Chiropractic
Natural Health Care
Dr. Thad Dall, D.C. & Dr Dane Starnes, D.C.

Patient Health History

Name:_____ _____ ___Date:_____
(Last Name) (First Name) (Middle Init.)

Address:_____
(City) (State) (Zip)

Physical Address:_____ _____
(if address isPO Box) (City) (State) (Zip)

Home Phone:_____Work Phone:_____Cell Phone/carrier:_____

I would like to receive reminders via- ☐ Text ☐ Email ☐ Neither Email:_____

Whom may we thank for referring you to us?_____

Sex: ☐ Male ☐ Female Age:_____ DOB:_____SSN#:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partner

Occupation:_____ Employer:_____

IN CASE OF EMERGENCY, CONTACT:_____
(Name) (Relationship)

_____
(Home Phone) (Work Phone) (Cell Phone)

Insurance Information:

Primary Ins. Company:_____Policy/ID #:_____

Group#_____ Subscriber's Name:_____

Subscriber's DOB:_____Subscriber's SSN#:_____

Subscriber's Address:_____

Relationship to Patient:_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Secondary Ins. Company:_____Policy/ID#:_____

Group #:_____Subscriber's Name:_____

Subscriber's DOB:_____Subscriber's SSN#:_____

Subscriber's Address:_____

Relationship to Patient:_____

Who is the responsible party for this account? _____

Responsible party's address:_____
(City) (State) (Zip)

Accident Information:

Is your condition due to an accident? ☐ Yes ☐ No **If yes, please see front desk for additional forms.*

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other State/time:_____

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Workers comp. ☐ Other_____

Attorney's Name (if applicable):_____Phone:_____

Assignment and Release:

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Chiropractic Natural Health Care all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance**. I hereby authorize Chiropractic Natural Health Care, Inc., to release all information necessary to secure the payment of benefits.

I authorize the use of this signature on all insurance submissions.

_____
(Responsible Party's Signature) (Relationship to Patient) (Date)

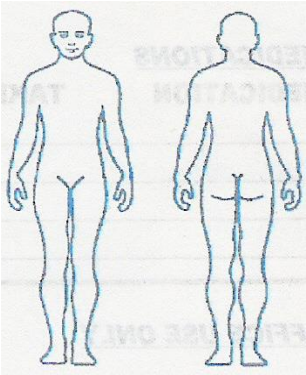
Patient Condition:

Reason for patient's visit:_____

When did your symptoms begin?:_____

Is this condition getting worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



A.) Rate the severity of your pain on the scale:
(least pain) 1 -----2-----3----4-----5------6-----7----8-----10 (most pain)

B.) Type of pain:
☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Burning
☐ Aching ☐ Shooting ☐ Tingling ☐ Cramps ☐ Stiffness
☐ Swelling ☐ Other_____

C.) How often do you have this pain?_____

D.) Is it constant or does it come and go?_____

E.) Does it interfere with your:
☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

F.) Activities or movements that are painful to perform:
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Health History:

Have you ever seen a Chiropractor before? ☐ Yes ☐ No

What treatment have you already received for your condition?
☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None
☐ Other:_____

Name and address of other doctor(s) who have treated you for your condition:_____
_____

Date of 1st Treatment:_____ Number of treatment in last 12 months:_____

Date of Last: Physical Exam_____Spinal X-Ray_____MRI, CT, Bone Scan_____

Please select symptoms you currently have:

☐ Balance Impairment	☐ Lightheadedness	☐ Ringing/Buzzing in Ears
☐ Burning Eyes	☐ Loss of Concentration	☐ Visual/Sensory Disturbance
☐ Depression	☐ Loss of Memory	☐ Vertigo
☐ Headaches	☐ Nausea	

Please select conditions or symptoms you currently have OR have had in the past.

☐ AIDS/HIV	☐ Diabetes	☐ Jaw Pain/TMJ	☐ Rheumatic Fever
☐ Anemia	☐ Emphysema	☐ Kidney Disease	☐ Rheumatoid Arthritis
☐ Anorexia	☐ Epilepsy	☐ Liver Disease	☐ Scarlet Fever
☐ Appendicitis	☐ Glaucoma	☐ Mononucleosis	☐ Stroke
☐ Arthritis	☐ Goiter	☐ Multiple Sclerosis	☐ Thyroid Problems
☐ Asthma	☐ Gout	☐ Osteoporosis	☐ Tuberculosis
☐ Blood Clots	☐ Heart Disease	☐ Pacemaker	☐ Tumors/Growths
☐ Breast Lump	☐ Hepatitis A, B or C	☐ Parkinson's Disease	☐ Varicose Veins
☐ Bronchitis	☐ Hernia	☐ Pinched Nerve	☐ Whiplash
☐ Bulimia	☐ Herniated Disc	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Herpes	☐ Polio	☐ Other:_____
☐ Cataracts	☐ High Blood Pressure	☐ Prosthesis	☐ Other:_____
☐ Chemical Dependency	☐ High Cholesterol	☐ Psychiatric Care	☐ Other:_____

Women only: Are you pregnant? ☐ Yes ☐ No Due Date:_____

Life Habits:

Alcohol	☐ None	☐ Light	☐ Moderate	☐ Heavy
Caffeine	☐ None	☐ Light	☐ Moderate	☐ Heavy
Tobacco	☐ None	☐ Light	☐ Moderate	☐ Heavy
Drugs	☐ None	☐ Light	☐ Moderate	☐ Heavy
Exercise	☐ None	☐ Light	☐ Moderate	☐ Heavy
Home Stress	☐ None	☐ Light	☐ Moderate	☐ Heavy
Work Stress	☐ None	☐ Light	☐ Moderate	☐ Heavy
Other Stress (Reason_____)	☐ None	☐ Light	☐ Moderate	☐ Heavy

Work Activity: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Please **describe and date** any auto accidents/injuries, head injuries, broken bones, dislocations, and surgeries you have had in the past:

Any other major medical information you would like the doctor to know about:

Allergies

Medications **Taking For**

Vitamins/Supplements

Chiropractic
Natural Health Care

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Manhattan, KS 66502
www.chironaturalhealth.com
naturalhlth@sbcglobal.net

AGREEMENT TO PAY FOR SERVICES AND ASSIGNMENT OF INSURANCE BENEFITS:
In consideration of the care and treatment provided to the patient, the undersigned, whether signing as patient or legal representative, agrees to pay TRD Chiropractic Inc., DBA Chiropractic Natural Health Care, further known as CNHC, all charges for undersigned affirms that no unwritten oral agreement between CNHC and the undersigned exists as of the date this agreement is signed.

******Note: A $25.00 missed appointment fee will be processed to your account if you do not cancel your appointment 24 hours in advance.***

I hereby assign to TRD Chiropractic Inc., DBA Chiropractic Natural Health Care, any and all medical benefits payable from any policy of insurance insuring the patient or person responsible for the patient's care to be paid directly to CNHC to be applied to charges for services rendered. I understand I am responsible for co-insurance payments, deductibles and/or any remaining balance. In the event pre-certification for such insurance is required by and health plan or policy of insurance, the undersigned patient or agent is responsible for obtaining pre-certification.

MEDICARE PATIENTS:
Please be advised, you Medicare coverage only covers a portion of you adjustment, after satisfying your Medicare deductible. Any other services you receive (physical therapies, x-rays, supplements/products, exams) are your responsibility.

RELEASE OF INFORMATION:
It is agreed that all records concerning my treatment remain the property of TRD Chiropractic Inc., DBA Chiropractic Natural Health Care. CNHC may release confidential information, to health insurance providers liable for treatment charges for my care. CNHC may also release such information to other health care providers if necessary to ensure proper care for me. I also authorize my insurance carrier to release to CNHC any information concerning my insurance coverage or benefits, if any, connected with my care. **For worker compensation patients** this information will be released to your worker compensation insurance and/your employer.

CONSENT TO X-RAY/PREGNANCY RELEASE:
I hereby authorize Dr. Thad Dall D.C. and Dr. Jared Schneider D.C. and whomever they may designate as their assistants to examine, perform necessary x-rays, and administer treatment as needed to my child or said minor in my custody.

_____
PRINT Patient Name

_____ _____
Date Signature of Patient or Legal Representative

_____ _____
Witness Relationship

CHIROPRACTIC NATURAL HEALTH CARE

Dr. Thad Dall DC & Dr. Dane Starnes DC

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____ SS#_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

***Smoking Status (Circle one)*:** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **Check this box if you choose to decline receipt of your clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

Height: _____ Weight:_____ Blood Pressure:_____ /_____ HR_____