CRANE CHIROPRACTIC

★ ALL-STAR CARE IN STAR ★

Stephen Crane, DC

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status: Single ☐ Mar ☐ Div ☐ Sep ☐ Widow ☐	
Spouse Name:	Is the above your legal name? ☐ Yes ☐ No	If no, please list name(s):	Birthdate:	Age:	Sex: ☐ M ☐ F	
Street address:			City	State	Zip Code:	
Cell Phone: ( )	Cell Phone Company: For appointment reminders only	Work phone:	Social Security No.			
Occupation:	Employer:					
Email:			May we send you a newsletter? ☐ Yes ☐ No			

Chose clinic because/referred to clinic by (Please check one box): ☐ Dr. _____ ☐ Ins. Plan ☐ Hospital

☐ Family ☐ Friend ☐ Close to home/work ☐ Internet ☐ Other Explain:

RESPONSIBLE PARTY

Person responsible for account:	Address (if different):	Phone: ( )	
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other Explain:			
Occupation	Employer:	Employer address:	Employer Phone: ( )

INSURANCE INFORMATION

(Please give your insurance card and photo ID to the Front Desk Assistant)

Name of Insured:	Social Security Number: -- --	Birth Date:	Name of Insurance:	ID Number:
Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other If other, please explain:				
Name of secondary insurance (if applicable):	Name of Insured:	ID Number:	Date of Birth:	
Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Explain:				

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home/Cell: ( )	Work: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance without statute of limitation. I also authorize Crane Chiropractic or insurance company to release any information required to process my claims.

Patient/Guardian Signature ***Date***

PLEASE CHECK THE APPROPRIATE BOX FOR ANY OF THE FOLLOWING SYMPTOMS YOU HAVE OR HAD
****THIS IS A CONFIDENTIAL HEALTH REPORT****

OCC FREQ

GENERAL
- ☐ ☐ Allergy (list below)*
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness or Fainting
- ☐ ☐ Headache
- ☐ ☐ Neuralgia
- ☐ ☐ Numbness

MUSCLE
- ☐ ☐ Arthritis
- ☐ ☐ Bursitis
- ☐ ☐ Foot Trouble
- ☐ ☐ Low back pain or Stiffness
- ☐ ☐ Pain between Shoulders
- ☐ ☐ Sciatica
- ☐ ☐ Swollen Joints

PAIN,NUMBNESS, CRAMPS
- ☐ ☐ Shoulders
- ☐ ☐ Arms
- ☐ ☐ Elbows
- ☐ ☐ Hands
- ☐ ☐ Hips
- ☐ ☐ Legs
- ☐ ☐ Knees
- ☐ ☐ Feet
- ☐ ☐ Head
- ☐ ☐ TMJ
- ☐ ☐ Neck

DATE OF LAST (APPROX):
- _____ Physical Exam
- _____ Blood Test
- _____ Chest x-ray
- _____ Spinal x-ray/MRI/CT
- _____ Dental x-ray
- _____ Urine test

GASTRO-INTESTINAL
- ☐ ☐ Colon Trouble
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Difficult Digesting
- ☐ ☐ Gall Bladder Trouble
- ☐ ☐ Hemorrhoids
- ☐ ☐ Liver Trouble
- ☐ ☐ Pain over Stomach

EYES,EARS,NOSE,THROAT
- ☐ ☐ Asthma
- ☐ ☐ Colds
- ☐ ☐ Deafness
- ☐ ☐ Earache
- ☐ ☐ Ear Discharge
- ☐ ☐ Ear Noise
- ☐ ☐ Eye Pain
- ☐ ☐ Nasal Obstruction
- ☐ ☐ Sinus Infection

CARDIO-VASCULAR
- ☐ ☐ Hardening of the Arteries
- ☐ ☐ High Blood Pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Pain over Heart
- ☐ ☐ Poor Circulation
- ☐ ☐ Rapid Heart Beat
- ☐ ☐ Swelling of Ankles

NONE LIGHT MOD HEAVY

- ☐ ☐ ☐ ☐ Alcohol
- ☐ ☐ ☐ ☐ Coffee
- ☐ ☐ ☐ ☐ Tobacco
- ☐ ☐ ☐ ☐ Drugs
- ☐ ☐ ☐ ☐ Exercise
- ☐ ☐ ☐ ☐ Soft Drinks

RESPIRATORY
- ☐ ☐ Chest Pain
- ☐ ☐ Chronic Cough
- ☐ ☐ Difficult Breathing
- ☐ ☐ Spitting up Blood
- ☐ ☐ Spitting up Phlegm
- ☐ ☐ Wheezing

SKIN
- ☐ ☐ Bruise Easily
- ☐ ☐ Dryness
- ☐ ☐ Skin Eruptions (rash)
- ☐ ☐ Varicose Veins

GENITO-URINARY
- ☐ ☐ Bed-Wetting
- ☐ ☐ Blood in Urine
- ☐ ☐ Frequent Urination
- ☐ ☐ Inability to Control Kidneys
- ☐ ☐ Kidney Infection or Stones
- ☐ ☐ Painful Urination
- ☐ ☐ Prostate Trouble

FOR WOMEN ONLY
- ☐ ☐ Breast Pain
- ☐ ☐ Cramps or Backache
- ☐ ☐ Excessive Menstrual Flow
- ☐ ☐ Hot Flashes
- ☐ ☐ Irregular Cycle
- ☐ ☐ Lumps in Breasts
- ☐ ☐ Menopausal Symptoms
- ☐ ☐ Painful Menstruation
- ☐ ☐ Vaginal Discharge

Pregnant ☐ **Yes** ☐ **No**
Date of Last Period _____
Miscarriages ☐ Yes ☐ No

HAVE YOU EVER:
- ☐ Been knocked unconscious?
- ☐ Had an arterial dissection or stroke?
- ☐ Been treated for spine or nerve dis?
- ☐ Had a fractured bone?
- ☐ Been hospitalized other than surgery?
- ☐ Ever had spinal surgery? (list below)

PLEASE LIST ANY PRESCRIPTION DRUGS, VITAMINS, ALLERGIES, AND PAST SURGERIES:

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD (circle conditions family members have or had)

☐ Aids	☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Pneumonia	☐ Tuberculosis
☐ Alcoholism	☐ Chicken Pox	☐ Foot Problems	☐ Measles	☐ Polio	☐ Typhoid Fever
☐ Anemia	☐ Diabetes	☐ Goiter	☐ Mult Sclerosis	☐ Rheumatic Fever	☐ Ulcers
☐ Appendicitis	☐ Eczema	☐ Gout	☐ Mumps	☐ Scarlet Fever	☐ Venereal Disease
☐ Arteriosclerosis	☐ Emphysema	☐ Heart Disease	☐ Pacemaker	☐ Stroke	

After reading and filling out the case history, your signature will verify all the information is accurate, and the case history questions are answered entirely.

Patient/Guardian Signature _____ ***Date*** _____

REASON FOR YOUR VISIT

Please describe your complaint and location(s):

This is due to: ☐ Auto Accident ☐ Work Injury (Worker's Comp) ☐ Chronic ☐ Unknown Cause ☐ Other

Date symptoms appeared:	How long have you had this condition?	Is it getting worse? ☐ Yes ☐ No

What activities are difficult to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Sleeping ☐ Coughing

Rate the Severity of your pain (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

What makes the problem better?

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramping ☐ Stiffness ☐ Swelling ☐ Other

Overall Frequency of complaint: ☐ Intermittent (0-25%) ☐ Occasional (26-50%) ☐ Frequent (51-75%) ☐ Constant (76-100%)

Overall Intensity of complaint: ☐ Minimal ☐ Mild ☐ Moderate ☐ Severe

Have you had this or similar conditions in the past: ☐ Yes ☐ No If yes, please explain:

Have you seen a Chiropractor before? ☐ Yes ☐ No If yes, whom and how long ago?

Have you seen another Doctor for this condition? ☐ Yes ☐ No If yes, whom and how long ago?

STAFF USE/NOTES

INFORMED CONSENT AND PRACTICE OBJECTIVES

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While Chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care and to allow you to be fully informed in agreeing to treatment. In our office, we utilize some of the most gentle, specific adjusting techniques.

- ***Soreness***: Chiropractic care is a process rather than a one-time event. Time and repetition are essential for best results. Therefore, in the beginning, adjustments are sometimes accompanied with post treatment soreness. This is normal, but please advise the Doctor any soreness.
- ***Soft Tissue***: Occasionally, Chiropractic treatment may aggravate a disc injury, or cause minor joint, ligament, tendon, or other soft tissue pain.

Chiropractic is a system of health care delivery and therefore, as with any healthcare delivery system, we cannot promise a cure for any symptoms, condition, or disease. An attempt to provide the best Chiropractic care is our goal, and if the results are not successful, we will refer you to another health care provider.

When a patient seeks Chiropractic care, it is essential for all parties involved to be working towards the same objectives. Our Practice objectives are as follows:

- Help decrease the patient's pain level as it relates to the Chiropractic scope of practice.
- Improve spinal nerve function by adjusting misaligned joints.
- Improve joint function by adjusting misaligned joints in the spine and extremities.
- Provide patients with information concerning diet, exercise and lifestyle for improved quality of life.

Patient/Guardian Signature ***Date***

SCHEDULE OF PROFESSIONAL FEES

Experience has shown it is wise to have an understanding with patients concerning our office policies and fees. This form has been prepared for your convenience and information. We offer several methods of payment for your chiropractic care. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well-being, and we will do our best to assist you.

Consultation and Chiropractic Examination	$40-125
Routine X-Ray Series	$115
X-Ray (per view)	$45
Chiropractic Adjustment	$35-75
After Hours, Emergency Fee	$45-105
Re-Examination	$35-100
Trigger Point Therapy/Massage	$35-45
Manual Therapy	$35-45

Note: Fees listed above are full retail price, a ***time of service discount*** is given when full payment is made at the time of each visit.

Important: All patients, with or without insurance, are responsible for full payment of fees for services rendered on the first visit. If we have confirmed that your deductible has been met, only the co-pay is due.

*****Payment is due at the time of each visit***** _____ *Initial*

Payment today will be made by: cash _____ check _____ credit/debit _____ *Check which applies*

I choose the following method for my care at Crane Chiropractic (**check one** please):

I will be paying for my care on a cash basis _____

I have insurance coverage and would like to have my benefits confirmed _____

I have been in a collision for which I am seeking accident benefits _____

I have been hurt on the job and have filed a workers' compensation claim _____

AGREEMENT

My signature below signifies my agreement to pay all fees in full on a cash basis if I have no insurance. I will also pay in full on the second visit if I have not provided Dr. Crane with all of the necessary documents and information from my health insurance policy.

I have read and agree to the above fee statement.

_____ _____

Patient/Guardian Signature ***Date***