



Eat Well • Move Well • Think Well

PT. # _____

Date: _____

Name		Preferred Name			
Address & Street				Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	
City, State, Zip			Phone	Date of Birth	Age
<input type="checkbox"/> Married <input type="checkbox"/> Widowed	Health Insurance		Primary _____	Alternate Phone	
<input checked="" type="checkbox"/> Single <input type="checkbox"/> Divorced	<input type="radio"/> Yes <input type="radio"/> No	Secondary _____			
E-Mail Address					
No. of Children	Ages				
Occupation	Employer			Work Phone No. ()	
Is this appointment for a particular symptom or for wellness care? Please explain:				Preferred contact <input type="checkbox"/> work <input type="checkbox"/> home <input type="checkbox"/> cell	
Emergency Contact					
Relationship		Phone ()			
Referred by	Have you had chiropractic care before? <input type="checkbox"/> Yes Where? <input type="checkbox"/> No		Are you here because of a recent: <input type="checkbox"/> on the job injury <input type="checkbox"/> an auto accident		

Have you ever had any falls, accidents or injuries? <input type="checkbox"/> Yes if needed use space below <input checked="" type="checkbox"/> No	MONTH, YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY	
Have you ever had surgery? <input type="checkbox"/> Yes if needed use space below <input checked="" type="checkbox"/> No	MONTH, YEAR	TYPE OF SURGERY	COMMENTS	
Any prior or present illnesses? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	MONTH, YEAR	TYPE OF ILLNESS	COMMENTS	
Are you presently taking medication? <input type="checkbox"/> Yes if needed use space below <input checked="" type="checkbox"/> No	NAME OF DRUG	DOSES PER DAY	NAME OF DRUG	DOSES PER DAY
Is it possible you are pregnant? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				

Please check any of the following that give you difficulty.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fainting | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Shooting head pains | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> Numbness in legs or feet |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Heart attacks | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Menstrual cramps and pain |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Anemia | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Grinding in neck | <input type="checkbox"/> Nerves and nervousness | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Inflammation of throat | <input type="checkbox"/> Tightness of shoulders and arms | <input type="checkbox"/> Inner tension | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Pain in shoulders and arms | <input type="checkbox"/> Irritability | <input type="checkbox"/> Painful joints |
| <input type="checkbox"/> Twitching of face | <input type="checkbox"/> Pins and needles in arms & hands | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Ear ache | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Pins and needles in legs |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numbness in arms / hands | <input type="checkbox"/> Intestinal gas | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Cold hands / fingers | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Dizziness | | | <input type="checkbox"/> Pains in legs and feet |

Please indicate which activities of daily living are affected by your present complaints

- | | | | | |
|-------------------|--|---|---|--|
| General | <input type="checkbox"/> Walking | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Playing piano | <input type="checkbox"/> Using keyboard |
| | <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Using a telephone | <input type="checkbox"/> Exercising |
| | <input type="checkbox"/> Climbing Stairs | <input type="checkbox"/> Lifting children | <input type="checkbox"/> Running | <input type="checkbox"/> Sitting in recliner |
| | <input type="checkbox"/> Chewing | <input type="checkbox"/> Reading | <input type="checkbox"/> Bending | <input type="checkbox"/> Getting into/out of an automobile |
| | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Swimming | <input type="checkbox"/> Lying in bed | |
| Housework | <input type="checkbox"/> Doing Laundry | <input type="checkbox"/> Vacuuming | <input type="checkbox"/> Ironing | <input type="checkbox"/> Caring for pets |
| | <input type="checkbox"/> Making beds | <input type="checkbox"/> Washing dishes | <input type="checkbox"/> Carrying groceries | <input type="checkbox"/> Cooking |
| Yardwork | <input type="checkbox"/> Mowing Lawn | <input type="checkbox"/> Raking leaves | <input type="checkbox"/> Gardening | <input type="checkbox"/> _____ |
| Personal Grooming | <input type="checkbox"/> Combing hair | <input type="checkbox"/> Shaving | <input type="checkbox"/> In/out bathtub | <input type="checkbox"/> Brushing teeth |
| Travel | <input type="checkbox"/> Driving a car | <input type="checkbox"/> Riding in a car | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

NOTE: It is understood and agreed the amount paid Correct Care Chiropractic for x-rays is for examination only and the x-ray negatives will remain in the property of this office, being on file where they may be seen while a patient of this office.

Signature: _____ Date: _____

To avoid bookkeeping expense, payment is expected at the time service is rendered unless other arrangements are made.

Doctor's Use Only

R.O.P. / P.D. / P.S. (F.A.) / F.T. / L.O.T. / D.O.C. / H.P. / A.E.P. / N.L.W.

COMMENTS _____

SECONDARY COMPLAINT _____

A- 5/6/4 B- 3/5/4 C- 2/5/4 1/5/4 -C 0/2/5 -C _____ OTHER



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Dr. James Kravis, D.C., Director

Authorization, Assignment, Acknowledgment and Understanding

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any information concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Correct Care Chiropractic and hereby release you of any consequence thereof.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay directly to Correct Care Chiropractic any monies due them on account, the same to be deducted from any settlement made on my behalf. Further, it is understood that I, the undersigned, agree to pay the full amount of the charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim.

ACKNOWLEDGEMENT OF PROTECTED HEALTH INFORMATION PRACTICES: It is understood that by Federal Law, my personal health information is protected. This office has available for review its Health Privacy Policy regarding the sharing of that information. Should I have any questions regarding this policy, I will contact this office.

TERMS OF ACCEPTANCE: It is understood that the chiropractic care received in this office is not meant to diagnose or treat any disease or condition other than vertebral subluxation.

CONSENT TO CARE FOR A MINOR: I hereby authorize Correct Care Chiropractic to administer care as deemed necessary to: _____ Relationship: _____ D.O.B. _____

ACKNOWLEDGEMENT OF SPECIAL PROMOTIONAL FEE: I acknowledge that this fee (_____) is a special promotion at Correct Care Chiropractic and does not reflect their normal and customary charges for services. I expect to receive no further notice of this policy.

ACKNOWLEDGEMENT OF X-RAY FEES: It is understood and agreed the amount paid to Correct Care Chiropractic for x-rays is for examination & interpretation only. I understand that there is a copy charge for x-ray or record copies.

Patient Name

Patient Signature

Date

Witness



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Insurance and Payment Policies

- All estimated co-pay/coinsurance amounts are due at the time of service.
- All products and services not covered by insurance must be paid in full at the time of service.
- All services that are subject to deductible will be billed to insurance. Once the insurance carrier has processed the claim, any balance owed must be paid in full upon receipt of statement.
- Any disputed balances will be reviewed by our billing service. Once the balance has been confirmed, the balance owed must be paid in full upon receipt of statement.
- We will attempt to confirm all insurance benefits prior to your visit. If benefits cannot be confirmed, cash fees will apply.
- In cases where an insurance carrier's fee schedule cannot be determined, all estimated coinsurance amounts will be based on our full fees.
- If you have used all of your insurance benefits for your policy year, you will have the option of paying our current cash fees, purchasing a prepaid care package, or paying the participating provider rate (as determined by your insurance carrier).
- Balances past 30 days due will be transferred to Transworld Systems for collection.

I have read and understand the above policies.

Patient Name

Patient Signature

Date

Witness

31395 W. Seven Mile Rd., Suite G · Livonia, MI 48152 · (248) 426-6600

www.correctcarechiro.com



Name: _____ Date: _____

Do you have allergies to any Medications? Yes ____ No ____ . If yes, please fill out the attached sheet.

Ethnicity: Hispanic or Latino ____ Not Hispanic or Latino ____

Race: African/African American ____ Asian/Asian American ____ Caucasian/European American ____
Native American/Native Alaskan ____ Native Hawaiian/Other Pacific Islander ____ Other ____

Preferred Language: _____

Smoking Status: (13years or older)

- ____ Current every day smoker
- ____ Current some day smoker
- ____ Former smoker
- ____ Never smoked

Medicare patients only: Do you also have Medicaid? Yes ____ No ____

Doctors Use Only

2 years or older: Blood Pressure: _____/_____ Pulse: _____/minute
Height/length _____ inches Weight _____ lbs. Body Fat % _____ BMI _____
Head circumference (0-3 years old) _____ inches.
Growth Chart: 0-3 years old Height ____% Weight ____% 3-20 years old Height: ____% Weight ____%

Medication Allergic Reactions

Patient Name: _____

Date: _____

Medication Name: _____

Please check your reactions to this medication:

Rash: Local ___ General ___	Bloating/Gas _____	Trouble Swallowing _____
Itching _____	Vomiting _____	Trouble Breathing _____
Swelling: Skin ___ Face ___	Diarrhea _____	Dizzy/lightheaded _____
Hives _____	Nausea _____	Blackouts _____
Red eyes _____	Shortness of Breath _____	Chest pain _____
Runny nose _____	Wheezing _____	Irregular heart beat _____
Cough _____	Swelling of Tongue _____	Fast heart beat _____
Abdominal Pain/Cramps _____	Trouble speaking _____	Slow heartbeat _____

Medication Name: _____

Please check your reactions to this medication:

Rash: Local ___ General ___	Bloating/Gas _____	Trouble Swallowing _____
Itching _____	Vomiting _____	Trouble Breathing _____
Swelling: Skin ___ Face ___	Diarrhea _____	Dizzy/lightheaded _____
Hives _____	Nausea _____	Blackouts _____
Red eyes _____	Shortness of Breath _____	Chest pain _____
Runny nose _____	Wheezing _____	Irregular heart beat _____
Cough _____	Swelling of Tongue _____	Fast heart beat _____
Abdominal Pain/Cramps _____	Trouble speaking _____	Slow heartbeat _____

Medication Name: _____

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Hives _____	Nausea _____	Blackouts _____
Red eyes _____	Shortness of Breath _____	Chest pain _____
Runny nose _____	Wheezing _____	Irregular heart beat _____
Cough _____	Swelling of Tongue _____	Fast heart beat _____
Abdominal Pain/Cramps _____	Trouble speaking _____	Slow heartbeat _____