Name: _____ Age: _____ Date: _____

Address: _____ City _____ State _____ Zip _____

Home Telephone ( ) _____ Work ( ) _____ Cell ( ) _____

We use text messaging for appointment reminders. Who is your cell phone company? _____

Email Address: _____ Male _____ Female _____

Social Security # _____ Birth Date: _____

Occupation: _____

Employer Name and Address: _____

Single _____ Married _____ Spouse's Name _____

Have you seen a Chiropractor before? Yes No If yes, when? _____

Whom may we thank for referring you to our office ? _____

YOUR HEALTH SUMMARY

Please ☑ check all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pins and Needles in legs	☐ Fainting	☐ Neck Pain
☐ Pins and Needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Neck stiff	☐ Cold hands	☐ Cold feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot flashes
☐ Cold sweats	☐ Lights bother eyes	☐ Problem urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual Pain	☐ Menstrual irregularity	☐ Ulcers

List any medications you are taking _____

_____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office To examine me for further evaluation.

Patient Signature_____ Date_____

Guardian Signature _____ Date_____

Functional Rating Index

For use with Neck and/or Back Problems only.
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

_____ _____
Signature Date

Patient Quality Of Life Survey Example

blueprint to Gut Health

PRACTICE INFORMATION HERE

Patient Quality Of Life Survey

Name: _____ ***Date:*** _____

Please take several minutes to answer these questions so we can help you get better.
(Please circle as many that apply)

1. How have you taken care of your health in the past?
   - a. Medications
   - b. Emergency Room
   - c. Routine Medical
   - d. Exercise
   - e. Nutrition/Diet
   - f. Holistic Care
   - g. Vitamins
   - h. Chiropractic
   - i. Other (please specify): _____

2. How did the previous method(s) work out for you?
   - a. Bad results
   - b. Some results
   - c. Great results
   - d. Nothing changed
   - e. Did not get worse
   - f. Did not work very long
   - g. Still trying
   - h. Confused

3. How have others been affected by your health condition?
   - a. No one is affected
   - b. Haven't noticed any problem
   - c. They tell me to do something
   - d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?
   - a. Job
   - b. Kids
   - c. Future ability
   - d. Marriage
   - e. Self-esteem
   - f. Sleep
   - g. Time
   - h. Finances
   - i. Freedom

5. Are there health conditions you are afraid this might turn into?
   a. Family health problems
   b. Heart disease
   c. Cancer
   d. Diabetes
   e. Arthritis
   f. Fibromyalgia
   g. Depression
   h. Chronic Fatigue
   i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

What are you most concerned with regarding your problem?

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

What would be different/better without this problem? Please be specific

What do you desire most to get from working with us?

What would that mean to you?

blueprint nutrition

Trust Your Gut Wellness Evaluation

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to LGS go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please take the quiz to help our doctors evaluate how we can help your condition and any underlying triggering limiting your health in process

Let's get started.

Please circle any that apply to you prior to taking the quiz below:

Sub-Clinical symptoms including:
Headaches and migraines

Hormone imbalance including:
PMS
Emotional imbalance

Gastrointestinal issues including:
Abdominal bloating and cramps or painful gas
Irritable Bowel Syndrome
Ulcerative Colitis
Crohn's Disease and other intestinal disorders

Respiratory Conditions including:
Chronic sinusitis
Asthma
Allergies

Autoimmune Conditions including:
Diabetes Mellitus
Lupus
Rheumatoid Arthritis
Fibromyalgia
Chronic Fatigue

Developmental and social concerns including:
Austism
ADD/ADHD

Skin Conditions: (urticaria)
Eczema
Skin rashes
Hives

Please complete our TYG wellness quiz. While there's more to it than a single quiz, the answers below can give you a good idea of how happy your gut really is. Circle the number that most closely fits, then add up your results.

TYG Wellness Questionnaire

	None	Mild	Moderate	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Moderate	Severe
Asthma, hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Ulcerative colitis or celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight Trouble	0	1	2	3

FINANCIAL POLICY

For Champaign Chiropractic Clinic

The following statement is our Financial Policy. It is required that the patient and/or responsible party read and sign this statement prior to any treatment.

Co-Pays

All co-pays and deductibles are due at time of service. If you are unable or unwilling to pay the co-pay, your appointment will be rescheduled until such a time that you can pay the co-pay.

Workers' Compensation

You must notify us prior to being seen by the physician if we are seeing you for a work related injury. Your employer must complete and sign an "employer's worker's compensation acknowledgement" form. It is your responsibility to bring this completed form with you along with all billing information for your account (carrier name and address, contact person, telephone number and claim number if applicable). This information must be provided to us prior to treatment.

Liability Injury

If you are being seen due to a liability injury you must provide the following information for billing and verification of payment prior to treatment:

*auto accident: if you were injured in your own car you must provide us with the name and address of your auto insurance company, your agent/adjuster's name, telephone number, your claim number and date of accident. If your injury occurred in someone else's car, we require all of the above information "and" the following, their name, the name and address of their auto insurance company, their agent/adjuster's name, telephone number and their claim number. We do not bill 3rd party insurance.

*slip and fall, etc: if you were injured on residential property or in a residential dwelling, we require the following, homeowner's name, the name and address of their homeowner's insurance company, their agent/adjuster's name, telephone number, their claim number and the date of accident. If your injury occurred at a place of business, please provide basically the same information.

Delinquent Account

You understand that your balance is due upon receipt of your statement. If you do not pay the balance in full within 60 days of the statement, your account will become delinquent. You agree to pay a finance charge at the rate of 1 1\2% per month (18% per year) on all unpaid balances commencing 60 days from the date of service. You also agree to pay a $20.00 service charge on all returned checks.

Collection Costs and Procedures

I agree to pay all reasonable costs you incur to collect this debt. This includes, unless prohibited by law, all reasonable attorney's fees, filing fees, court costs, collection agency costs, service fees, and other related collection costs or contingencies. I understand that if any unpaid balance is turned over to our collection agency that a fee ranging from 30%-50% will be added to the total balance due. I hereby give you or any of your agents or assignees to whom you turnover any unpaid balance permission to obtain a report from a credit reporting agency and to take reasonable steps to verify my credit and or employment information. I give you or any of your agents or assignees to whom you turnover any unpaid balance to contact me regarding this transaction or any future transaction at any telephone numbers of which they are aware including cellular telephones by manually dialing, using an auto-dialer or pre-recorded message. **By signing below you affirm that you read and understood our Financial Policy and that you agree to its contents.**

No-show, Cancellation, and Late Arrival Policy

Effective 7/22/2019 all appointments must be cancelled if you are unable to attend within a 24-hour period. Failure to notify any of our staff that you will not be coming to your scheduled appointment will result in a $25.00 no-show fee. You will also be considered a no-show if you arrive 30 minutes or greater for your scheduled appointment time. This will also result in a $25.00 no-show fee. CMS and all other medical insurance companies will not cover late cancellation, missed appointments, or late arrivals, therefore the patient will be financially liable.

Champaign Chiropractic Clinic will be enacting this new policy to ensure that all of our patients have a positive experience in our office as well as allowing someone else your appointment time. The new policy will ensure that our staff and doctors can work more efficiently without having to alter their schedules due to one or two patients.

We sincerely hope our patients never have to be charged for such events. However, when multiple patients are waiting days and in some cases a week or more for an appointment, a last minute cancellation/no-show/late patient affects not only the doctors but also other patients.

Thank you for understanding!

Kindly,

Champaign Chiropractic Clinic

Signature:_____