Patient Information

Name: _____ Date: _____

Birthdate: _____ /_____ /_____ Age: _____ Gender: _____ Height: ____'____" Weight: _____

Phone: _____ Email: _____

Address: _____ City: _____ Zip code: _____

Occupation: _____ Years employed: _____

Status: Married Single Widowed Divorced In a relationship

Spouse/Significant other's name: _____ Number of children: _____

Emergency Contact: _____ Phone: _____

Relationship: _____ How did you hear about our office? _____

Patient Condition

Reason for visit: _____ When symptoms appeared: _____

Pain level from 1 to 10: _____ Pain felt when: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down

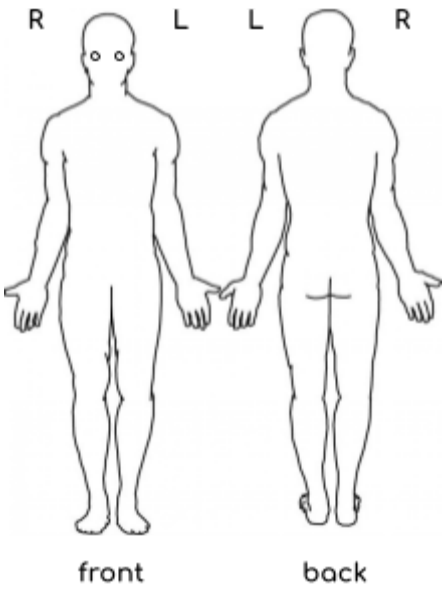
Type of Pain: ☐Sharp ☐Numb ☐Burning ☐Tingling ☐Throbbing ☐Stiff ☐Cramping ☐Aching

Current medications: _____

Other doctor(s) seen for this condition: _____

Have you seen a chiropractor before? _____ If so, how long ago? _____

Please mark on the picture where you have pain:



For Doctor's use only

Health History

Please circle any conditions that you have, or have had previously.

AIDS/HIV	Emphysema	Mumps
Alcoholism	Epilepsy	Osteoporosis
Allergies	Fractures	Pacemaker
Anemia	Glaucoma	Parkinson's disease
Anorexia	Goiter	Pinched nerve
Anxiety	Gonorrhea	Pneumonia
Appendicitis	Gout	Polio
Arthritis	Headaches	Psychiatric care
Asthma	Heart attack	Scarlet fever
Bowel abnormalities	Hernia	Scoliosis
Bladder abnormalities	Herniated disk	Seizures
Breast lump	Herpes	STD
Bronchitis	High blood pressure	Stroke
Bulimia	High cholesterol	Suicide attempts
Cancer	Hypoglycemia	Thyroid problems
Cataracts	Kidney disease	Tonsillitis
Chest pain	Liver disease	Tuberculosis
Chicken pox	Measles	Tumors
Depression	Metal implants	Ulcers
Diabetes	Miscarriage	Genital infections
Dizziness	Mono	Whooping cough

Are you currently pregnant? _____ If yes, when is your due date? _____

Do you have a special diet? _____ If yes, please explain: _____

Activity level: ☐Sedentary ☐Light ☐Moderate ☐Active **Exercise level:**☐Low☐Moderate☐Vigorous

Work activity: ☐Sitting ☐Standing ☐Light ☐Heavy **Days worked per week:** _____

Habits: ☐Smoking Packs per week: _____ ☐Caffeinated drinks Cups per day: _____

☐Alcohol Drinks per week: _____ ☐ High stress level Reason: _____

☐Drugs Days per week: _____

Please list and date any previous injuries, surgeries, and/or auto accidents:

_____

_____

Informed Consent to Chiropractic Treatment and Care

I hereby request and consent to the performance of procedures within the scope of the practice of chiropractic, including, but not limited to chiropractic adjustments, various modes of physical therapy (including Pulsed Electromagnetic Field Therapy), and diagnostic x-rays for myself (or the patient for whom I am legally responsible) by Dr. Toy and his associates. I understand that, as in the practice of medicine and other clinical therapies, there are some risks to treatment, including, but not limited to temporary aggravation of my condition or soreness. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on their judgment during the course of my treatment regarding what they feel will be most profitable and effective, with my best interest in mind.

Signature: _____ Date: _____

Price Acknowledgment and Past Due / Collection Agreement

I acknowledge that all payments are due at the time of service, unless prior payment arrangements have been made. In the event that my account has an outstanding balance that exceeds 30 days with no contact from me, my account will be forwarded to American Capital Ent. Inc., a collection agency.

I acknowledge that Dr. Toy and his associates do not accept insurance and do not have a medical billing department to handle the submitting of claims; as such, I am requesting that I receive treatment and that medical bills not be sent to any insurance that I may have. Additionally, I recognize that the rendered chiropractic services will be considered maintenance care and are a non-covered service by most insurances. I recognize that, to be treated as a patient, I will need to pay an out-of-pocket price. I accept the following: the initial adult exam is $105.00 and subsequent visits are $45.00; for students in high school or younger, as well as seniors who are 65 years of age and over, the initial exam is $85.00 and subsequent visits are $40.00 and $35.00 respectively. If two years have passed between visits, there will be an additional $15.00 re-exam fee; there is a $15.00 missed appointment fee. X-RAYS ARE AN ADDITIONAL CHARGE.

Signature: _____ Date: _____

Pregnancy Release (if applicable)

To the best of my knowledge, I am not pregnant. The doctor has my permission to perform an x-ray evaluation which can be hazardous to an unborn child. Date of last menstrual period: _____

Signature: _____ Date: _____

Authorization for the Release of Medical Records (if desired)

I consent to the release of any and all medical records for services rendered at Dr. Toy Chiropractic. I understand that my records may include sensitive materials, that I may revoke this authorization at any time, and that the revocation will not apply to my insurance company when contesting a claim.

Signature: _____ Date: _____