GATEWAY CHIROPRACTIC, P.C.
14930 LaPlaisance Rd #116 Monroe, MI 48161
(734) 242-4422

Date: _________________

NAME (last) __________________________________ (first) _________________________ (MI) _____

Address____
(Street) (City) (State) (Zip)

Home Phone #___________________ **Cell #** _____________________

Birth Date__________________ **Email** __________________________________

Marital Status: S M OTHER **SS#**_____________________________________

Occupation: ____________________________ Employer: ____

Emergency Contact: _____________________________________ Phone: ____________________________________

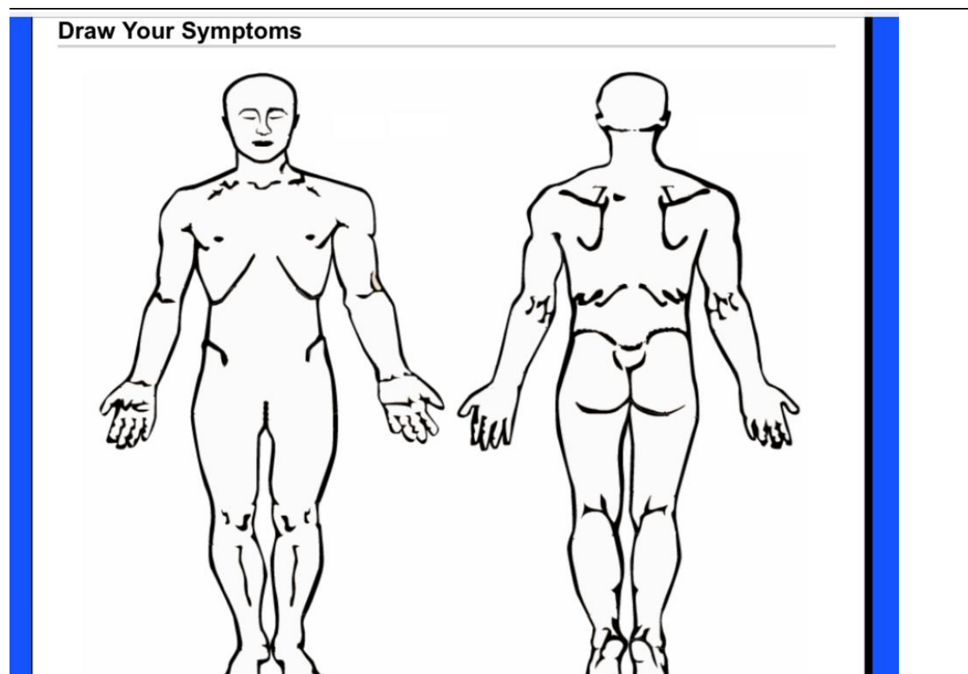
Health INS: BCBS PPOM AETNA PARAMOUNT NONE OTHER_______________________

Policy Holder: ____________________________________ **Policy Holders DOB:** _______________________

Enrollee ID# ________________________________ Group #_____________________________________

What is your chief complaint for your visit today?

____



What symptoms are you having? Check all that apply.

Aching __	Numbness__	Stabbing __	Diffuse __	Radiating __	Tightness __
Dull __	Sharp __	Tingling __	Cramping__	Pulsating __	Throbbing__
Excruciating__	Shooting __	Weakness__	Burning __	Pounding __	Stabbing __

Rate the severity of your pain at its least and greatest times by checking two boxes on scale.

0 1 2 3 4 5 6 7 8 9 10

When did this happen? ____

How did this happen? ____

How often do you feel the symptoms?
Less than 10% 25% 50% 75% 100%

What makes symptoms better? ______________________________________
What makes symptoms worse? ______________________________________

What other treatments have you done for this symptom?
Chiropractic ________ Pain Medication________ Exercise____________
Ice ________________ Heat _________________ Rest ________________

How is this affecting your daily life? What activities are you unable to do?
____
____

Height_________Weight___________ Do you use: **Alcohol** **Tobacco** **Caffeine**

Any previous illnesses/injuries? Please List
____
____

List all Surgeries:
Type_____________________________________ When______________________________
Type______________________________________ When______________________________
Type______________________________________ When______________________________

Current medications?
Name______________________________For what_____________How Long________
Name______________________________For what_____________How Long________
Name______________________________For what_____________How Long________
Name______________________________For what_____________How Long________

Please list any allergies :____
.
Any family history of back/neck problems? __________________________________

Do you have any vomiting, nausea, fever, chills, or any unexplained weight loss or weight gain? _________

Have you ever broken ribs or had any serious spinal injuries? ______ If yes, please explain to doctor upon examination

Past and Present Conditions
Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or presently troubled by a listed disorder.

Headaches_______
Neck Pain ____
Low Back Pain _____
Diabetic problems _____
Breathing problems _____
Sinus problems _____
Eye problems _____
Indigestion _____
Skin problems _____
Constipation _____
Liver problems _______
Weight problems ________

Dizziness ______
Pins/Needles in arms/hands ____
Pain in legs and feet _____
Heart Problems ______
Asthma _____
Allergies _____
Ear problems _____
Stomach problems _____
Gall Bladder problems _______
Bladder problems ______
Kidney problems ______
Fatigue ________

Weak Immune system_____
TMJ ______
Pain in joints _______
High Blood Pressure _____
Thyroid problems _______
Bowel problems ______
Menstrual problems ________
Sleeping problems ________

Whom can we thank for referring you to our office? ____

TERMS OF ACCEPTANCE

The goal of the chiropractor is not to diagnose/treat any disease but to locate, analyze, and correct vertebral subluxations. The purpose being to improve joint mechanics and to restore the innate healing mechanisms of the body via a nervous system free of irritation/interference. I consent to the customary examinations, tests and procedures performed at Gateway Chiropractic, P.C. and to routine chiropractic treatment ordered or administered by my chiropractor or other Clinic staff. I recognize that the practice of chiropractic is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of services administered to me in connection with this Agreement. I understand as with any health care procedure that certain complications may rarely occur such as fractures, disc injuries, muscle or vertebral strains, arterial dissection, or others.

*_________ INITIALS

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this clinic. Not limited to but including deductible, co-payment, and any services rejected by my insurance company.

Financial Policies:

-We will try our best to inform you of your insurance benefits, however we cannot be held responsible for what your insurance company tells us over the phone. Your EOB (Explanation of Benefits) is what we have to legally go by.

*__________ INITIALS

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional/chiropractic expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as original *_________ INITIALS

RELEASE OF INFORMATION

I authorize this clinic to release any patient information from my case to any insurance company, adjuster, and/or attorney involved in my case; and hereby release this clinic of any consequence thereof.

*_________ INITIALS

MISSED APPOINTMENT POLICY

Gateway Chiropractic, P.C. reserves the right to bill any patient for a missed appointment with no advance notice of cancellation or reschedule. *_________ INITIALS

SIGNATURE____ DATE____________.

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Gateway Family Chiropractic's "Notice of Privacy Practices" has been provided to me.

I understand that I have a right to review Gateway Family Chiropractic's Notice of Privacy prior to signing this document. Gateway Family Chiropractic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Gateway Family Chiropractic. The Notice of Privacy Practices for Gateway Family Chiropractic is also provided on request at the main administration desk of this practice. Notice of Privacy Practices also describes my rights and Gateway Family Chiropractic's duties with respect to my protected health information.

Gateway Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the offices and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____ __________________

Signature of Patient or Personal Representative Date

____

Print Name of Patient or Personal Representative

____

Description of Personal Representative's Authority