

Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:

Last Name:

Date:

SS #:

DOB:

Sex: M F

Marital Status:

of Children:

Occupation:

Street Address:

Height:

City, State, Zip:

Weight:

Email:

Cell Phone:

Other Phone:

Emergency Contact:

Emergency Relation:

Emergency Phone:

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit:

Are you also receiving care from any other health professionals? Yes No

- If yes, please name them and their specialty:

Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

Have you received care for this problem before? Yes No

- If yes, please explain:

When did the condition(s) first begin?

How did the problem start? Suddenly Gradually Post-Injury

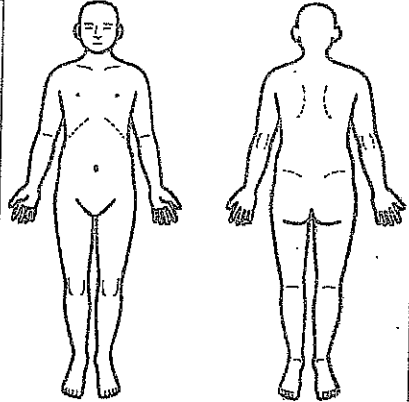
How is this condition: Getting worse Improving Intermittent Constant Unsure

What makes the problem better?

What makes the problem worse?

Please indicate where you are experiencing pain or discomfort.

X= Current condition O= Past condition



The figure shows two human silhouettes, one facing forward and one facing backward. The silhouettes are simple line drawings with no facial features. The text above the silhouettes asks the patient to indicate where they are experiencing pain or discomfort, with 'X' for current conditions and 'O' for past conditions.

YOUR HEALTH GOALS

Our top three health goals:

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? Resolve existing condition(s) Overall wellness Both

Have you ever visited a chiropractor? Yes No If yes, what is their name? _____

What is their specialty? Pain Relief Physical Therapy & Rehab Nutritional Subluxation-based Other: _____

Do you have any health concerns for other family members today?

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? Yes No

- If yes, please explain: _____

Notable childhood injuries? Yes No If yes, please explain: _____

Youth or college sports? Yes No If yes, list major injuries: _____

Any auto accidents? Yes No If yes, please explain: _____

Exercise Frequency? None 1-2x per week 3-6x per week Daily

What types of exercise? _____

How do you normally sleep? Back Side Stomach Do you wake up: Refreshed and ready Stiff and tired

Do you commute to work? Yes No If yes, how many minutes per day? _____

List any problems with flexibility. (ex. Putting on shoes/socks, etc.) _____

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone? _____

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None	Moderate	High		None	Moderate	High			
Alcohol	①	②	③	④	⑤	①	②	③	④	⑤
Water	①	②	③	④	⑤	①	②	③	④	⑤
Sugar & Sweets	①	②	③	④	⑤	①	②	③	④	⑤
Dairy	①	②	③	④	⑤	①	②	③	④	⑤
Gluten	①	②	③	④	⑤	①	②	③	④	⑤
						①	②	③	④	⑤
						①	②	③	④	⑤
						①	②	③	④	⑤
						①	②	③	④	⑤

Please list any drugs/medications/vitamins/herbs/other that you are taking, and why. _____

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None	Moderate	High		None	Moderate	High			
Home	①	②	③	④	⑤	①	②	③	④	⑤
Work	①	②	③	④	⑤	①	②	③	④	⑤
Life	①	②	③	④	⑤	①	②	③	④	⑤
						①	②	③	④	⑤
						①	②	③	④	⑤

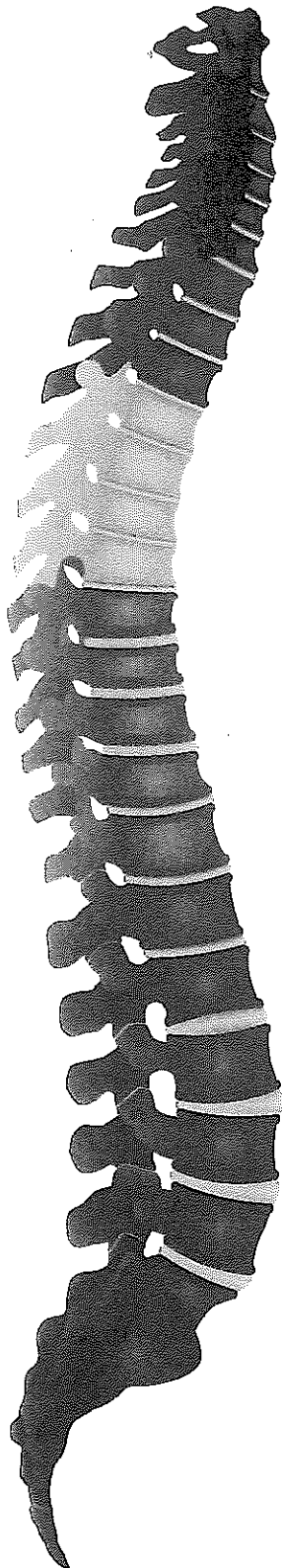
ACKNOWLEDGMENT & CONSENT

Patient Name: _____ Date: _____

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS						
		PAST	PRESENT					
Cervical	• Autonomic Nervous System	<input type="checkbox"/>	<input type="checkbox"/>	Colic & Excessive Crying	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy & Seizures	
	• ENT System	<input type="checkbox"/>	<input type="checkbox"/>	Ear & Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	Sensory & Spectrum	
	• Vision, Balance & Coordination	<input type="checkbox"/>	<input type="checkbox"/>	Allergies & Congestion	<input type="checkbox"/>	<input type="checkbox"/>	ADD / ADHD	
	• Speech	<input type="checkbox"/>	<input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Focus & Memory Issues	
	• Immune System	<input type="checkbox"/>	<input type="checkbox"/>	Headaches & Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety & Stress	
	• Digestive System	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo & Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Balance & Coordination	
	• Nerve Supply to Shoulders, Arms & Hands	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat & Strep	<input type="checkbox"/>	<input type="checkbox"/>	Speech Issues	
	• Sympathetic Nucleus	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Tonsils & Adenoids	<input type="checkbox"/>	<input type="checkbox"/>	TMJ / Jaw Pain	
	• Metabolism	<input type="checkbox"/>	<input type="checkbox"/>	Vision & Hearing Issues	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck & Shoulders	
			<input type="checkbox"/>	<input type="checkbox"/>	Low Energy & Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Depression
			<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
			<input type="checkbox"/>	<input type="checkbox"/>	Pain, Numbness & Tingling in Arms to Hands	<input type="checkbox"/>	<input type="checkbox"/>	Poor Metabolism & Weight Control
	Upper Thoracic	• Upper G.I.	<input type="checkbox"/>	<input type="checkbox"/>	Reflux / GERD	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis & Pneumonia
• Respiratory System		<input type="checkbox"/>	<input type="checkbox"/>	Chronic Colds & Cough	<input type="checkbox"/>	<input type="checkbox"/>	Functional Heart Conditions	
• Cardiac Function		<input type="checkbox"/>	<input type="checkbox"/>	Asthma				
Mid Thoracic	• Major Digestive Center	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Pain / Issues	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion & Heartburn	
	• Detox & Immunity	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Pains & Ulcers	
		<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Blood Sugar Problems	
Lower Thoracic	• Stress Response	<input type="checkbox"/>	<input type="checkbox"/>	Behavior Issues	<input type="checkbox"/>	<input type="checkbox"/>	Allergies & Eczema	
	• Filtration & Elimination	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions / Rash	
	• Gut & Digestion	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	
	• Hormonal Control	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Stress	<input type="checkbox"/>	<input type="checkbox"/>	Gas Pain & Bloating	
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility)	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica & Radiating Pain	
		<input type="checkbox"/>	<input type="checkbox"/>	Chrohn's, Colitis & IBS	<input type="checkbox"/>	<input type="checkbox"/>	Lumbopelvic / SI Joint Pain	
	• Gut-Immune System	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Hamstring Tightness	
	• Major Hormonal Control	<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	Disc Degeneration	
		<input type="checkbox"/>	<input type="checkbox"/>	Bladder & Urination issues	<input type="checkbox"/>	<input type="checkbox"/>	Leg Weakness & Cramps	
		<input type="checkbox"/>	<input type="checkbox"/>	Cramps & Menstrual Issues	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation & Cold Feet	
		<input type="checkbox"/>	<input type="checkbox"/>	Cysts & Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Knee, Ankle & Foot Pain	
		<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Weak Ankles & Arches	
		<input type="checkbox"/>	<input type="checkbox"/>	Impotency	<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain	
		<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Gluten & Casein Intolerance	

Patient Name _____ Date _____

Bakersfield Chiropractic, Perry Chiropractic, Inc.

Dr. Stephanie M. Perry & Dr. William E. Perry
3900 Truxtun Avenue * Bakersfield, CA * 93309
661-631-0750

TERMS OF ACCEPTANCE

When a patient seeks Chiropractic health care and when a Chiropractor accepts a patient for such care, it is essential that they are both seeking and working for the same goals.

Chiropractic has only one goal. It is, therefore, important that the patient understands the goal and the means and methods that will be used to attain it. In this way, there will be no confusion, misunderstanding, nor disappointment.

Patients usually are only interested in getting rid of whatever ailment or condition that is bothering them. This, however, is **not** the goal of the Chiropractor.

The purpose of Chiropractic is to restore and maintain the mechanical integrity of the spinal cord and its nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine. Tiny misalignments of the vertebrae or bones of the spine which interfere with the function of these nerve pathways are called **SUBLUXATIONS**. They come from many causes and prevent various organs and glands from working properly.

By means of a Chiropractic adjustment, **SUBLUXATIONS** are corrected, thus restoring normal nerve function. The goal of chiropractic is to correct **vertebral subluxations** for the purpose of restoring the proper transmission of nerve energy over the nerve pathways, so that every part of the body may have a proper nerve supply at all times. This allows the innate healing ability of the body to work at maximum efficiency.

With proper nerve supply, health improves. Often, symptoms clear up; sometimes quickly- sometimes slowly- sometimes only partially- or not at all. Regardless of what disease a patient may or may not have, a Chiropractor does not offer to cure it, treat it, or offer advice regarding it. The only goal of Chiropractic is to allow the body to better express its own innate health potential. The only method used is the correction of the **vertebral subluxation**.

PLEASE BE AWARE THAT BY SIGNING YOUR NAME ON THIS FORM, YOU AGREE TO FOLLOW ALL INSTRUCTIONS THE DOCTOR GIVES YOU IN ORDER TO AFFECT THE GREATEST RECOVERY THAT IS POSSIBLE.

MUTUAL COOPERATION BETWEEN YOU AND THE DOCTOR IS A VERY NECESSARY PART OF YOUR RETURN TO GOOD HEALTH!!!

Patient's signature _____ Date _____

BAKERSFIELD FAMILY CHIROPRACTIC

3900 Truxtun Ave. Bakersfield, CA 93309
661.631.0570

Thank you for selecting us.

To help us meet all your healthcare needs, please read this form completely. If you have any questions or need assistance, please ask us and we will be happy to help.

WELCOME

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies please discuss them with our office. We are dedicated to providing the best possible care and service to you, and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless either you or your health insurance carrier has made other arrangements in advance, full payment is due at the time of service. For your convenience we accept VISA, MasterCard and Discover.

- The patient understands and agrees by his/her signature agrees upon the charges for professional services provided by Perry Chiropractic, Inc.
- Although you are responsible for the entire balance at the time of service, it is our office policy to bill your insurance carrier as a courtesy to you. We do require that your co-payment or deductible, if applicable, be paid at the time of service.
- Our fees are considered as usual, customary and reasonable fees based on the (RVU) of the Bakersfield city area. Some insurance companies set their own (UCR) fees, which may not be the same as our fees.
- The patient further understands and agrees that if the balance due is not paid in full within 60 days from the date of service, there will be a billing charge of 1.5% per month or 18% per annum until the outstanding balance is paid in full.
- If the account is assigned to collections, the patient will be responsible for the entire account balance owed plus any collection and reasonable attorney fees.

Patient/Guardian Signature _____ Date _____

Witness Signature _____ Date _____

4
ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
AND PRIVATE GROUP ACCIDENT AND HEALTH INSURANCE

RE:

Patient: _____

Employer: _____

Claim/Group # _____

SS#/ID# _____

I hereby instruct and direct the _____ Insurance Company
to pay by check made out and mailed directly to:

Or

If my current policy prohibits direct payment to doctor, then I hereby also instruct
and direct you to make out the check to me and mail it as follows:

c/o

for professional or medical expense benefits allowable, and otherwise payable to me
under my current insurance policy as payment toward the total charges for professional
services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND
BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to
the above mentioned assignee, and I have agreed to pay, in a current manner, any balance
of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the
original.

I also authorize the release of any information pertinent to my case to any insurance
company, adjuster, or attorney involved in this case.

Dated at _____ this _____ day of _____ 20____
City, State Date Month Year

Signature of Policyholder

Witness

Signature of Claimant, if other than Policyholder

**Bakersfield Family Chiropractic
Perry Chiropractic, Inc.**

Dr. Stephanie M. Perry & Dr. William E. Perry

EXPLANATION OF NON-COVERED MEDICARE SERVICES

Dear Patient:

In accordance with current Medicare regulations, this is to advise you that Medicare **will not** reimburse you for your initial examination, x-rays and any supports, supplements, ect, you may need in your recovery process.

All non –covered services will be charged directly to you and payment arrangements will be made for you.

Medicare will reimburse 80% of ALLOWABLE charges after a \$183 annual deductible has been met.

The follow procedures are also considered “non-covered services” and **are not** reimbursable to Medicare: supports and supplements.

Medicare pays on what they deem as medically necessary and your co-pay is \$8.63 per visit

If Medicare does not deem services medically necessary and do not pay your charge is \$43.13 per office visit.

I, _____ fully understand the above AND
Have received a copy of this explanation of non-covered services.

Patient signature _____ Date: _____

Witness _____ Date: _____

Bakersfield Family Chiropractic

Dr. William E. Perry
Dr. Stephanie M. Perry

Privacy Notice Consent

All California chiropractic patients are protected by the Health Insurance Portability and Assurance Act or (HIPAA). Passed by the US Congress in 1996, about a third of the Act deals with the privacy of your personal health information.

- You have the right to review and copy your own health information
- You have the right to request changes to your health records
- You have the right to request privacy protection for your health records
- You have the right to obtain an accounting of your personal health information disclosures
- The individual has the right to receive written notice of a covered entity's policies regarding privacy
- You have the right to consent to allow your personal health information to be used for the core functions of treatment, payment and health care operations
- You have the right to consent to allow your personal health information to be used or disclosed for other functions (authorization)
- You have the right to agree or object to certain limited disclosures of your personal health information

Most of this is common courtesy. Relax, knowing that California chiropractors, like all doctors, keep your health information private and protected.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Tatsuno Chiropractic, Inc. with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care information as described in the privacy notice.

Name (Print)

Date

Patient Signature

Authorized Facility Signature

Date

Informed Consent to Chiropractic Treatment

Bakersfield Family Chiropractic

3900 Truxtun Avenue

Bakersfield, CA 93309

661-631-0570

Dr. William E. Perry & Dr. Stephanie M. Perry

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

- 1.) Some patients may experience some stiffness or soreness following the first few days of treatment.
- 2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
- 3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
- 4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

Patient Signature

Patient Name (Please Print)

Witness Signature

Date

Tatsuno, Pedersen, Kinoshita, Perry & Huynh Chiropractic Offices

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name: _____ Last Name: _____

Email address: _____@_____

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

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

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked Start Date: _____

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

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

Religion: _____

Family Medical History

Family Medical History (Record one diagnosis in your family history and the affected relative)				
Health Condition (Write in below)	Father	Mother	Sibling: (Brother/Sister)	Offspring: (Son/Daughter)

Mothers Maiden Name: First: _____		Last: _____	
Next of Kin: _____		Relationship: _____	
Address: _____		City: _____	State: _____
Phone: _____			

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.) You can request copies at any time.

Patient Signature: _____

Date: _____