CARR
Chiropractic Clinic
A FAMILY PRACTICE

OFFICE USE ONLY
Patient No.:____________
Date: ____________________

APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. **(PLEASE PRINT)**

First Name_________________________ M.I. ___ Last Name __________________________________ Sex: M F

Home Phone ____________________ Work Phone ___________________ Cell Phone _______________________

E-Mail Address ____

Address ___________________________________ City ____________________ State ________ Zip ___________

Birth date _____________________ Age _____ Marital Status: S M W D Number of Children _____

Driver's License # ___________________ Social Security # _________________________

Your Employer ________________________________ Occupation _____________________Years On Job ____

Employer Address ________________________________ City _______________________ State _____ Zip ______

Do you have Medicare? Yes ____ No ____ Do you have Medicaid? Yes ____ No ____

Insurance Company ________________________________ Insured's Name: _________________________________

Relationship: ________________ Insured's Birth date: ________________ Insured's SS#: ___________________

Insured Employed By: __________________________________ Occupation: ________________________________

Employer Address ___________________________________ City _____________________State _____ Zip _____________

Office Phone # ____________________ Years On Job _____

COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, constant, off & on, when standing, when sitting, etc………

MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)

____
____
____
____
____
____
____
____

(TURN OVER)

Whom may we thank for referring you to our office?

____

How payment will be made:

__________ Cash __________ Worker's Comp. __________Health Insurance

__________ Check __________ Credit Card __________Automobile Insurance Policy

Is your condition due to an accident? Yes _____ No _____ Date of accident? ____________________

Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____________________

Have you ever been in an auto accident? Past Year ____ Past 5 Years ____ Over 5 Years ____ Never ____

FINANCIAL POLICY

We want you to feel comfortable with our office regarding your financial and insurance matters and thereby prevent misunderstandings. We believe you, our patients, expect and deserve the highest quality care we can provide at a reasonable cost. While we take advantage of every possible avenue to keep costs down, we are committed to not sacrificing quality for less expensive care. Please feel free to contact us if you have any questions regarding our services or our financial policies.

INSURANCE

1. You are ultimately responsible for your bill regardless of insurance coverage.
    a. Many people are under the impression if they have insurance, it is the insurance company that owes the doctor for services. This is NOT the case. The insurance contract is between the patient and the insurance company.
2. As a **courtesy**, we will attempt to contact your insurance company for benefit verification. Verbal confirmation is NOT a guarantee of benefits or payment, as exclusions and limitations apply.

It is your responsibility to know your policy. It is your responsibility to pay any deductible amount, co-pay, or any other balance not covered by your insurance plan.

- All co-pays and deductibles must be paid at the time of your appointment. We will estimate as close as possible what your treatment's "patient portion" or "out -of- pocket" expense will be. If there is any difference after we receive final payment from your insurance company, you will receive a statement for the balance for which you are responsible or a credit to your account.
- All charges are your responsibility regardless of if your insurance pays or not. Not all services are a covered benefit in all contracts.
- We will make every attempt to get payment from your insurance company, however any balance unpaid by insurance after 90 days will become your responsibility. We suggest following up with your insurance company if payment has not been made within 60 days.
- Delinquent accounts will be considered for referral to a collection agency at the discretion of the billing manager.

Full payment for services rendered is due at the end of each visit.

For individuals with insurance, your signature below hereby authorizes your insurance benefits to be paid directly to Dr. Michelle M. Carr, D.C. It also authorizes the doctor to release any information required for the payment and processing of this claim. Please sign below to acknowledge your understanding and agreement of the information above

Patient /Guardian Signature: ____ Date: ______________________

(TURN OVER)

Confidential Patient Case History

Name ______________________________ Date ________________

Please check the appropriate box for any of the following symptoms which you now currently have or have had previously.

C – CURRENT P - PAST

CONSTITUTIONAL

☐ DENY ALL

C P
- ☐ ☐ Chills
- ☐ ☐ Drowsiness
- ☐ ☐ Fainting
- ☐ ☐ Fatigue
- ☐ ☐ Fever
- ☐ ☐ Night Sweats
- ☐ ☐ Weakness
- ☐ ☐ Weight Gain
- ☐ ☐ Weight Loss

INTEGUMENTARY

☐ DENY ALL

C P
- ☐ ☐ Breast Lumps / Pain
- ☐ ☐ Changes in Skin Color
- ☐ ☐ Eczema
- ☐ ☐ Hair Loss
- ☐ ☐ Hives or Rash
- ☐ ☐ Itching
- ☐ ☐ Paresthesia
- ☐ ☐ Skin Lesions

NEUROLOGICAL

☐ DENY ALL

C P
- ☐ ☐ Changes in Concentration
- ☐ ☐ Change in Memory
- ☐ ☐ Dizziness
- ☐ ☐ Headache
- ☐ ☐ Imbalance
- ☐ ☐ Loss of Memory
- ☐ ☐ Numbness
- ☐ ☐ Seizures
- ☐ ☐ Sleep Disturbance
- ☐ ☐ Slurred Speech
- ☐ ☐ Stress
- ☐ ☐ Stroke
- ☐ ☐ Tremors

ENDOCRINE

☐ DENY ALL

C P
- ☐ ☐ Cold Intolerance
- ☐ ☐ Diabetes
- ☐ ☐ Excessive Appetite
- ☐ ☐ Excessive Hunger
- ☐ ☐ Excessive Thirst
- ☐ ☐ Goiter
- ☐ ☐ Heat Intolerance
- ☐ ☐ Voice Changes

EYES

☐ DENY ALL

C P
- ☐ ☐ Blindness
- ☐ ☐ Blurred Vision
- ☐ ☐ Cataracts
- ☐ ☐ Change in Vision
- ☐ ☐ Double Vision
- ☐ ☐ Dry Eyes
- ☐ ☐ Eye Pain
- ☐ ☐ Glaucoma
- ☐ ☐ Sensitivity to Light
- ☐ ☐ Tearing
- ☐ ☐ Wears Glasses

GASTROINTESTINAL

☐ DENY ALL

C P
- ☐ ☐ Abdominal Pain
- ☐ ☐ Belching
- ☐ ☐ Black, Tarry Stools
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Heartburn
- ☐ ☐ Hemorrhoids
- ☐ ☐ Indigestion
- ☐ ☐ Jaundice
- ☐ ☐ Nausea
- ☐ ☐ Rectal Bleeding
- ☐ ☐ Vomiting
- ☐ ☐ Vomiting Blood

PSYCHIATRIC

☐ DENY ALL

C P
- ☐ ☐ Agitation
- ☐ ☐ Anxiety
- ☐ ☐ Appetite Changes
- ☐ ☐ Behavioral Changes
- ☐ ☐ Bipolar Disorder
- ☐ ☐ Confusion
- ☐ ☐ Convulsions
- ☐ ☐ Depression
- ☐ ☐ Homicidal Indication
- ☐ ☐ Insomnia
- ☐ ☐ Location Disorientation
- ☐ ☐ Substance Abuse
- ☐ ☐ Suicidal Indication
- ☐ ☐ Time Disorientation

CARDIOVASCULAR

☐ DENY ALL

C P
- ☐ ☐ Angina
- ☐ ☐ Chest Pain
- ☐ ☐ Claudication
- ☐ ☐ Heart Murmur
- ☐ ☐ Heart Problems
- ☐ ☐ High Blood Pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Orthopnea
- ☐ ☐ Palpitations
- ☐ ☐ Shortness of Breath
- ☐ ☐ Swelling of Legs
- ☐ ☐ Varicose Veins

GENITOURINARY

☐ DENY ALL

C P
- ☐ ☐ Burning Urination
- ☐ ☐ Erectile Dysfunction
- ☐ ☐ Frequent Urination
- ☐ ☐ Hesitancy/ Dribbling
- ☐ ☐ Hormone Therapy
- ☐ ☐ Lack of Bladder Control
- ☐ ☐ Prostate Problems
- ☐ ☐ Urine Retention

FOR WOMEN ONLY
- ☐ ☐ Congested Breasts
- ☐ ☐ Cramps or Backache
- ☐ ☐ Heavy Menstrual Flow
- ☐ ☐ Hot Flashes
- ☐ ☐ Irregular Cycle
- ☐ ☐ Menopausal Symptoms
- ☐ ☐ Painful menstruation
- ☐ ☐ Vaginal discharge

Are You Pregnant ☐ Yes ☐ No

HEMATOLOGIC/ LYMPHATIC

☐ DENY ALL

C P
- ☐ ☐ Anemia
- ☐ ☐ Blood Clotting
- ☐ ☐ Blood Transfusions
- ☐ ☐ Bruise Easily
- ☐ ☐ Lymph Node Swelling

MUSCULOKELETAL

☐ DENY ALL

C P
- ☐ ☐ Arthritis
- ☐ ☐ Neck Pain
- ☐ ☐ Decreased Motion
- ☐ ☐ Gout
- ☐ ☐ Joint Pain
- ☐ ☐ Joint Stiffness
- ☐ ☐ Back Pain
- ☐ ☐ Muscle Pain
- ☐ ☐ Muscle Weakness
- ☐ ☐ Swelling

ENMT

☐ DENY ALL

C P
- ☐ ☐ Bad Breath
- ☐ ☐ Deviated Septum
- ☐ ☐ Difficulty Swallowing
- ☐ ☐ Dry Mouth
- ☐ ☐ Ear Drainage
- ☐ ☐ Ear Pain
- ☐ ☐ Frequent Sore Throat
- ☐ ☐ Head Injury
- ☐ ☐ Hearing Loss
- ☐ ☐ Hoarseness
- ☐ ☐ Loss of Smell
- ☐ ☐ Loss of taste
- ☐ ☐ Nasal Congestion
- ☐ ☐ Nose Bleeds
- ☐ ☐ Post Nasal Drip
- ☐ ☐ Sinus Infections
- ☐ ☐ Runny Nose
- ☐ ☐ Ringing in Ears
- ☐ ☐ TMJ Problems
- ☐ ☐ Ulcers

ALLERGIC/ IMMUNOLOGIC

☐ DENY ALL

C P
- ☐ ☐ History of Anaphylaxis
- ☐ ☐ Itchy Eyes
- ☐ ☐ Sneezing
- ☐ ☐ Specific Food Intolerance

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- ☐ Alcohol/ Drug Abuse
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Chorea
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

PLEASE PRINT

What's your major complaint? ____

____

List surgical operation and years: ____

____

Drugs you now take: ☐ Anti-Depressants ☐ Pain Killers ☐ Muscle Relaxers ☐ ADHD Medication ☐ Anxiety Medication ☐ Birth Control Pills

Others: ____

Age of mattress: __________________ ☐ Comfortable ☐ Uncomfortable ☐ Do you use a bed board? _________

Are you wearing: ☐ Heal lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never

Describe: ____

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? ______________________

Family History Of : ☐ Heart Disease ☐ Stroke ☐ High Blood Pressure ☐ Diabetes ☐ Mental/Emotional Disorder ☐ High Cholesterol

☐ Cancer: ______________________

HAVE YOU EVER:	Yes	No	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	______________________
Used a cane, crutch, or other support?	☐	☐	______________________
Been treated for a spine or nerve disorder?	☐	☐	______________________
Had a fractured bone?	☐	☐	______________________
Been hospitalized for anything other than surgery?	☐	☐	______________________

DO YOU:			
Now take vitamins or minerals?	☐	☐	______________________
Think you may need vitamins or minerals?	☐	☐	______________________
Have an allergy to any drug?	☐	☐	______________________

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X- ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
	☐	☐	☐	☐

IN CASE OF EMERGENCY: (Name of relative or close friend **not** living in your home):

NAME ______________________________ RELATIONSHIP ______________________

ADDRESS: ______________________________ PHONE: ______________________