WELCOME TO SAUTRE CHIROPRACTIC

We are truly pleased that you are seeking care with us. The following Protected Health Information is needed to better serve you. Please complete all questions to the best of your ability. If you need help, ask the assistant.

PATIENT: Today's Date ___/___/___

Last Name:_____ First Name_____ Middle Initial: ____

Gender: M F Date of Birth: ___/___/___ Age: ____ Marital Status: M W D S No of children:_____

If minor, Name of Mother_____ Father:_____

Home Address: _____City:_____ State: ____ Zip: _____

Cell phone:_____ Home phone: _____ SS#: _____

email: _____ Occupation : _____

Employer: _____ Years of employment ____ Work phone: _____

Referred to the office by:_____

EMERGENCY CONTACT:

Last Name:_____ First Name_____

Relation to patient: _____ Occupation:_____ Phone: _____

PAYMENT Circle preferred method of payment: Cash Check Debit / Credit Card

FINANCIAL RESPONSIBILITY: Self___ Other person___

RESPONSIBLE PARTY: Insured's Name: _____

Insurance Plan: _____ ID/Policy #_____

Date of Birth if responsible party is not the patient: ___/___/___

For which of these reasons are you seeking care?

Referred by MD ___ Atlas Orthogonal ___ Pediatric/Family Care ___ Sports Chiropractic ____

Better Life Expression/Wellness___ Other (please describe):_____

Is your condition due to an accident? Yes ___ No ___ If yes, Date of Accident: ____/____/____

Type of Accident? Auto___ Work/On job ____ At Home ____ Sports ____ Other: _____

Have you ever been in a similar accident? Past year ___ Past 5 years ___ Over 5 years___ Never ___

Describe: _____

Primary Care Doctor:_____ **Phone #**_____

Check off any drugs you are now taking: ___Pain killers ___Muscle relaxers ___ Birth Control ___Blood Pressure Rx

___ Sleeping Pills ___ Cholesterol medication ___ Tranquilizers/Antidepressant ___ Nerve medication

Other (please list) _____

Recent X-rays or MRI/CT Scan: Yes ___ No ___ Date:___/___/__ Location where taken:_____

2016 Insurance Information Update:

Patient Name: _____

Date of Birth: _____/_____/_____

PLEASE MARK ALL OPTIONS THAT MAY APPLY, *our staff will review your options so you can choose the best plan for your situation:*

□ **I have a Flex Account/Health Saving Account.** We will provide you with receipts to document use of your account for chiropractic services.

□ **I have Medicare Part B as my primary coverage.** Please note that Medicare covers care for a condition considered acute when the patient is being treated for a **new injury or accident**, identified by x-ray and/or physical exam. Chiropractic care for chronic conditions is only allowed when some functional improvement is expected. Once the clinical status has remained stable, Medicare considers chiropractic care **maintenance and it is not covered**.

□ **I have insurance for chiropractic care** (please provide us with insurance card) Please remember that insurance is a contract between the beneficiary (patient) and the insurance company and ultimately the patient is responsible for payment in full. We will file insurance for you; you will be responsible for any deductibles, non-covered services and co-pays at the time of service.

□ **I am an active CLA member** (please provide us with CLA card)

□ **I am interested in CLA membership.** Better than your insurance? You decide:

Chiropractic Lifecare of America (CLA) is a medical discount organization. The membership cost is $49.95 per year. No limited number of visits, no deductibles, no claim forms, no maximum dollar limits, no age limits for subscribers, allows maintenance visits, promotes wellness care and it includes the entire family!

CLA will save you and your family members 50% off examinations, consultations and diagnostics, 50% off in-house x-ray studies, and a spinal adjustment/visit fee of $40. With CLA membership you are eligible for Individual, Family, Senior and Student monthly plans.

□ **I do not have health insurance.** I will pay for chiropractic care at the time of service.

□ **I choose not to use my insurance.** Do not bill my insurance and do not disclose private health information to my insurance.

_____ _____

Patient Signature Date

(Staff only) Insurance benefits verified with third party:

___Deductible ___Copay ___ Visits/Year Estimated payment per visit: _____

Your body is designed to function at its maximum potential. Throughout life, events occur which may affect your health. This questionnaire will uncover the layers of damages, especially to your spine and nervous system, that have affected your life and health.

CURRENT HEALTH INFORMATION: Please Circle

Do you have back pain? Describe _____ Yes No
Do you have neck pain? Describe _____ Yes No
Do you experience pain in other articulations? Describe _____ Yes No
Do you like your posture? _____ Yes No
Do you practice spinal stretching on a routine basis? _____ Yes No
Do you feel some restriction with certain movements? Describe _____ Yes No
Do you think you have spinal degeneration? _____ Yes No
Have you ever had a serious injury to your head, neck or spine? _____ Yes No

List accidents, sports injuries or trauma you have had: _____

FROM BIRTH TO CHILDHOOD

Was your birth process difficult?	Yes	No	Were you breastfed?	Yes	No
Did you carry a heavy backpack?	Yes	No	Did you experience serious falls?	Yes	No
Did you have ear infections?	Yes	No	Were you picked on by siblings?	Yes	No
Did you have teeth problems?	Yes	No	Were you pulled by your arm?	Yes	No
Did you experience mental stress at school or with family?	Yes	No	Were you taught how to take care of your spine?	Yes	No

Please indicate if you had (or have been diagnosed with) any of the following:

Alcoholism	Yes	No	Fracture	Yes	No	Pacemaker	Yes	No
Allergies	Yes	No	Goiter	Yes	No	Parkinson's	Yes	No
Anemia	Yes	No	Gout	Yes	No	Pinched nerve	Yes	No
Appendicitis	Yes	No	Heart Trouble	Yes	No	Prostate problems	Yes	No
Arthritis	Yes	No	Hepatitis	Yes	No	Psychiatric care	Yes	No
AIDS	Yes	No	Hernia	Yes	No	Respiratory conditions	Yes	No
Blood disease	Yes	No	Herniated disc	Yes	No	Stroke	Yes	No
Breast Lumps	Yes	No	High Cholesterol	Yes	No	Suicide attempt	Yes	No
Bulimia	Yes	No	Kidney Condition	Yes	No	Thyroid problems	Yes	No
Cancer	Yes	No	Liver Condition	Yes	No	Tumors/Growths	Yes	No
Chest pain	Yes	No	Headaches	Yes	No	Ulcers	Yes	No
Low blood pressure	Yes	No	Hypertension	Yes	No	Skin problems	Yes	No
Diabetes	Yes	No	Miscarriages	Yes	No	Indigestions	Yes	No
Epilepsy	Yes	No	Multiple Sclerosis	Yes	No	Swelling in legs/ankles	Yes	No
Hearing problems	Yes	No	Muscle Spasms	Yes	No	Skin conditions	Yes	No
Eye condition	Yes	No	Osteoporosis	Yes	No	Sinus pain	Yes	No
Genital condition	Yes	No	Loss of balance	Yes	No	Urinary problems	Yes	No
Fertility issues	Yes	No	Ringing in ears	Yes	No	OTHER _____		

Please Circle All That Apply:

EXERCISE	WORK ACTIVITY	NUTRITION	REST
None	Sitting/Standing	8-10 glasses of water daily	Sleep on back / Side
Weekly	Light labor	Fresh fruits and vegetables	Sleep on stomach
Daily	Heavy labor	Skip meals	I have a day off each week
Training Program	Stress: Moderate - Severe	Caffeine - Alcohol	After sleeping, I feel good - Tired

SOCIAL AND PERSONAL HISTORY

Smoking
Enjoy sufficient recreation time
Spend time with family or friends
Family Stress
Pray or meditate
Feel depressed

FAMILY HISTORY

Scoliosis
Cancer
Stroke
Cardiovascular condition
Diabetes
Other: _____

Parents age: Father ____ Mother____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status, I shall inform the doctor and staff at the next appointment.

X _____ **DATE** _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Print Name of Patient or Legal Guardian _____

NAME:_____ Date: ____/____/____

CURRENT COMPLAINT(s) HISTORY:

Describe the current complaint(s) _____

How long have you had this condition? Years___ Months___ Days___ Date of Onset:_____

How would you describe your pain:

Sharp___ Soreness___ Throbbing___ Tingling___ Dull___ Stiffness___

Spasm___ Burning___ Ache___ Weakness___ Numbness___ Shooting___

How would you rate the intensity of the pain (circle the appropriate number)

0 1 2 3 4 5 6 7 8 9 10

(No pain) (Moderate pain) (Terrible/unbearable pain)

How often is the pain present?

Constant____(81-100%) Frequent____(51-80%) Occasional____(26-50%) Intermittent___(25% or less)

Since your problem began is the pain: Getting worse____ Getting better____ Staying the same____

How did your condition begin?

Gradual____ Sudden____ No specific reason____

Auto Accident____ Work-related injury____ Sports injury____ Other accident_____

What makes your problem better?

Nothing____ Walking____ Standing____ Sitting____ Moving/exercise____ Laying Down____

What makes your problem worse?

Nothing____ Walking____ Standing____ Sitting____ Moving/exercise____ Laying Down____

Is this condition interfering with your: Work____ Sleep____ Daily activities____ Other_____

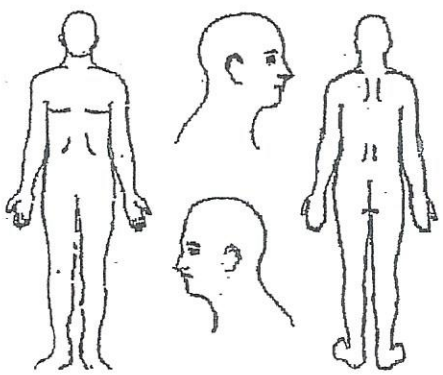
Did another doctor treat you for this condition? _____

Are you currently taking any medication? No___ Yes:_____

Do you use any home remedies or non-prescription drugs? No___ Yes:_____

Did you have any surgical procedures? Past____ Present____ Please list:_____

Place an "X" on the drawing where you have pain or other symptoms



I have reviewed the information contained on this form with the patient

_____
Patient Name

_____
Provider Initials

ANNUAL CONSENT FORM

Sautre Chiropractic

Consent to Release Protected Health Information (PHI) and/or Records to a Spouse, Family Member or Significant Other: *Please check box that applies.*
Sautre Chiropractic (Serge Sautre DC, PC) designated employee may want to contact you by phone with information such as scheduling follow ups or checkups, to see how you are doing after your visit or instructions from your doctor. We can leave detailed PHI on your voicemail and/or email with your consent.

Which phone number may we leave messages?

□Phone #_____(□ Cell □Home □Work)

□**Email** _____

May we leave messages with a representative of your choice?

□Name_____□Relationship_____

□I do not consent to messages being left with anyone other than myself.

Consent for Chiropractic Care: Permission is hereby given for any chiropractic procedures including necessary x-rays, clinical tests or adjustments as may be deemed necessary by licensed Doctor of Chiropractic. I understand that as in the practice of medicine, in chiropractic there are some risks to care including, but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to be able to anticipate and explain risks and complications, and I wish to rely on the doctor's judgment during the course of the procedure which the doctor feels necessary at the time, based on facts then known, is in my best interest.

Financial Responsibility: I understand the responsibility of each patient is to arrange for payment for the services received in this office. I hereby authorize any insurance benefits to be paid directly to Sautre Chiropractic (Serge Sautre, DC, PC), and recognize my responsibility to pay for all non-covered services, including out of network insurance expenses that may apply. All insurance will be verified at the time of service at no charge. I also authorize the release of any information necessary to process an insurance claim. Charges for all minors are the responsibility of the parent, guardian, or individual presenting the child for treatment.

Consent to Obtain Health Records: I hereby authorize Sautre Chiropractic to obtain medical records from any other physician or medical facility necessary in the course of my care.

Acknowledgement of Privacy Rights:

By signing below I acknowledge that I have reviewed Sautre Chiropractic notice of Privacy Practices and Individual Rights.

I acknowledge that I have read the above, am giving my consent to the above, and am acknowledging I have been informed of my rights to privacy.

Print Name_____

Signature_____ Date_____

FEMALE PATIENTS ONLY

By my signature on this form I,_____
do hereby state that I am not pregnant, neither suspected nor confirmed at this particular time.

The first day of my last menstrual period was: _____/_____/_____

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date