

Patient Information:

Last Name:		First Name:			MI:
Address:				Apt/Suite #:	
City:	St:	Zip	Date of Birth:		
Marital Status:	Single Married Other	Sex:	M / F	Social Sec. #(SSN):	
Home Phone:		Employer:			
Work Phone:		Occupation:			
Cell Phone:		Email Address:			
Name of Emergency Contact:					
Emergency Contact Phone #:			Relationship to Emergency Contact:		
How did you hear about us?					

If you intend to use insurance, please be sure to present your insurance card to the receptionist – OR – complete the information below..

Primary Insurance Name and Address:	
Policy #:	Group #:
Primary Insured Name:	
Primary Insured Phone #:	Primary Insured DOB
Relation to Primary Insured:	SSN:
Primary Insured Employer	

Authorization – I hereby authorize Tierney Chiropractic (TC) to examine and care for my condition. TC has the right to release any medical or other information necessary to process this claim. I request payment of medical benefits from either a government or non-government source to TC. I authorize TC to initiate deemed complaints to the Insurance Commissioner on my behalf. **I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered**, and I understand that I will be charged at a 6% annual percentage rate on any non-contract insurance balances over 90 days. I further understand that I will be legally responsible for all collection costs involved with the collection of this account including all court costs, reasonable attorney fees and all other expenses incurred with collection, if I default on this agreement. In addition, if I issue a check that is returned by the bank for non-sufficient funds, I understand I will be charged \$30.00 for each returned check. While TC will aide in the processing of my non-contract insurance claim, I understand that if my insurance does not pay within 60 days, my account will be adjusted to self-pay and due in full. I certify this information in true and correct to the best of my knowledge.

Signature

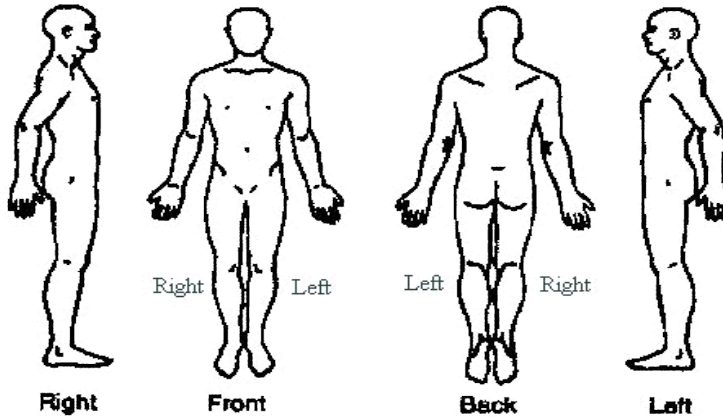
Date

Chief Complaint (your current presenting condition)

Describe your current injury or your current problem, if any: _____

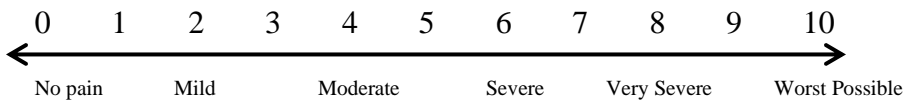
Please mark/draw your symptoms on the diagram:

- Aching - XXX
- Burning - ###
- Numbness - ///
- Pins/Needles - 000
- Stabbing - ●●●



Doctor Use Only:

Rate your pain right now (mark as "O"); average pain level (mark as "X")



Is your condition due to a recent accident or a recent injury? Yes No

If Yes, what type; Worker's Comp Motor Vehicle Accident Sports Injury Slip & Fall

(or other) _____

When did your complaints and/or symptoms begin? _____

What helps/alleviates this condition? _____

What aggravates this condition? _____

Have you sought alternative or medical care for this specific condition? Yes No If yes,

How do you want us to handle your current problem? (Check)

- Temporary/Relief Care – Treat the problem to reduce the symptom (with the problem likely to return)
- Stabilization Care – Treat the problem until the issue has stabilized and is improved
- Wellness Care - (Schedule Regular and on-going “tune-ups” for true preventative care)
- I would prefer to have Dr. Tierney discuss these options with me.

Review of Systems:

Please check any **PRESENT** or **RECENT PAST** (less than 3 months) symptoms you have experienced:

<p><u>HEAD, FACE & JAW,</u> <u>PAIN / HEADACHE</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Side <input type="checkbox"/> Front <input type="checkbox"/> Base of Skull <input type="checkbox"/> Top <input type="checkbox"/> Band around Head <input type="checkbox"/> Hat-type pressure <input type="checkbox"/> Migraine <input type="checkbox"/> Heavy head <input type="checkbox"/> Throbbing from neck <input type="checkbox"/> Affects Vision <input type="checkbox"/> Produces Nausea <input type="checkbox"/> Incapacitating <p><u>FACE:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain <input type="checkbox"/> Flushing <input type="checkbox"/> Twitching <p><u>JAW:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain <input type="checkbox"/> Clicking <p><i>WORSE WHEN:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Sleeping <input type="checkbox"/> Eating <p><u>EYES, EARS, NOSE,</u> <u>THROAT & MOUTH:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain <input type="checkbox"/> Strain <input type="checkbox"/> Red <input type="checkbox"/> Light hurts <input type="checkbox"/> Double vision <input type="checkbox"/> Spots <input type="checkbox"/> Glasses <p><u>EAR:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Ache <input type="checkbox"/> Ringing <p><u>NOSE:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Bleeding <p><u>THROAT:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Sore <input type="checkbox"/> Painful <input type="checkbox"/> Tightness <input type="checkbox"/> Swallow Problems 	<p><u>NECK:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Weakness <input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Pain on motion <input type="checkbox"/> Limited motion <input type="checkbox"/> Throat muscles swollen/sore <p><i>WORSE:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> After sleeping <input type="checkbox"/> During the day <input type="checkbox"/> End of day <p><u>SHOULDER:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Local pain <input type="checkbox"/> Pain Down Arm <input type="checkbox"/> Pain on motion <input type="checkbox"/> Limited Pain <input type="checkbox"/> Pain from Neck <p><i>WORSE:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> After sleeping <input type="checkbox"/> During the day <input type="checkbox"/> End of day <p><u>ARMS:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Local Pain <input type="checkbox"/> Radiates from Neck <input type="checkbox"/> On movement <input type="checkbox"/> Down arm- Sleeping <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Pins and needles <input type="checkbox"/> Swelling <input type="checkbox"/> Cold Hands <input type="checkbox"/> Cannot Raise <input type="checkbox"/> Loss of Grip Strength <input type="checkbox"/> Down arm end of day <p><i>LOSS OF FEELING</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Fingers 	<p><u>MID-BACK:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Weakness <input type="checkbox"/> Pain <input type="checkbox"/> Spasms <input type="checkbox"/> Rib pain <p><i>WORSE:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> After sleeping <input type="checkbox"/> During the day <input type="checkbox"/> End of day <p><u>LOW-BACK:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Weakness <input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Pain on motion <input type="checkbox"/> Limited motion <p><i>WORSE:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> After sleeping <input type="checkbox"/> During the day <input type="checkbox"/> End of day <p><i>PAIN IN:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Hip <input type="checkbox"/> Tailbone <input type="checkbox"/> Groin <p><u>HIPS, KNEES, LEGS:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Local Pain <input type="checkbox"/> Radiating pain <input type="checkbox"/> From back <input type="checkbox"/> On movement <input type="checkbox"/> Down leg <input type="checkbox"/> Knee-Swelling <input type="checkbox"/> Sciatica <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Loss of Feeling <input type="checkbox"/> Ankle swelling <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Cramps – Spasms <input type="checkbox"/> Charlie horses <p><u>FEETS:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Swelling <input type="checkbox"/> Pain on walking <input type="checkbox"/> Pain with back <input type="checkbox"/> Cold <input type="checkbox"/> Numbness 	<p><u>NERVES:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Burning <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Pins and needles <input type="checkbox"/> Tremor <input type="checkbox"/> Nervous tension <input type="checkbox"/> Dizziness <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Poor equilibrium <input type="checkbox"/> Loss of balance <p><u>SLEEP:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Poor due to pain <input type="checkbox"/> Excessive amount <p><u>FATIGUE:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Must rest during day <input type="checkbox"/> Cannot get enough rest <p><i>INTERMITTENT:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Tiredness <input type="checkbox"/> Exhaustion <input type="checkbox"/> Fatigue <p><i>CONSTANT:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Tiredness <input type="checkbox"/> Fatigue <input type="checkbox"/> Exhaustion <p><i>WALKING CAUSES:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Tiredness <input type="checkbox"/> Fatigue <input type="checkbox"/> Exhaustion <p><u>OTHER:</u></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Doctor's Use Only</p>
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Past History/Lifestyle

Have you had any previous chiropractic, alternative or medical care for other condition(s)? Yes No
 If yes, provide clinic name, care type and date range seen: _____

Have you ever suffered from or been diagnosed as having:

LIFESTYLE

- | | | | |
|--|--|-------------------------|--|
| Broken or Fractured Bones | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gall Bladder issues | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Pressure Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Head Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cholesterol Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Insomnia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Disease/disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of Bladder Control | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Constipation | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of Bowel Control | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Coughing Blood | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neuropathies | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervousness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Needing a Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Digestion Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ruptures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty Breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures/Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ear/Hearing Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Speech Difficulty | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eating Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Strokes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye/Vision Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other diagnosed conditions not listed: _____ | | | |

- Do you use Tobacco?
 Yes No
- Do you use Alcohol?
 Yes No
- Do you use Caffeine?
 Yes No
- Do you exercise regularly?
 Yes No
- On average, how many fruits and vegetables do you consume Daily?
Fruits:
Vegetables:

Have you ever been hospitalized? Yes No

If yes, describe _____

Have you ever had any x-rays/MRI/radiographic films taken? Yes No

If yes, what? _____

Have you ever had surgery? Yes No

If yes, describe _____

Are you currently taking any prescription medication or over-the-counter medication? Yes No

If yes, what? _____

Are you currently taking any vitamin or mineral supplements? Yes No

If yes, what? _____

Have you ever had or do you have any allergic reactions? Yes No If so, describe. _____

Do any immediate family members have (or had) a significant illness or disease? (i.e., Cancers, Diabetes, Hypertension, Migraines, High cholesterol, Strokes or other serious health conditions?) Yes No

If yes, what? _____

Is there anything else? Are there additional complaints or seemingly unrelated conditions, not yet covered, that will be helpful in better understanding your case?

Initial _____ Upon signature of this document I am certifying that all the information provided above is true, correct and complete. If more information about my condition or illness becomes known, I will tell the doctor when possible so that it can be added to my record.

Informed Consent of Care

Chiropractic care, includes chiropractic adjustments that move bones via the doctor's hands or with the use of a mechanical device. It frequently create a "pop" or "click" sound/sensation in the area being treated) like all forms of health care, while providing considerable benefit to many, may also provide some level of risk. This level of risk is most often very minimal, yet in a rare number of cases, injury has been associated with chiropractic care.

Prior to receiving chiropractic care, a health history and physical examination will be completed. These procedures will be performed to assess your specific condition or concern. These procedures will assist the doctor in determining if chiropractic care is warranted, if we need to refer you to another clinic or if any further examinations or studies are needed.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system we cannot promise a cure for any symptom, condition or disease as a result of treatment. In addition, your health history helps determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be provided to you along with a care plan approach prior to beginning care. We strive for the best level of care and if the results are not acceptable, we will refer you to another provider whom we feel will assist your situation.

Possible risks associated with chiropractic care:

Soreness- Chiropractic adjustments as well as many physical therapy procedures may produce post-treatment soreness. This is nearly always temporary. This is an accepted response accompanying care yet do inform your doctor about the soreness experienced.

Soft-Tissue Injury – Occasionally chiropractic treatment may overstretch soft tissue (most commonly effecting muscles and/or ligaments). This could result in a temporary increase of pain and the necessity of further treatments for resolution. There are no available statistics to quantify incidence of soft-tissue injuries as this occurs rarely.

Rib Injury – Manual adjusting to the thoracic spine, in rare cases, may cause rib injury or fracture. This occurs only in patients with weakened bones (osteoporosis). Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully and individualized to minimize such risk. These problems occur so rarely that there are no available statistics to quantify their incidence.

Physical Therapy Burns – Everyone's skin has different sensitivity to heat or ice generated by physical therapy applications and/or modalities. These modalities and/or devices may temporarily increase pain, possibly blister the skin from minor burns. These problems occur so rarely that there are no available statistics to quantify their incidence. As this is rare, if it happens to occur, you should report it to your doctor. Any home icing must have an insulating towel between your skin and the ice pack.

Stroke – A stroke occurs when a portion of the brain or spinal cord does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The literature is mixed or uncertain as to whether chiropractic adjustments are associated with stroke or not. The most recent evidence suggests that it is not (2008, 2015, 2016), although the same evidence suggests that the patient may be entering the chiropractic office for neck pain/headaches or other symptoms that may in fact be a spontaneous dissection of the vertebral artery. If we think this is happening, you will be immediately referred to emergency services.

As one of the rarest complications associated with chiropractic care, it is estimated that the incidence of stroke ranges between 1 per every 400,000 - 3,000,000 upper neck adjustments. The average chiropractor would need to be in practice for hundreds of years before they would statically be associated with a single patient stroke.

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc) will aggravate the problem and rarely surgery may become necessary for correction. These problems occur so rarely that there are no available statistics to quantify their incidence.

Other Problems – There could be other problems or complicates that arise from care other than those noted above. As these problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

I, (print name) _____, understand and accept that there are risks associated with chiropractic care and I hereby give my informed consent to the examinations and treatments deemed necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment. The doctor will not be held responsible for any pre-existing medically diagnosed conditions. My name and other personal identifying information will be kept confidential following the rules of HIPPA.

Patient Signature

Date

Parent or Guardian Signature

Date

Interpreter Signature

Date

Financial and Attendance Policy

This clinic might utilize techniques, services and protocols that insurance carriers may classify as “experimental/investigational”. **As a result, insurance carriers may deny services it deems as a “non-covered service” or “not medically necessary”. This may decrease the insurance-portion of your bill, while increasing your personal-portion of the billed services provided.** It is ultimately in your best interest to know your insurance policy benefits regarding chiropractic care as it varies greatly from plan to plan.

Range of the Most Common Office Fees (January 1, 2019, subject to change)

Services	Billed Fees	At “Time-of-Service” Fees
Initial Exam & Diagnosis	\$88.20-\$265.00	\$116.70-\$217.00 (New/last visit >36 mo.)
Established Pt Exam & Diagnosis	\$57.75-\$176.80	\$75-\$120
Spinal Adjustment(s)	\$52.50-\$73.20	\$52.50-73.20
Extremity Adjustment (s)	\$38.35-\$76.70	\$10 per region; \$20 maximum
Various Therapies	\$25.13 - \$53.58	\$15.00 per therapy
Functional Medicine Work-up	Non-covered service	\$250-400
Functional Lab Test	Non-covered service	Varies \$10.00-\$1,285.00
X-ray/Imaging	Refer out when necessary	

We will submit insurance claims on your behalf and we will work with your insurance company(ies) to receive payments. Non-covered services, denied bills, or slow payments by an insurance company will be billed directly to you. Any balance over 90 days old may be placed with our collection agency. You are responsible for any fees that are incurred by the collection agency. This includes required co-payments and deductible amounts, and certain limitations. We recommend that you call your insurance company before you visit to verify your benefits.

In certain instances your health insurance may not be responsible for you treatment. Additionally information is required if you intend to utilize one of the following options.

1. Worker’s Compensation & Auto Injuries – It is important that you provide us with the names, addresses and telephone numbers of your employer, the insurance carrier, the date and cause of the injury, and the claim number. We will also require your private health insurance information should your claim be denied or our benefits exhausted.
2. Patients without Insurance – We want to work with you if you do not have health insurance. If you need to set up a payment plan, please let us know in advance. Otherwise, we request payment at the time of service.

Providing your insurance information permits us to work on your behalf to verify your insurance policy(s) so that you are utilizing your maximum insurance benefits. If you choose not to provide this information, we are unable to bill your insurance company, therefore, you will be held personally responsible for payment of your services.

Attendance Policy

In the event you are unable to make one of your appointments, please call our office in advance. We will reschedule your appointment as needed. **There may be a \$60 charge for a same-day cancellation or appointment show.** If you, the patient, are more than 15 minutes late for you appointment, it is the doctor’s discretion if there will be time to treat or if you will need to reschedule your appointment.

I acknowledge that I have read, understand and accept the above policies.

Patient Signature (Parent/Guardian if under 18 years old)

Date