IDAHO FALLS
870 S Woodruff Ave
Idaho Falls, ID 83401
208-529-2044

EGBERT CHIROPRACTIC

REXBURG
1134 Bond Ave
Rexburg, ID 83440
208-356-8818

We are excited to start
working with you.

We are committed to excellence in chiropractic care and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Have you received Chiropractic care in the past? Yes / No If Yes, Who was your doctor? _____

ABOUT YOU

First Name: _____ Last Name:_____ I Prefer to be Called: _____

Male / Female Date of Birth: ____/____/____ S.S. #: _____ (needed if we are billing Insurance)

Home Address: _____ City: _____ State: _____ Zip: _____

Cell: (____)_____ Phone Carrier: _____Work: (____)_____ Ext:_____

Email Address: _____ Marital Status: Single Married Divorced Widowed Partnership

Emergency Contact: _____ Phone Number: _____

Employer: _____ How long there: _____ Title: _____

What do your duties include? _____

How did you hear about us? / Who Referred you to our office? _____

How would you like to pay for your care?

_____ Self Pay (ask about our Self Pay Program - **Health Initiative**)

_____ **Corporate Wellness Partner** - Please tell us who you (or your family) work for _____

_____ **Insurance Policy** - Please provide us with a current copy of your cards

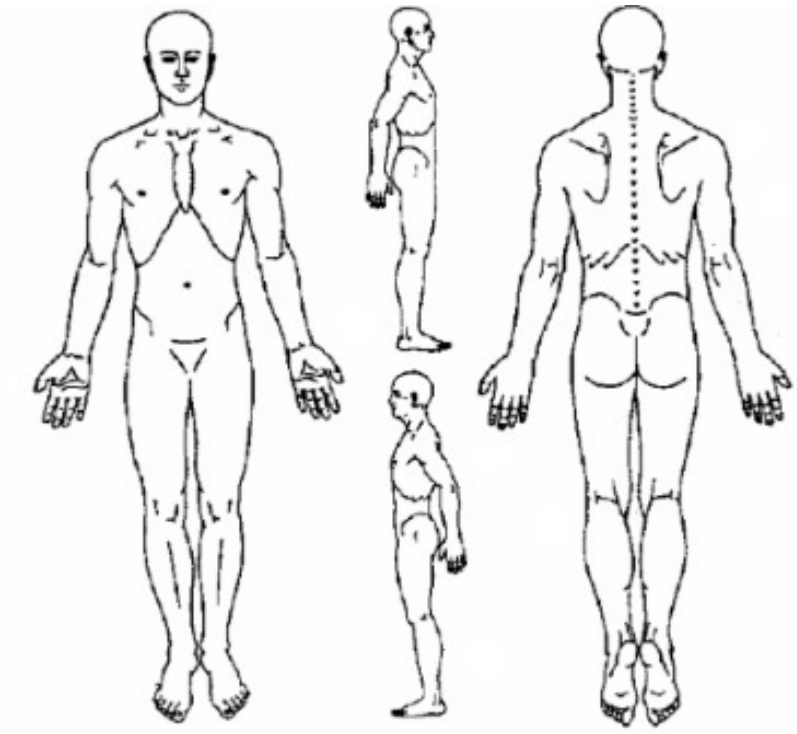
IF POLICY HOLDER IS SOMEONE OTHER THEN THE PATIENT PLEASE PROVIDE THE FOLLOWING INFORMATION

Policy Holders Name: _____

Relation to Patient: _____ Date of Birth: _____

ABOUT YOUR PAIN

Show us where you have pain



Tell us what happened or what you were doing when the pain started.

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

When did your symptoms begin? _____ **Have you had this pain before?** _____

What best describes your pain? Circle all that apply
Aching Shooting Sharp Burning Numb Tender Stabbing Throbbing Miserable Unbearable Exhausting

What time of day is your pain the Worst? Circle all that apply
Morning upon arising Later in the morning Afternoon Evening Night Bedtime Pain Always the Same Varies

Does anything make your pain BETTER? Circle all that apply
Rest Ice Heat Stretching Pain medication Massage Exercise Walking Laying Down Standing
Sitting Sleeping Biofreeze Physical Therapy Decompression Chiropractic Adjustments

Does anything make your pain WORSE? Circle all that apply
Rest Ice Heat Stretching Pain medication Lifting Massage Exercise Walking Standing
Sitting Work Laying down Sleeping Physical Therapy Decompression Chiropractic Adjustments

How often do you experience your symptoms?
Constantly (76-100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day) Intermittently (0-25% of the day)

MEDICAL HISTORY INFORMATION

Please circle if you have had trouble with the following in the PAST or CURRENTLY.

GENERAL:
Headaches
Fatigue
Loss of sleep
Depression
Nervousness
Weight Loss / Gain
Cancer
Dizziness
Fainting
Mental Illness
Tremors

Skin:
Bruises easily
Varicose veins
Rash
Discoloration
Hives / Allergies
Itching

Cardiovascular:
Atherosclerosis
High blood pressure
Low blood pressure
Poor circulation
Swelling of ankles
Chest pain
Irregular pulse
Palpitations
Rapid heart beat
Slow heart beat

Respiratory:
Chronic cough
Difficulty breathing
Shortness of breath
Spitting phlegm / blood
wheezing
Asthma
Emphysema

Gastrointestinal:
Abdominal pain
Colitis / Crohn's
Diarrhea
Constipation
Hernia
Vomiting
Vomiting blood
Bloody stools
Difficult digestion
Poor appetite
Nausea

Ears / Eyes / Nose / Throat:
Cold / Flu
Sore throat
Glasses / Contacts
Hearing Loss
Ringing in ears
Tonsillitis
Ear Ache
Gum / Teeth problems
Nasal obstruction
Sinus infection
Eye pain
Hoarseness
Nose bleed

Genitourinary:
Blood in urine
Decreased flow / force
Prostate problems
Stress incontinence
Bed-wetting
Infections
Painful urination
Wake up at night to urinate

Reproductive:
Irregular Menstrual Cycle
Menopause
Breast problems
Vaginal discharge
Testicular problems

Muscle / Joint:
Arthritis
Fractures / Breaks
Lower extremity pain
Upper extremity pain
Muscle weakness
Sprain / Strain
Bursitis
Neck pain
Mid-back pain
Low back pain

DOCTOR'S NOTES ONLY:

WOMEN ONLY:
1st Day of Last Period: _____
Number of Children: _____
Last Visit to OB/GYN: _____
Birth Control Method: _____

MEDICATIONS
1._____ 4._____
2._____ 5._____
3._____ 6._____

Surgical History:
1._____ Date: _____
2._____ Date: _____
3._____ Date: _____
4._____ Date: _____

Accident History:
Job / Auto / Sport / Other _____
Job / Auto / Sport / Other _____
Job / Auto / Sport / Other _____
Job / Auto / Sport / Other _____

Allergies: seasonal / non-seasonal / medications
Explain:_____

Do You **Smoke?** YES / NO
How Much? _____

Do you **Drink?** YES / NO
How much? _____

PAST Medical History: Circle all that apply

High Cholesterol	Diabetes	Seizures
Glaucoma	Heart attack	Thyroid problems
Hepatitis	Pacemaker	Reflux
Blood clots	Stroke	HIV

FAMILY HISTORY: Circle all that apply & Relation to you
Obesity / Cancer / Diabetes / High blood pressure: _____
Obesity / Cancer / Diabetes / High blood pressure: _____
Obesity / Cancer / Diabetes / High blood pressure: _____
Obesity / Cancer / Diabetes / High blood pressure: _____

HIPPA

I understand and agree to allow Egbert Chiropractic to use my Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of our policy and procedures concerning the privacy of your Patient Health Information, we encourage you to ask for the HIPPA Notice that is available for you. If there is anyone you do not want to receive your medical records please inform our office.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy by Egbert Chiropractic physicians and/or its employees. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, 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 upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her, is in my best interest. I understand the results are not guaranteed. I have read, or have had read to me, the above consent. I understand that I will also have an opportunity to ask questions about treatments and the risks, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from the doctors of Egbert Chiropractic.

Financial Agreement

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our office. Necessary forms will be completed to file for insurance carrier payments. I understand that I am responsible for turning over payments and EOBs from my insurance carrier for medical services rendered by this office within seven days of receipt or be subject to finance charges and the cost of the collection process.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, **to issue payment check(s) directly to Egbert Chiropractic** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. I furthermore understand that I am waiving any anti-assignment clauses that are written in to my health care contract. I have requested that the Egbert Chiropractic be my agent in the filing, processing and appealing of claims related specifically to medical treatment rendered by this office. I understand that I have the opportunity to submit my bills directly to my health insurance carrier but have chosen voluntarily to have the claims submitted by and paid directly Egbert Chiropractic with accompanying explanation of benefits.

Print Name: _____ **Signature:** _____ **Date:** ____/____/____