PERRAS CHIROPRACTIC
Dr. Michael Perras

~WELCOME~

PATIENT INFORMATION

First Name _____ Middle _____ Last _____

Male ____ Female ____ Date of Birth _____ Social Security Number _____-_____-_____

Home Phone _____ Cell Phone _____ Work Phone _____

Address _____

City _____ State _____ Zip _____ Marital Status - S M W D

Email Address _____

Spouse's Name _____ Date of Birth _____ Social Security Number _____-_____-_____

Person Responsible for This Account _____

Name of Person on Your Health Insurance Card _____

Name of Their Employer _____ City _____ Phone _____

Children - Names & Ages _____

_____

Emergency Contact _____

Phone _____ Family Physician _____

What is your primary complaint? _____

_____

Is this Workman's Compensation? _____ Personal Injury? _____

Patient Informed Consent

I, _____, the undersigned, consent to care at this clinic. I understand that I have the opportunity to discuss with the doctor and/or with other office personnel, the nature and purpose of chiropractic adjustments and progressive wellness. I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy and any supportive therapies on me (or the patient above, for whom I am legally responsible) by the doctor of chiropractic and support team at Perras Chiropractic. I also understand that as is with all healthcare treatments, results are not guaranteed, there is no promise to cure and that there are some risks. Risks include, but are not limited to, aggravating and/or temporary increase in symptoms, muscle spasms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor's judgement, based upon the facts then known, in my best interests. I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures.

Patient Signature _____

Perras Chiropractic
CASE HISTORY

Name:_____ D.O.B:____/____/_____ Today's Date:____/____/_____

How did you hear about us? _____ Profession: _____

Are you currently pregnant or nursing? ___ Yes ___ No Do you currently see a chiropractor? ___ Yes ___ No

Chief Complaint and its location:_____

If this pain radiates or travels, please identify where to: _____

How often do you have this pain? ___Constant ___Frequent ___Intermittent ___Occasional

How would you describe the sensation of the pain/symptom:

___Aching ___Burning ___Dull ___Diffuse ___Numb ___Sharp ___Shooting

___Stiff ___Tingling ___Sharp w/ Motion ___Stabbing w/ Motion ___Electric Like

Over the past weeks/months this complaint is: ___Improving ___Getting Worse ___About the same

Please rate the following on a scale of 0-10 (with 0 representing no pain and 10 being the most severe pain imaginable).

Sitting here today, right now, what is the intensity of your pain? 0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been? _____ What is the most intense the symptom has been? _____

How much does this interfere with work? ___Not at all ___A little bit ___Moderately ___Quite a bit ___Extremely

How much does this interfere with your social life? ___Not at all ___A little bit ___Moderately ___Quite a bit ___Extremely

Have you seen anyone for this condition? ___YES ___NO WHOM?_____

What caused the onset?_____

Date of onset? _____

Do you consider this problem to be severe? ___ Yes ___ Yes, at times ___ No

<u>What aggravates the pain/symptom?</u>

___Working @ computer ___Nothing ___Bending ___Driving Car ___Flexing & Extending ___Golfing ___Painting

___Playing ___Running ___Sitting ___Sleeping ___Stairs (climbing) ___Standing Up ___ Standing (long time)

___Stress ___Traveling ___Walking ___Weather Changes ___@ work ___Working Out

Other:_____

<u>What relieves the pain/symptom?</u>

___ Adjustments ___Analgesic Cream ___Bending Forward ___Exercising ___Heat ___Ice ___Lying Face Down

___Lying on Side ___Massage ___Muscle Relaxers ___NSAID ___Pilates ___Prescription Pain Meds ___Resting ___Standing

___Stretching ___Swimming ___T.E.N.S. Unit ___Tylenol ___Walking ___Warm bath ___Orthotics ___Yoga ___Nothing

Other:_____

<u>What concerns you most about this condition?</u>

___ It isn't going away ___ It is getting worse ___ It is affecting friends/family ___ It is affecting leisure time

Other _____

Overall Health Rating: ___Excellent ___Very Good ___Good ___Fair ___Poor

Regular Exercise: ___Strenuous ___Moderate ___Light ___None

Family History: ___ALS ___Cancer ___Diabetes ___Heart Problems ___Lupus ___RA

Perras Chiropractic
CASE HISTORY

Please place a check mark by the condition that applies to you:

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
☐	☐	Headaches	☐	☐	Tumor	☐	☐	Hepatitis
☐	☐	Neck Pain	☐	☐	Asthma	☐	☐	Liver / Gall Bladder Disorder
☐	☐	Upper Back Pain	☐	☐	Chronic Sinusitis	☐	☐	General Fatigue
☐	☐	Mid Back Pain	☐	☐	High Blood Pressure	☐	☐	Muscular Incoordination
☐	☐	Low Back Pain	☐	☐	Heart Attack	☐	☐	Visual Disturbances
☐	☐	Shoulder Pain	☐	☐	Chest Pains	☐	☐	Dizziness
☐	☐	Elbow/Upper Arm	☐	☐	Stroke	☐	☐	Diabetes
☐	☐	Wrist Pain	☐	☐	Angina	☐	☐	Excessive Thirst
☐	☐	Hand Pain	☐	☐	Kidney Stones	☐	☐	Frequent Urination
☐	☐	Hip Pain	☐	☐	Kidney Disorders	☐	☐	Smoking / Tobacco Use
☐	☐	Upper Leg Pain	☐	☐	Bladder Infection	☐	☐	Drug / Alcohol Dependence
☐	☐	Knee Pain	☐	☐	Painful Urination	☐	☐	Allergies
☐	☐	Ankle / Foot Pain	☐	☐	Loss of Bladder Control	☐	☐	Depression
☐	☐	Jaw Pain	☐	☐	Prostate Problems	☐	☐	Systemic Lupus
☐	☐	Joint Pain / Stiffness	☐	☐	Abdnormal Weight Gain	☐	☐	Epilepsy
☐	☐	Arthritis	☐	☐	Loss of Apetite	☐	☐	Dermatitis / Eczema / Rash
☐	☐	Rheumatoid Arthritis	☐	☐	Abdominal Pain	☐	☐	HIV / AIDS
☐	☐	Cancer	☐	☐	Ulcer			

Please list past surgeries:

1. _____ Year _____
2. _____ Year _____
3. _____ Year _____
4. _____ Year _____

List any other key slips, falls or accidents you've had from childhood to present: (Include Date)	Have you ever taken:	YES	YEAR	NO
1)	Insulin:			
2)	Cortisone:			
3)	Thyroid Medicine			
4)	Male/Female Hormones			
5)	Blood Pressure			
What Medications are you currently taking? (Include Date)	Tranquilizers/Sedatives			
1) 2)	Birth Control			
3) 4)				
5) 6)				
Hospitalizations:				

Work Activites:

1. *Sitting* ___Most of the day ___Half of the day ___A little of the day ___None
2. *Standing* ___Most of the day ___Half of the day ___A little of the day ___None
3. *Computer Work* ___Most of the day ___Half of the day ___A little of the day ___None
4. *On the Phone* ___Most of the day ___Half of the day ___A little of the day ___None
5. *Driving* ___Most of the day ___Half of the day ___A little of the day ___None
6. *Manual Labor* ___Most of the day ___Half of the day ___A little of the day ___None
7. *Reading* ___Most of the day ___Half of the day ___A little of the day ___None
8. *Traveling* ___Most of the day ___Half of the day ___A little of the day ___None

Hours of Sleep: ___Less than 6 ___6 ___8 ___10 ___More Than 10

What do you enjoy doing most in your life? _____

Patient Signature: _____ Doctor Signature: _____

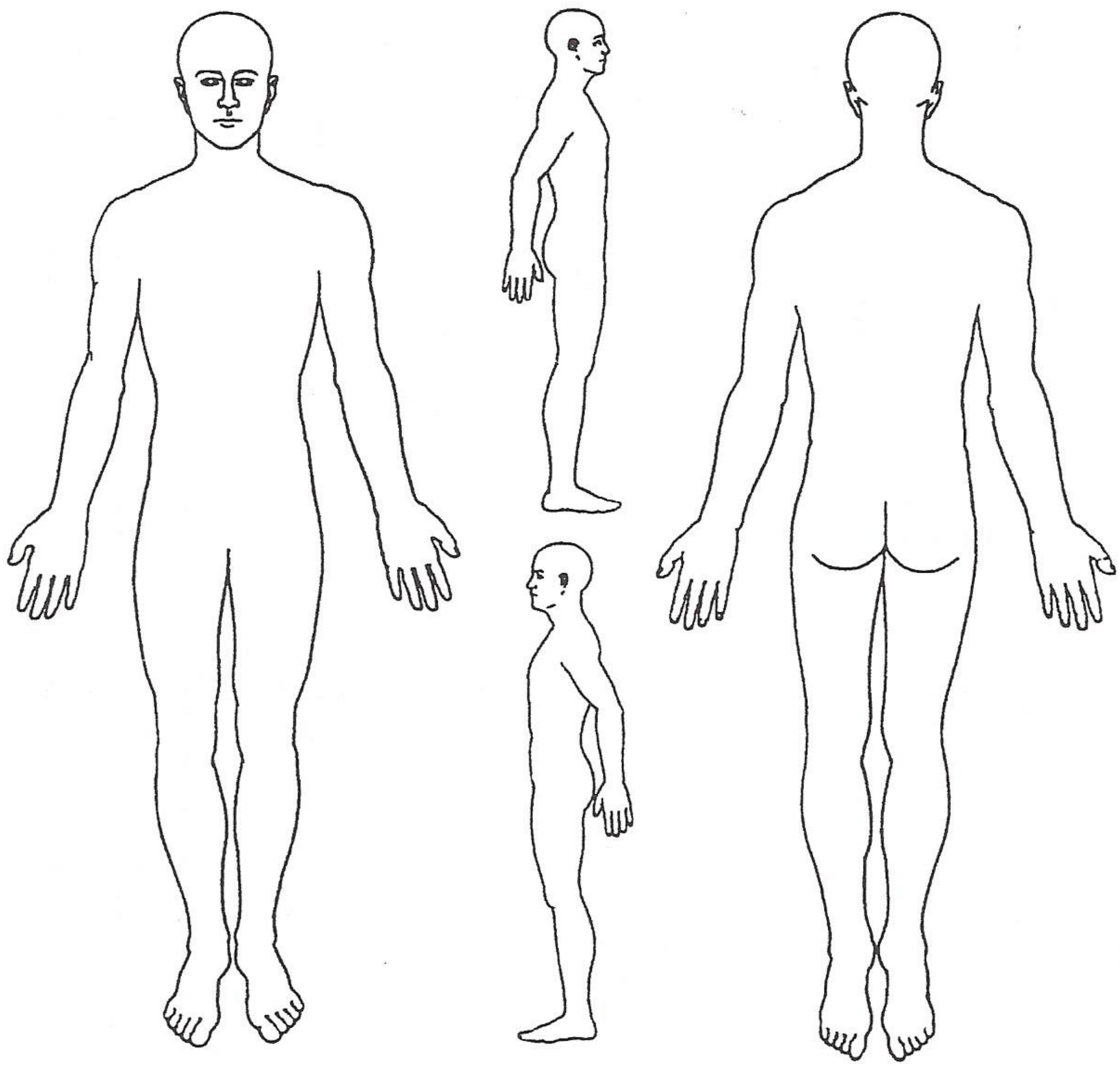
PATIENT PAIN FORM

NAME: ______________________________

AGE: ________ DATE OF BIRTH: ________________ OCCUPATION: ________________

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas.

Numbness	Dull Ache	Hot Burning	Sharp Stabbing	Pins & Needles
= = =	OOO	XXX	/ / /	+ + +



Please mark on this line the level or intensity of pain that you are presently experiencing.

No Pain ▬▬▬▬▬▬▬▬▬▬▬▬▬▬▬▬▬▬▬▬ Worst Possible Pain

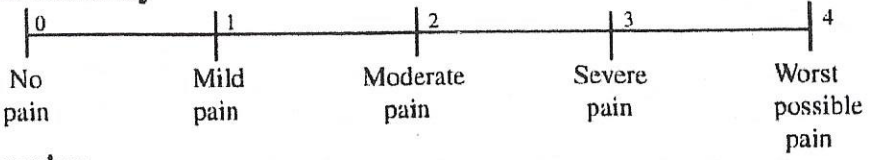
Signed: ______________________________ Date: ________________

Functional Rating Index

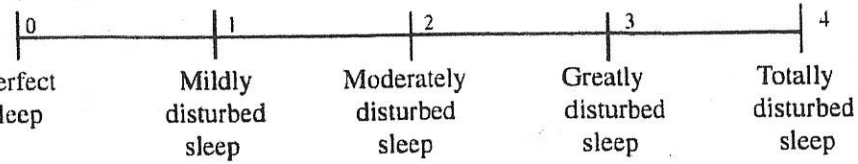
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

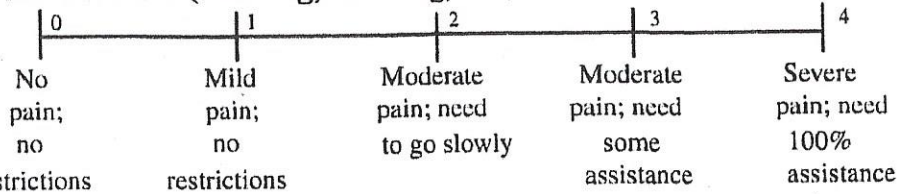
1. Pain Intensity



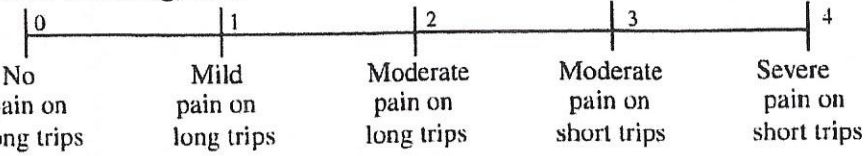
2. Sleeping



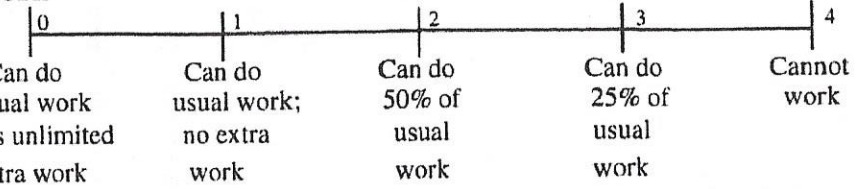
3. Personal Care (washing, dressing, etc.)



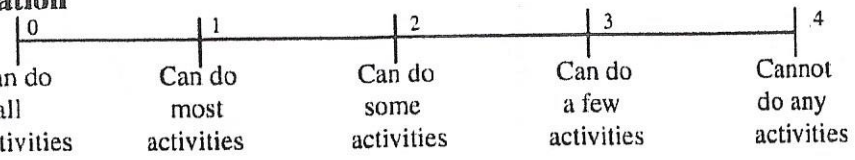
4. Travel (driving, etc.)



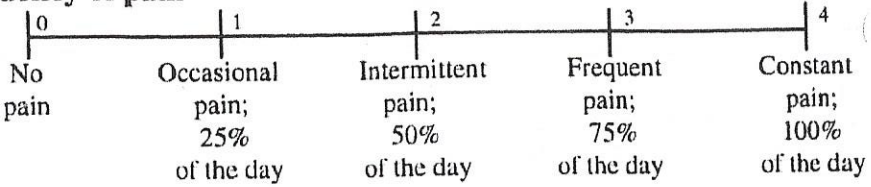
5. Work



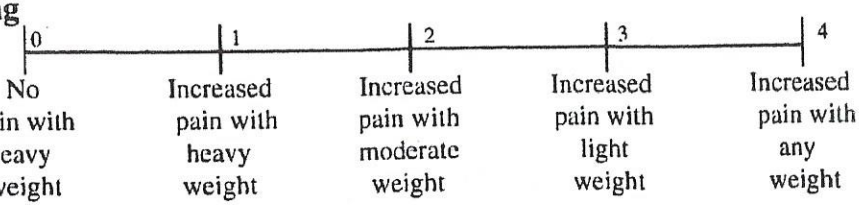
6. Recreation



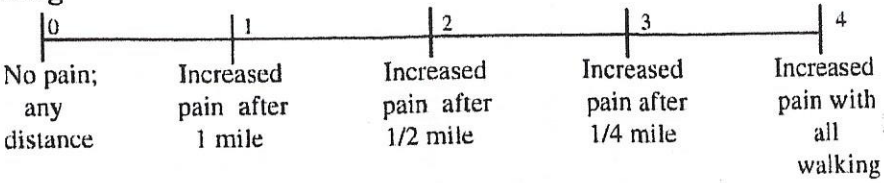
7. Frequency of pain



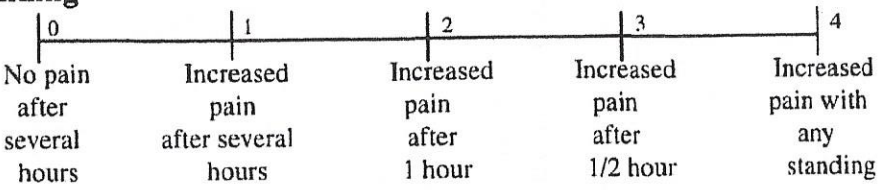
8. Lifting



9. Walking



10. Standing



Total Score _____

Name _____
PRINTED

_____
Signature

_____
Date

PERRAS CHIROPRACTIC
Dr. Michael Perras

FINANCIAL AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, Perras Chiropractic shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

PATIENT SIGNATURE _____ INSURED'S SIGNATURE _____

DATE _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expanses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Perras Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator of fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expense.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

SIGNATURE OF INSURED/GUARDIAN _____ DATE _____

PERRAS CHIROPRACTIC
Dr. Michael Perras

HIPPA PATIENT CONSENT FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. **You have the right to review our Notice before signing this Consent and you are advised to do so.**

By signing this form, you consent to our use and disclosure to third parties of your PHI for treatment, payment and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Consent but later change your mind, you have the right to revoke this Consent by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The patient understands that:

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review this Notice before signing this consent. The Clinic encourages all patients to review the Notice of Privacy Practices.

The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

Protected health information may be disclosed or used for treatment, payment or health care operations, and for certain marketing purposes.

The Clinic or its business affiliates may use your PHI to contact you with educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or pre-recorded messages. We **WILL NOT** ever sell or "SPAM" your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures that require the patient's prior written consent will then cease.

The Clinic may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by: _____
Printed Name - Patient or Representative

_____
Signature Date

_____
Relationship to Patient (if other than patient)

Witness: _____
Printed Name - Clinic Representative

_____
Signature Date

FOR INTERNAL USE ONLY

___ Patient Refused to Sign ___ Patient unable to sign for the following reason: _____

_____