Health Record # _____

Alexander Chiropractic Center

22930 Three Notch Rd, California, MD 20619 * 301-737-4007
14350 Solomons Island Rd, Suite 103A, Solomons, MD 20688-1269 * 410-394-1000

Confidential Health Questionnaire

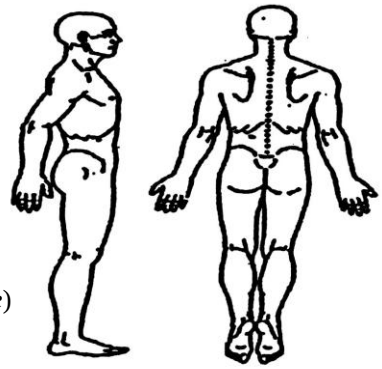
Patient Name: _____ **Date of Birth:** _____ **Date**: _____

Present Complaint(s): _____

1. Have you ever been in an automobile accident? □ No □ Yes, when_____

2. Have you ever been injured at work? □ No □ Yes, when_____

3. Indicate on the drawings below where you have pain/symptoms:



4. Please select all that apply: □Sharp □Dull □Achy □Burning □Stiff
□Numbness □Shooting □Tingly □Radiating □Soreness □Stabbing □Other
□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

5. Intensity of your symptoms: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable) (*Please circle*)

6. How do you think your problem began?_____

7. How long have you had this problem? _____ days _____ months _____ years

8. How are your symptoms changing with time? □ Getting Worse □ Staying the Same □ Getting Better

9. What aggravates your problem?_____

10. What alleviates your problem?_____

11. Have you had this problem before? _____

12. How much has the problem interfered with your work?
□ Not at all □ A little bit □ moderately □ Quite a bit □ extremely

13. How much has the problem interfered with your sleep?
□ Not at all □ A little bit □ moderately □ Quite a bit □ extremely

14. How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

15. This problem prevents me from:_____

16. Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Massage Therapist □ Primary Care Physician □ No one
□ ER physician □ Orthopedist □ Physical Therapist □ Other: _____

17. How would you rate your overall Health? □ Excellent □ Very Good □ Good □ Fair □ Poor

18. What level of exercise do you do? □ Strenuous □ Moderate □ Light □ None

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19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependence
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash/skin condition/acne
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss	□	□	STD'S
□	□	Ankle/Foot Pain	□	□	Loss of Appetite	□	□	Thyroid Problems
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Excessive Fatigue
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Unusual Hair Growth
□	□	Arthritis	□	□	Hepatitis	□	□	Hair Loss
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder	□	□	Inability to Loose/Gain Weight
□	□	Cancer	□	□	General Fatigue	□	□	Excessive Mood Swings
□	□	Tumor	□	□	Muscular Incoordination	□	□	Hot Flashes or Night Sweats
□	□	Asthma	□	□	Visual Disturbances	□	□	Mental Fog
□	□	Chronic Sinusitis	□	□	Dizziness / Mental Fog			
□	□	Other:_____						

For Females ONLY:

□	□ Birth Control Pills	□	□ Hormonal Replacement	□	□ Pregnancy _____weeks
□	□ Heavy/painful Menstrual Cycle	□	□ Irregular Menstrual Cycle		

20. Have you ever had any surgery: □ No □ Yes _____

21. Have you ever been hospitalized? □ No □ Yes, why_____

22. Have you had significant past trauma? □ No □ Yes

23. Indicate if you have any immediate family members with any of the following: □ Stroke □ High Blood Pressure □ Rheumatoid Arthritis □ Diabetes □ Lupus □ Heart Problems □ Cancer □ ALS

24. Primary care doctor and phone number: _____

25. Please list any medications including over the counter: _____

_____

26. Smoking Status (circle one): every day smoker / occasional smoker / former smoker / never smoked

27. Anything else pertinent to your visit today? _____

Print Name: _____

Patient / Guardian Signature:_____ Date:_____

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PLEASE PRINT ALL INFORMATION ***Patient Information***

First Name: _____ Last Name: _____MI: ___ Preferred Name:_____

Date of Birth: ____/_____/____ AGE: _____ SSN: ___-__-_____ ( ) Male ( ) Female

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: ( ) _____ ( ) _____ ( ) _____
(Home) (Work) (Cell)
Email address: _____@_____

May we leave a voicemail regarding detailed information? Y/N May we email regarding detailed information? Y/N

Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced

Emergency Contact: _____ Relationship: _____ Contact Phone:_____

How were you Referred: _____; if by a patient what is the patient's name: _____

Preferred Language:_____ Race:_____ Ethnicity:_____

Health Insurance Information: (Please complete if you have insurance.)

Primary Health Insurance:
Company: _____ PPO / HMO / Fed / EMO / POS Insured Name: _____
Relationship to patient: Self / Spouse / Child / Other _____ Insured DOB: _____
Policy #: _____ Group #: _____ Insured SSN: _____
Claim #: _____ Insurance Phone: _____ Insured Employer: _____

Secondary Health Insurance:
Company: _____ PPO / HMO / Fed / EMO / POS Insured Name: _____
Relationship to patient: Self / Spouse / Child / Other _____ Insured DOB: _____
Policy #: _____ Group #: _____ Insured SSN: _____
Claim #: _____ Insurance Phone: _____ Insured Employer: _____

Please Read *Before* Signing – Signature on File Statement.
I hereby give my permission to the doctor to perform such procedures and administer treatment as he may deem medically/chiropractically necessary in the diagnosis and/or treatment of my condition. I agree to participate in medical and therapy treatments by this provider and accept that no guarantee of results or outcome is expressed. I authorize use of this form on all of my insurance submissions. I authorize release of information to all of my insurance companies. I authorize payment directly to **Alexander Chiropractic Center**. I permit a copy of this authorization to be used in place of the original. I understand that my insurance coverage is a contract between my insurance co. and myself and that **Alexander Chiropractic Center** will submit claims on my behalf but will not be responsible for filing appeals or disputing rejections. I agree with the above requirements and request that **Alexander Chiropractic Center** submit claims on my behalf. I understand that I am responsible for all charges incurred regardless of my insurance status. I understand that there will be a $50.00 fee for all returned checks. I understand there will be a $15.00 broken appointment fee if 24 hours notice is not given.

_____ _____ _____
Patient Signature Parent / Guardian Signature Today's Date

Alexander Chiropractic Center

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Fax: 410-394-6800

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Fax: 301-737-4003

Authorization To Pay Physician

I, _____, hereby authorize the _____ insurance company to pay by check made out and mailed directly to:

Alexander Chiropractic Center
PO Box 1269
Solomons, Maryland 20688

The medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above-mentioned assignee, and I agree to pay, in a current manner, the balance of said professional service charges over and above this insurance payment.

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

_____
C/O Alexander Chiropractic Center
PO Box 1269
Solomons, Maryland 20688

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this assignment shall be considered as effective and valid as the original.

I understand that ultimately I am financially responsible for all services rendered to me.

I hereby give my permission to **Alexander Chiropractic Center** to release any information requested by my insurance company acquired in the course of my examination and treatment.

I hereby give my permission to **Alexander Chiropractic Center** to file formal grievances with the Maryland Insurance Commissioner when necessary on my behalf, should my insurance company deny payment of all or part of my medical bills.

_____
Patient / Guardian Signature

_____
Today's Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received ALEXANDER CHIROPRACTIC CENTER'S Notice of Privacy Practices for protected health information.

Date: _____ Name of Patient:_____
Print Name

_____
Signature of Patient/Personal Representative