# TQ CHIROPRACTIC
# CONFIDENTIAL PATIENT INFORMATION
(PLEASE PRINT)

**PATIENT:**

Last Name: _____ First Name: _____ Middle: _____

Gender: M F Date of Birth: _____/_____/_____ Age: _____ SSN#: _____

Martial Status: □ Married / □ Single / □ Divorced How many children? _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell phone #: _____

EMAIL: _____ REFERRED BY: _____

CONTACT METHOD (CHECK ONE): □ Home Phone □ Work Phone □ Cell Phone □ Email

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

EMPLOYMENT STATUS (check one):

□ Employed □ FT Student □ PT Student □ Retired □ Self Employed □ Other

Employer Name: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

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**SPOUSE or GUARDIAN:**

Last Name: _____ First Name: _____ Middle: _____

Home Phone #: _____ Work Phone #: _____ Cell phone #: _____

Employer Name: _____

Date of Birth: _____/_____/_____ SSN#: _____

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**EMERGENCY** (Name and address of nearest relative or friend **not living with you**)

Last Name: _____ First Name: _____ Middle: _____

Home Phone #: _____ Work Phone #: _____ Cell phone #: _____

Relation to Patient: _____

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PAYMENT METHOD: □ Cash □ Check □ Visa □ Mastercard

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**INSURANCE:**

Insurance Company: _____

Insured's Name: _____ ID/Policy #: _____

Insured's Date of Birth: _____ Insured's Gender: M F

Patient Relationship to Insured: □ **Self** □ **Spouse** □ **Child** □ **Other:**

Workers Compensation _____

Insured's Name: _____ ID/Policy #: _____

**Is there another health Benefit Plan?** □ YES □ NO (If yes, please indicate below)

Insurance Company: _____

Insured's Name: _____ ID/Policy #: _____

Insured's Date of Birth: _____ Insured's Gender: M F

Patient Relationship to Insured: □ Self □ Spouse □ Child □ Other:

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**Patient's Race:** □ White □ Black/African American □ Hispanic □ American Indian □ Asian

□ Chinese □ Filipino □ Japanese □ Korean □ Vietnamese □ Hawaiian or other pacific Islander

□ Samoan □ Cambodian □ Patient Refused to specify □ Other _____

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**Multi-Racial** (check one)**:** □ Yes □ No □ Unknown

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**Patient's Ethnicity:** □ Hispanic or Latino □ Not Hispanic or Latino □ Patient Refused to specify

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**Patient's Preferred Language:** □ English □ Spanish □ Vietnamese □ Chinese □ Other: _____

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**RESPONSIBLE PARTY:** Complete this section if you are not the patient but are responsible for the bill

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell phone #: _____

Employer Name: _____ Occupation: _____

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We are committed to providing you with the best possible care. Coinsurance (co-payment) is due at the time services are rendered. Returned checks and balances older than 30 days may be subject to additional collection fees and interest charge of 1.5 percent per month. All returned checks will be charged an additional $25 fee. Not all services are a covered benefit in all contracts. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are the patient's responsibility. If your insurance does not pay within 30 days of the date of service you will be responsible for paying this bill.

**ASSIGNMENT:** I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Further more, I understand that **TQ Chiropractic** will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to **TQ Chiropractic** will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I have read all the information above. I hereby assign all insurance benefits to TQ Chiropractic. I understand and agree that I am financially responsible for all charges incurred to my account whether my insurance pays or not. I agree that in the event of non-payment, within 30 days I will be responsible for the bill payment. I will bear the cost of collection or court costs and attorney fees. I certify that all the information is true and correct to the best of my knowledge. I will notify this office of any changes in my health or billing information. A photocopy of this authorization shall be as valid as the original.

**SIGNATURE:** (Patient, Parent, Legal Guardian or Responsible Party)

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

# TQ CHIROPRACTIC - NEW PATIENT FORM

**Patient Name** _____ **Date**_____

**Patient's Height:** _____ **Patient's Weight:** _____ **lbs**

Reason for today's visit: ☐ Emergency ☐ New Injury ☐ Old injury ☐ Chronic Pain ☐ Wellness Visit

Do you currently smoke tobacco of any kid? □ Yes □ Former Smoker □ Never been a smoker

Describe your current problem(s):

☐ Headache ☐ Neck Pain ☐ Mid-back Pain ☐ Low Back Pain ☐ Other _____

Are you in pain: ☐ Yes ☐ No Rate your pain with the following scale (how you feel today):

Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Did your injury occur during: ☐ Work ☐ Sports/play ☐ Auto Accident ☐ Routine/Household Activity

When did your condition/accident occur? ___/___/_____ Where did your injury occur? _____

Please explain what happened: _____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

How often are your symptoms present? Intermittent ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100 % (Constant)

Is your condition getting better with: ☐ Ice ☐ Heat ☐ Medicine

If with medicine, please list medicine being used here: _____

Is your condition interfering with your: ☐ Work ☐ Sleep or ☐ Daily routine?

If so,how: _____

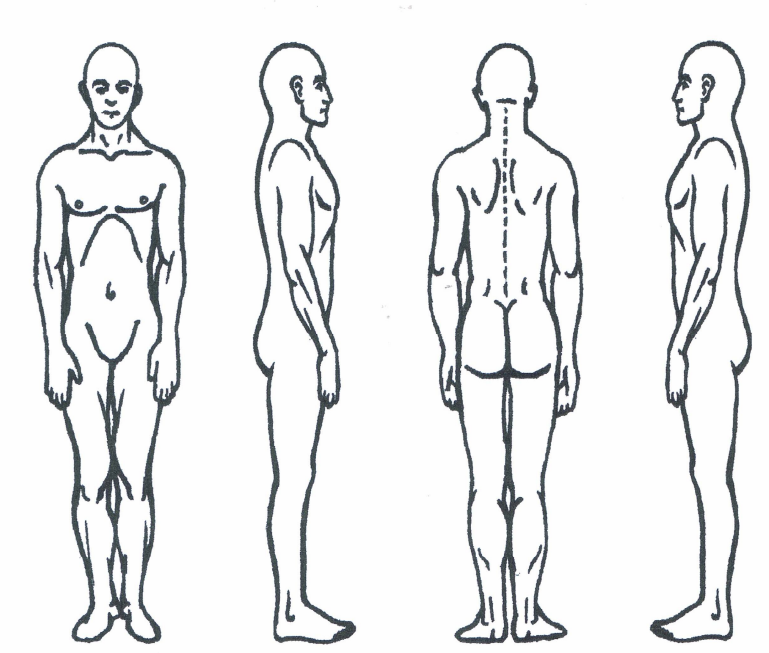
**HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINTS?** ☐ Yes ☐ No

If yes, when and location? _____

Has this or something similar happened in the past?

☐ Yes ☐ No If yes, please explain: _____

**Using the adjacent body charts, please circle all affected areas:**



Front Right Back Left

Have you been treated by a medical physician for this pain? ☐ Yes ☐ No

If so, where? _____

Have you ever been treated by a chiropractor?

☐ Yes ☐ No

Clinic or Dr's Name: _____

Clinic phone #: _____

Please list any medications you are currently taking and there use, including frequency and dosage if known:

_____

_____

_____

_____

_____

**Patient Name** _____ **Date**_____

Do you have or have you had any of the following diseases, medical conditions or procedures?

- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Alcohol/Drug Abuse
- ☐ Anemial/Diabetes
- ☐ Arthritis
- ☐ Artificial Bones/Joints/Implants
- ☐ Artificial valves
- ☐ Cancer / Tumor (explain) _____.
- ☐ Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Corticosteroid Use (cortisone, prednisone, etc.)
- ☐ Difficulty Breathing
- ☐ Dizziness
- ☐ Emphysema/Asthma
- ☐ Fainting/Seizures/Epilepsy
- ☐ Frequent Neck Pain
- ☐ Glaucoma
- ☐ Heart Attack/Stroke (date) _____
- ☐ Heart Murmur
- ☐ Heart/Surg./Pacemaker
- ☐ Hepatitis
- ☐ High/Low blood pressure
- ☐ Kidney Problems
- ☐ Lower Back Problems
- ☐ Marked Morning Pain/Stiffness
- ☐ Menstrual Problems
- ☐ Mitral Valve Prolapse
- ☐ Numbness in Groin/Buttocks
- ☐ Osteoporosis
- ☐ Pain at Night
- ☐ Pain Unrelieved by Position or Rest
- ☐ Prostate Problems
- ☐ Psychiatric problems
- ☐ Recent Fever
- ☐ Rheumatic Fever
- ☐ Severe/Frequent Headaches
- ☐ Shingles
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Ulcers/Colities
- ☐ Urinary Problems
- ☐ Venereal Disease
- ☐ Visual Disturbances

Please list any hospitalizations or surgeries with dates and/or any other serious medical condition(s) not listed above:

_____

_____

List any past serious accidents with dates:

_____

_____

Please list any known allergies you have had to any medications or anything that you may be allergic to:
If no allergies are known, check here □

_____

_____

_____

Family Health History: □ cancer □ high blood pressure □ heart disease □ stroke □ diabetes □ bone disease

Please list any other condition (s) not listed above: _____

Do you take Supplements or Vitamins? ☐ Yes ☐ No ☐ Do you exercise? ☐ Yes ☐ No _____ hours per week

Are you wearing: ☐ Shoe lifts ☐ Inner soles ☐ Arch Support Are you dieting? ☐ No ☐ Yes Since ____/____/____

**For Women:** Are you taking Birth Control? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No If so, how many weeks? _____

◊ **We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.**

◊ **Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 30 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.**

◊ **I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.**

◊ **I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.**

Signature _____ Date _____