the Healing Joint
...A WELLNESS PLACE

Rambod Derakhshani DC FIAMA

Today's Date: ____ /____ /_____

About You

First Name: _____ **MI:** _____

Last Name: _____ [ ] **Male** [ ] **Female** [ ] **Other**

Birthdate: _____/_____/_____ **Age:** _____ **Email address:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____**Cell #:** _____

Wk #: _____ **Ext:** _____

Occupation: _____ **Employer:** _____

Marital Status: S M D W **Spouse's Name:** _____ **# of children:** _____

(if minor) Parent or Guardian: _____

Who may we thank for referring you to our office: _____

Insurance Information

We will make a copy of your insurance card(s). However, please complete the following information.

Are you the policyholder? [ ] Yes [ ] No

Insurance Name: _____ **Policyholder's Name** _____

Birthdate: _____/_____/_____ [ ] **Male** [ ] **Female** [ ] **Other**

Address: _____ **Employer:** _____

Member ID#: _____**Group #:** _____

Reason For Visit

Please describe the pain/symptoms & location: _____

Circle which ones describe your symptoms:

Sharp	Dull Ache	Weak	Throbbing	Numb
Shooting	Gripping	Burning	Tingling	

The pain is a result of: _____

When did the pain begin?: _____

Is the pain/symptom getting worse?: [ ] Yes [ ] No

Is your pain/symptom present:

75-100% of time / 50-75% of time / 25-50 % of time / 0 - 25% of time

Does pain keep you awake at night? [ ] Yes [ ] No

Reason For Visit Cont.

Does pain wake you up from sleep? [ ] Yes [ ] No

Rate your Pain 0 1 2 3 4 5 6 7 8 9 10 (0 being no pain and 10 being excruciating)

Have you had this or a similar conditions in the past: [ ] Yes [ ] No

If **YES**, explain: _____

Have you been treated by another physician for this condition? [ ] Yes [ ] No

If **YES**, explain _____

Have you ever been treated by a chiropractor before:? [ ] Yes [ ] No

Name of your family doctor: _____

Family Doctor's #: _____

Health History

Cigarettes - [ ]Yes [ ] No **Alcohol -** [ ]Yes [ ] No

Coffee - [ ]Yes [ ] No **Exercise -** [ ]Yes [ ] No

Are you pregnant?: [ ]Yes [ ] No

Are you taking any medications?

If **YES,** list:

_____

Do you have or ever had any of the following conditions or diseases?

[ ]Yes [ ] No **Heart Attack/Stroke**

[ ]Yes [ ] No **Diabetes**

[ ]Yes [ ] No **Frequent Neck Pain**

[ ]Yes [ ] No **Difficulty Breathing**

[ ]Yes [ ] No **Sinus Problems**

[ ]Yes [ ] No **Fainting/Seizures/Epilepsy**

[ ]Yes [ ] No **Artificial Bones/Joints**

[ ]Yes [ ] No **Cancer**

[ ]Yes [ ] No **Tuberculosis**

[ ]Yes [ ] No **Psychiatric Problems**

[ ]Yes [ ] No **Sever/Frequent Headaches**

[ ]Yes [ ] No **Lower Back Problems**

[ ]Yes [ ] No **Asthma**

Please list any other serious medical condition(s) you have or had:

_____

List previous/past surgeries/treatments with dates:

_____

Family History

(please circle) **Headaches, Low Back Pain, Neck Pain**

Other spinal problems, explain: _____

Assignment & Release

*I understand & agree that health & accident insurance policies are an agreement between an insurance carrier & myself. Furthermore, I understand that this office will prepare any necessary reports & forms to assist me in making collection from the carrier & that any amount authorized to be paid directly to this doctor's office will be credited to my account upon receipt.

***As a courtesy to you we will verify your health care benefits for this office. You will then be responsible for any co pays and deductibles.**

*Your health insurance is a contract between you & the insurance carrier. In the "rare" event that your insurance company is in "bad faith" & after our office make every attempt to have all claims paid, we will have you, the patient, be responsible for contacting your insurance carrier to have the claims paid.

*If your insurance company has not paid within 120 days of billing, then you will be responsible to pay the balance due.

*If Collection efforts become necessary to enforce payment terms, the patient agrees to pay all collection costs, attorney's fees, & other costs associated with collecting this balance.

*I hereby authorize & release the doctor & whomever he/she assistants, to administer treatment, physical examination, x-rays studies, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to an y person or corporation which is or may be liable under a contract to this office or to patient or to a family member or employer of the patient for all or part of the clinic's charge, including & not limited to hospital or medical services companies, worker's compensation carriers, welfare funds, or the patient's employer.

Signature: _____

Date: _____/_____/_____