burning	^ ^ ^ ^
Aching	X X X
Stabbing	



Box Reserved for Doctor's Notes

- What is your **MAJOR COMPLAINT (#1)**? Where?.....

e. This is the result of: ☐Unknown ☐ Auto accident ...../...../.....

☐Gradual onset ☐Job related ..../...../....

.....

f. ***ONSET***. When did you first notice your current symptoms:
___days # ___weeks # ___months #___years ago

g. What makes it **WORSE**? ☐Lying down ☐Driving ☐Walking ☐Reaching ☐Twist

☐Standing ☐Standing after ___minutes ☐Bend ☐ Lift ☐ Exercising

☐Sitting ☐Sitting after ___ minutes ☐Sneezing ☐Turning Head ☐Defecating

h. What makes it **BETTER**? ☐ Ice ☐Heat ☐Resting ☐Standing ☐Sitting ☐Sleep/Rest

☐Lean forward ☐Lean to R / L side ☐Painkiller .....

e. ***QUALITY***. What does it feel like? __Achy __Sharp stabbing __Numb
__Tingling __Stiff / Cramps __Burning __Throbbing

f. ***RADIATE***. Does the pain shoot/travel/radiate to other body parts? Where? .....

g. ***SEVERITY***. Rate your symptoms intensity from zero (absent) to ten (excruciating):
0 1 2 3 4 5 6 7 8 9 10

h. **TIMING**. How often do you feel it? ☐Come+Go ☐Frequent ☐Constant

☐Getting Worse ☐Getting Better ☐Stay the same

i. Past interventions to relieve symptoms: __ Chiropractic __ Physical Therapy __Massage

Additional Info: .....

- What is your **SECONDARY COMPLAINT (#2)**? Where?.....

e. This is the result of: ☐Unknown ☐ Auto accident ...../...../..... ☐Gradual onset ☐Job related ..../...../....

.....

f. ***ONSET***. When did you first notice your current symptoms: # ___days # ___weeks # ___months #___years ago

g. What makes it **WORSE**? ☐Lying down ☐Driving ☐Walking ☐Reaching ☐Twist ☐Standing ☐Standing after ___minutes

☐Bend ☐ Lift ☐ Exercising ☐Sitting ☐Sitting after ___ minutes ☐Sneezing ☐Turning Head ☐Defecating

h. What makes it **BETTER**? ☐ Ice ☐Heat ☐Resting ☐Standing ☐Sitting ☐Sleep/Rest ☐Lean forward/ right /left

☐Painkillers / Medicines .....

i. ***QUALITY***. What does it feel like? __Achy __Sharp stabbing __Numb __Tingling __Stiff / Cramps __Burning __Throbbing

j. ***RADIATE***. Does the pain shoot/travel/radiate to other body parts? Where? .....

k. ***SEVERITY***. Rate your symptoms intensity from zero (absent) to ten (excruciating): **0 1 2 3 4 5 6 7 8 9 10**

l. **TIMING**. How often do you feel it? ☐Come+Go ☐Frequent ☐Constant ☐Getting Worse ☐Getting Better ☐Stay the same

i. Past interventions to relieve symptoms: __ Chiropractic __ Physical Therapy __Massage

Additional Info: .....

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