PATIENT INTRODUCTION FORM

Today's Date: ____________________________

Last Name:	**MI:**	**First Name:**
Home Address:		
City:	**State:**	**Zip:**
Home Phone:	**Cell:**	
Work Phone:	**Can we contact you at work** ☐ **Yes** ☐ **No**	
Date of Birth:	**Social Security No:**	
Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**		
Email:		
How Did You Hear About Our Office? ☐ Family Member ☐ Friend ☐ Co-worker ☐ Google ☐ Webpage ☐ Phone book ☐ Insurance book Name of the person who referred you to our office:		
Name of Family Physician:		
Employer's Name:		
Occupation:		

THIS VISIT IS RELATED TO:

☐ Motor Vehicle Collision Injury
☐ Non-Injury Pain/Symptoms
☐ Work Related Injury/Symptoms
☐ Sport / Recreational Injury
☐ Describe Others:
☐ Sport / Recreational Injury
☐ Weight Loss Program
☐ School Physical
☐ Nutritional Evaluation
☐ Wellness Care
☐ Home Injury Symptoms
☐ Chronic Pain
☐ Laser Pain Therapy

HEALTH-MEDICAL INSURANCE INFORMATION

Primary Health Insurance Information

Please present your insurance card to the front desk person.

Insurance Name: ____

Policy Number: ____

You are: ☐ The Insured ☐ A Dependent

Name of Insured Person: ____

Insured Person's Date of Birth: ____________________________

Secondary Health Insurance Information

Please present insurance card to the front desk person.

Insurance Name: ____

Policy Number: ____

You are: ☐ The Insured ☐ A Dependent

Name of Insured Person: ____

Insured Person's Date of Birth: ____________________________

Please Complete Other Side

AUTOMOBILE INSURANCE INFORMATION

(Only fill this portion if you were involved in a vehicular accident)

Do you or someone else have insurance coverage for the vehicle you were in?	☐ I have, ☐ Someone else has coverage. Indicate name of person policy is under:
How is this person related to you	☐ Self, ☐ Spouse, ☐ Parent, ☐ Friend, ☐ Other
Name of your Automobile Insurance Carrier:	
Address of your Automobile Insurance Carrier:	
Claim Adjusters Name/Telephone Number:	Name: Telephone (area code):
Claim Number:	
Do you have an Insurance Deductible?	☐ Yes, ☐ No Deductible is: $
Do you know your Policy Limits for medical bills?	☐ Yes, ☐ No Limit is: $
Have you reported this injury to your insurance carrier?	☐ Yes, ☐ No

Do you have an attorney representing You? ☐ Yes ☐ No If yes, indicate name and address:	Attorney Name: ____________________ Address: ____________________ Telephone:

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergency purpose only):
Name: ______________________________
Relationship: ______________________________
Telephone: ______________________________

IF APPLICABLE OUR OFFICE WILL PROVIDE INSURANCE BILLING SERVICES FOR YOU AS A COURTESY. HOWEVER, IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND CO-PAYMENT AND/OR DEDUCTIBLE FOR REGULAR HEALTH INSURANCE PATIENTS.

I am a responsible party and agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my health and/or automobile insurance carrier(s). I understand that all account balances over 30 days old are subject to a 1.5% monthly interest charge. I also agree that in the event collection procedures are needed, all cost for collection fees and/or attorney fees will be added to the cost of the services rendered, and will become part of the judgment. Minors must have parent or guardian's signature.

______________________________ ______________
Patient/Guardian Signature **Date**

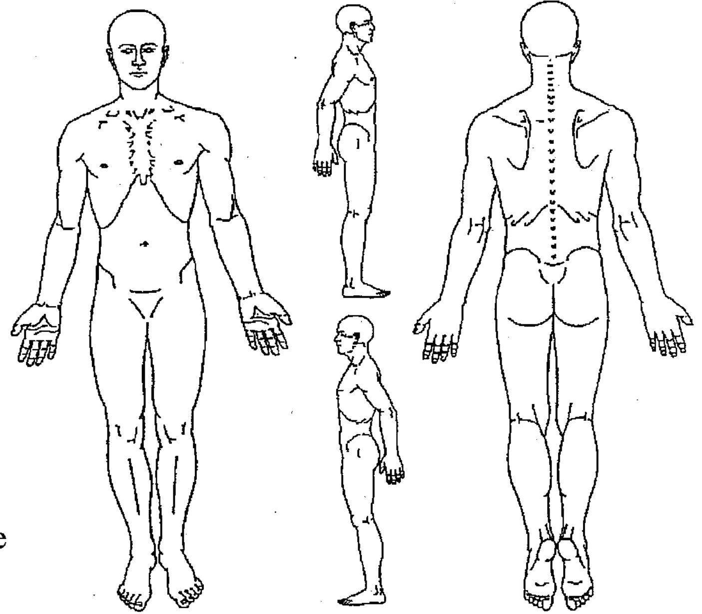
GENERAL HEALTH HISTORY

Patient Name:________________________________ **Date:** ____________

CHECK ALL PERTINANT SYMPTOM REGIONS AND HOW LONG YOU HAVE HAD THEM

CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
☐ Headaches/Migraines		☐ Upper Back Pain, Soreness, or Stiffness	
☐ Neck Pain, Soreness, or Stiffness		☐ Hip Pain	
☐ Low Back Pain, Soreness, Stiffness		☐ Leg or Foot Pain, Numbness, or Tingling	
☐ Arm/Hand Pain, Numbness, or Tingling		☐ Other:	

Please mark on the diagram to the right, the exact location of your discomfort. Use: **x** for Pain, **#** for Numbness, **o** for Tingling
Please describe below your major complaint.



Did your symptoms come on? ☐ **Suddenly,** ☐ **Gradually**
When did it start? ____________
Is it: ☐Getting ☐Worse ☐Getting Better ☐Staying the Same
Have you ever experience this or similar problem before?
☐Yes ☐No (if yes explain)____________

What caused it or how did it start: ____________
Have you had any treatment for this condition?: ☐ Yes ☐ No (if yes explain) ____________

Previous diagnosis:____________
Have you ever been to a Chiropractor before for any condition?
☐ No, ☐ Yes If yes, Chiropractors Name :____________ Year:______
Problem seen for: ____________

WHAT ACTIVITIES OR TIME INCREASE YOUR PAIN LEVELS?

☐ Morning	☐ Bending your back	☐ Walking
☐ Afternoon or evening	☐ Lying down flat	☐ Standing
☐ During sleep hours	☐ Sitting	☐ Exercise/Stretching
☐ Standing up from sitting	☐ Poor posture	☐ Other:

HAS YOUR PAIN BEEN ASSOCIATED WITH THE FOLLOWING?

☐ Excessive fatigue-malaise	☐ Bowel or bladder disorders	☐ Night pain or night time sweats
☐ Weight loss	☐ Ovarian pain	☐ Abdominal pain
☐ Low grade fever	☐ Kidney pain/painful urination	☐ Balance problems

DO YOU EXERCISE?

☐ I do no regular exercise	☐ I exercise 1-2 times a week	☐ I exercise 3-5 times a week
☐ I stretch regularly	☐ I do weight lifting at gym/home	☐ I do cardiovascular work outs
☐ I am willing to do exercise	☐ I am not willing to do exercises	☐ I do regular sports activities

ARE YOU TAKING ANY MEDICATIONS?

☐ **I am not taking any medications currently.** Check any of the following that you are taking currently.

☐ Muscle Relaxants	☐ Blood pressure/Stroke prevention medications	☐ Cortisone injections
☐ Pain/Anti-inflammatory meds	☐ Osteoporosis (bone strengthening) medications	☐ Other:

Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST	PRESENT
☐	I bruise easily	☐	☐
☐	I heal slowly	☐	☐
☐	My body temperature is normally low (feel cold)*	☐	☐
☐	Smoke cigarettes or use tobacco products How Many: Pk/Day	☐	☐
☐	Diabetes, hypoglycemia, thyroid disorder, kidney or liver disease, or tuberculosis	☐	☐
☐	Heart attack or have a heart pacemaker or neck or chest shunt?	☐	☐
☐	Currently or recently had any disease such as AIDS, Tuberculosis, etc	☐	☐
☐	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	☐	☐
☐	Do you have problems with dizziness, blacking out, balance, fainting, or tripping	☐	☐
☐	Epilepsy-Seizure-Convulsion history or other neurological disease	☐	☐
☐	History of multiple sclerosis, lupus, psoriasis, temporary paralysis, or meningitis	☐	☐
☐	Cancer history or cancer treatment of any type	☐	☐
☐	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	☐	☐
☐	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae	☐	☐
☐	Told that you have a bulging/herniated disc or disc degeneration	☐	☐
☐	Have you ever been hospitalized? Why:	☐	☐
☐	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm	☐	☐
☐	Hypertension or high blood pressure	☐	☐
☐	Told you have osteoporosis, osteopenia, or ankylosing spondylitis	☐	☐
☐	Told you have osteoarthritis, rheumatoid arthritis, or gout of your spine or joints	☐	☐
☐	**Women only**: Check this box if you currently have any type of breast implants	N/A	N/A
☐	**Women only**: Check this box if there any chance that you are currently pregnant	N/A	N/A

PRIOR INJURY OR MUSCULOSKELETAL PAIN HISTORY

(☐ **I have no history of previous painful injury or pain**) If you have had prior injuries or pain, please check below:

☐ Work Injury	☐ Fall	☐ Sports Injury	☐ Lifting Injury	☐ Car accident
☐ Motorcycle Injury	☐ Head Injury	☐ Pedestrian Injury	☐ Military Injury	☐ Other Injury
☐ Headaches/Migraines	☐ Neck Pain/Arm Pain	☐ Middle Back Pain	☐ Low Back/Leg Pain	☐ Other Pain

FRACTURES/BROKEN BONES

(☐ **I have never had any broken bones).** If you have broken any bones, indicate where and when below:

Region	Year	Region	Year
☐ Spinal Vertebra		☐ Skull	
☐ Collar bone (clavicle)		☐ Rib bone	
☐ Arm or hand bone		☐ Leg or foot bone	
☐ Pelvis or hip bones		☐ Other	

PREVIOUS SURGERIES

(☐ **I have never had any surgical procedure).** If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
☐ Spine Surgery (neck, back, or pelvis)		☐ Hernia	
☐ Disc surgery in neck or back		☐ Gallbladder/Stomach/Kidney	
☐ Heart		☐ Cancer (any type)	
☐ Head/Brain		☐ Rib / Collar bone	
☐ Shoulder / Arm / Hip / Leg		☐ Other	

*See common question answers.

Date ________________

Mobile Chiropractic Associates
801 Downtowner Blvd
Mobile, AL 36609

Name: ____

Dear Doctors:

I have been made aware of the HIPAA law that went into effect in April of 2003. According to this new law, your office is forbidden by law to divulge information to my family concerning my care.

As of this date I would like to waive my right to privacy and have this letter put in my file stating that I am allowing the following people, upon their request, the right to receive my medical information from your office.

____

____

____

I am confident that your office will only release my medical information to these individuals and I appreciate your cooperation in this matter.

Thank You,

____

Mobile Chiropractic Associates
801 Downtowner Boulevard
Mobile, AL 36609
Phone: 251 341-1211 Fax: 251 414-5104

Dr Douglas R Kaul, D.C.
Dr Jonathan W Krause, D.C.
Dr James D Henry, D.C.
Dr Bridget A Dixon, D.C.

PRIVACY NOTICE TO PATIENTS

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

EFFECTIVE DATE
This notice is effective as of April 14, 2003.

ACKNOWLEDGEMENT
I acknowledge that I have received a copy of the Practice's Privacy Notice that is effective as of April 14, 2003.

______________________________ ______________________________
Name of Individual (Printed) Signature of Individual

Date Signed ___/___/_____

Insurance Disclaimer

Mobile Chiropractic Associates is committed to providing the very best chiropractic care to all of our patients. MCA strives to accurately verify your insurance benefits and inclusion of our doctors in your network as a courtesy to you, our patient. However, do to the complexity and constantly changing dynamics of insurance, we can not guarantee that the benefits quoted will be the benefits paid. You are ultimately responsible for knowing your policy. All balances not paid by your insurance carrier are your responsibility. Thank you for allowing us to help you with your chiropractic needs.

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