

## WEBSTER CHIROPRACTIC CARE

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status: M S W

Email: \_\_\_\_\_

May we contact you or send helpful health information via Email?

Yes No

### **Workers Compensation/No Fault :**

Claim# \_\_\_\_\_

Social Security# \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Adjustor Name: \_\_\_\_\_

Employer when injured: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Dates of Missed Work: \_\_\_\_\_

Names of other treating doctors: \_\_\_\_\_

**NAME:** \_\_\_\_\_

How did your pain start? \_\_\_\_\_

Date pain started? \_\_\_\_\_ How long have you had this pain? \_\_\_\_\_

What do you think is causing your pain? \_\_\_\_\_

What makes the pain better? \_\_\_\_\_

What makes the pain worse? \_\_\_\_\_

Can you describe the way your pain feels?  
\_\_\_\_\_

What have you done to treat the pain?  
\_\_\_\_\_

What current activities would you like to do, that your pain inhibits you from doing? (please list)(ex. Golfing, biking, vacuuming, gardening, walking etc.)

How is most of your day spent? Standing Sitting Other \_\_\_\_\_

Please Circle:

Is the pain: Intermittent Continuous Positional W/Activities

Is this condition getting progressively worse? Yes No

Does this interfere with Sleep? Yes No

Have you gained or lost weight unexpectedly? Yes No

Have you ever had a similar condition? Yes No

Bowel or bladder problems from pain? Yes No

Do you currently wear shoe inserts? Yes No

**NAME:** \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of last: (Circle all that apply)

Physical exam: 1-4months    5-9mths    12mths or greater    never

Blood Work:    1-4months    5-9mths    12mths or greater    never

Urine:            1-3months    5-9mths    12mths or greater    never

Bone Density: 1-3months    5-9mths    12mths or greater    never

List surgical operations and year performed:

Medications/Supplements/Herbs: \_\_\_\_\_

Have you undergone: (Circle all that apply)

Physical Therapy    Massage Therapy    Acupuncture    Injections

Have you had Chiropractic Care before?    Yes            No

Date of Last Treatment: \_\_\_\_\_

Do you have a chiropractic physician preference in this office?

Female

Male

No Preference

**In case of an Emergency Contact:** \_\_\_\_\_

Relation \_\_\_\_\_ Phone \_\_\_\_\_

**NAME:** \_\_\_\_\_

Have you ever had any of the following? <u>Circle all that apply:</u>		
Anxiety	Osteoporosis	Tremors/Shakes
Aneurysm	Stroke	Blood Clots
Heart Attack	Heart Disease	Atrial Fibrillation
Chest Pain	Jaw Pain	Sweating/Night Sweats
High Blood Pressure	High Cholesterol	Acid Reflux
Hernia	Blood Thinners	Rib Disorder
Pregnancy	Hormone Replacement	Birth Control
Multiple Sclerosis	Rheumatoid Arthritis	Diabetes
Dizziness	Headaches	Migraines
Sinus Trouble	Cancer	Prostate Disorder
Joint Replacement	Pacemaker	Heart Surgery
Ulcerative Colitis	Autoimmune Dz	Allergies
Crohns	Gallbladder Trouble	Gout
Skin Ulcerations	HIV/AIDS	Shingles

Life Style:

Exercise: \_\_\_\_\_ times a week - month - year.

Tobacco: \_\_\_\_\_ packs per day - week - month - year.

Alcohol: \_\_\_\_\_ drinks a day - week - month - year.

Family Medical History (first degree relatives only): Circle all that apply:

Heart attack	Diabetes	Stroke	Cancer
Multiple Sclerosis	Rheumatoid Arthritis	Autoimmune Dz	

Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION OF INSURANCE PAYMENT**  
**Webster Chiropractic Care, P.C.**

I hereby instruct and direct my insurance company to pay by check made out and mailed to:

**Webster Chiropractic Care**  
**Dr. Alaina Keem & Dr. Matthew Keem**  
**60 Barrett Drive**  
**Webster, New York 14580**

or If my current policy prohibits direct payment to the doctors, I acknowledge that I will make payment to the above mentioned health care provider.

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This insurance payment along with any required deductible, co-insurance, or co-payment will be accepted as payment in full. 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.

I authorize the doctors to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

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**Signature of Policyholder or Patient**

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**Date**

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**Name of Policyholder or Patient (Print)**

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**Date**

---

**Witness**

---

**Date**

**HIPPA Release**  
**Webster Chiropractic Care, P.C.**

*Patient consent for use and disclosure of  
protected health information (HIPPA) for  
Webster Chiropractic Care*

I hereby give my consent for Alaina Keem DC, Matthew Keem DC, or any other personnel of **Webster Chiropractic Care** to use and disclose protected health information (PHI) about me in order to carry out treatment, payment and healthcare operations (TPO).

With this consent, Alaina Keem DC, Matthew Keem DC, or other personnel of **Webster Chiropractic Care** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, **Webster Chiropractic Care** may mail to my home or other alternative location any item that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, **Webster Chiropractic Care** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Webster Chiropractic Care** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Webster Chiropractic Care** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Webster Chiropractic Care** may decline to provide treatment to me.

\_\_\_\_\_  
Patient's Name (PRINT)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

# CURRENT PAIN DIAGRAM

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

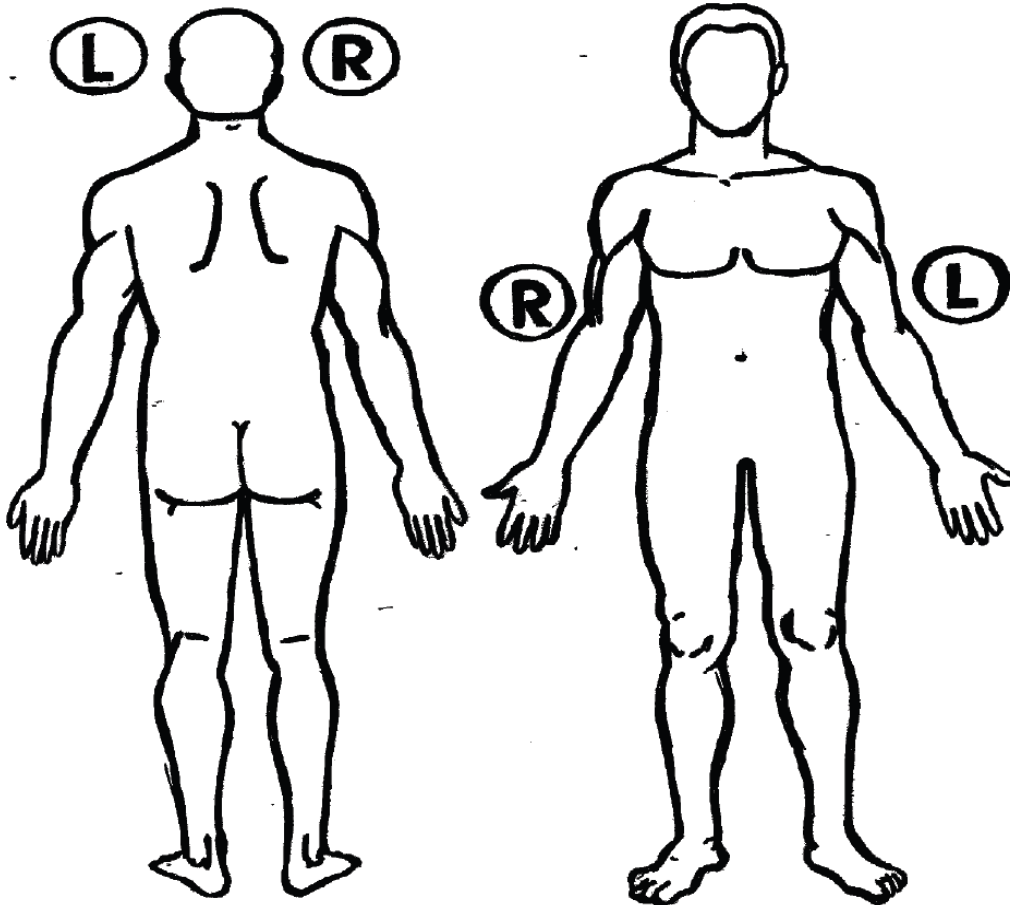
Mark all the areas of your body where you feel pain NOW.  
Use the symbols below to describe the type of pain in the area of pain.

ACHE #####  
BURNING xxxxx

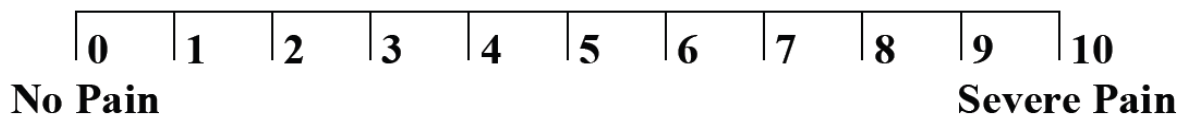
NUMBNESS =====  
STABBING ////

PINS& NEEDLES oooo  
OTHER ^^^^ (please describe)

**Draw At The Location Of Your Pain**



Rate Your Pain For TODAY



What is your chief complaint today? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

