NEW PATIENT QUESTIONNAIRE

Name_____ Birthdate ____/____/___ Sex_____

Address_____(Apt #___) City_____ State____ Zip_____

Home phone (___)_____ Cell phone (___)_____

Social Security# _____-___-_____ Driver license #_____ State____

E-Mail:_____ Preferred contact: ☐ home, ☐cell, ☐work, ☐email

Employer_____ Occupation_____

Work address_____City_____ State____ Zip____

Work phone (___)_____ Years employed_____

Marital status ☐ Single ☐ Married ☐ Other Preferred Language _____

Ethnicity: ☐ Native American ☐Asian ☐ African/American ☐ Hispanic/Latino
☐White ☐ Pacific Islander ☐ Mexican/American ☐ Decline to state

Current Height:_____ Current Weight:_____

Spouses name_____ Spouses employer _____

Nearest relative (not living with you)_____ Relationship_____

Address_____ Phone (___) _____

Family physician_____ Phone (___)_____

Emergency contact_____ Phone(___)_____

Who is financially responsible for this bill_____

Insurance information: ☐ Medicare ☐ Group ☐ Worker's Comp ☐ Auto ☐ None

Primary insurance:_____ Policy #_____

Address_____ Group #_____

City_____ State_____ Zip_____ Phone ( )_____

Name of insured_____ Relationship to insured_____

Secondary insurance _____ Policy #__

Address_____ Group #_____

City_____ State_____ Zip_____ Phone ( )_____

Name of insured_____ Relationship to insured_____

PRESENT COMPLAINTS

Please describe the health problem for which you came to our office_____

_____

Please describe the character of your current pain: ❒ **Sharp/stabbing** ❒ **Dull** ❒ **Aches**
❒ **Soreness** ❒ **Weakness** ❒ **Throbbing** ❒ **Numbness** ❒ **Cramping** ❒ **Burning**

How often are the complaints present? ❒ **Constant (76-100%)** ❒ **Frequent (51-75%)**
❒ **Occasional (26-51%)** ❒ **Intermittent (25% or less)**

How bad is your level of pain? Please circle a number: 0 1 2 3 4 5 6 7 8 9 10
NO PAIN UNBEARABLE

Since your problem began is the pain: ❒ **Increasing** ❒ **Decreasing** ❒ **Not Changing**

When did your problem begin? Specific date if possible:_____

Did your problem begin: ❒ **After a specific incident** ❒ **Multiple incidents** ❒ **Gradually**

Describe how your problem began_____

_____

How many times have you had a problem similar to or the same as this in the past?
❒ **None previously** ❒ **6-10 episodes** ❒ **Single continuous episode**
❒ **1-5 episodes** ❒ **more than 10 episodes**

When was the very first time you ever felt something similar to or the same as this problem?
❒ **Less than 6 months ago** ❒ **1-5 years ago** ❒ **10-20 years ago**
❒ **6 months- 1 year ago** ❒ **5-10 years ago** ❒ **more than 20 years ago**

What treatment have you received for the present condition? ❒ **Surgery** ❒ **Spinal injections**
❒ **Physical therapy** ❒ **Medication** ❒**Other**_____ ❒ **None**

What makes your problem better?❒ **Nothing** ❒ **Laying down** ❒ **Walking** ❒**Standing** ❒ **Sitting**
❒ **Movement/Exercise** ❒ **Inactivity** ❒ **Other**_____

What makes your problem worse?❒ **Nothing** ❒ **Laying down** ❒ **Walking** ❒**Standing** ❒ **Sitting**
❒ **Movement/Exercise** ❒ **Inactivity** ❒ **Other**_____

Are your symptoms the result of an auto accident, work injury or other personal injury?_____

If you answered yes, please fill out an accident specific form available at the desk.

MEDICAL HISTORY

Are you now or have you suffered from the following?

Past	Present		Past	Present	
☐	☐	Asthma	☐	☐	Neck pain
☐	☐	Arthritis	☐	☐	Shoulder pain
☐	☐	Cancer	☐	☐	Upper back pain
☐	☐	Diabetes	☐	☐	Arm/Hand pain
☐	☐	Dizziness/Fainting	☐	☐	Low back pain
☐	☐	Headaches	☐	☐	Hip pain
☐	☐	Heart attack/disease	☐	☐	Knee pain
☐	☐	High blood pressure	☐	☐	Foot/ ankle pain
☐	☐	Migraines	☐	☐	Stroke
☐	☐	Emphysema	☐	☐	Ulcers
☐	☐	Thyroid problems	☐	☐	Kidney or Urinary problems
☐	☐	Digestive disorders	☐	☐	Prostate problems
☐	☐	Anorexia	☐	☐	Heartburn/ indigestion
☐	☐	Hepatitis	☐	☐	Drug or alcohol dependence

WOMEN ONLY:

Are you pregnant or think you may be pregnant?_____

Date of last menstrual period_____

Do you have any condition, disease or problem not listed above?_____

Do you smoke or use any tobacco products?_____ If yes, how much_____

Former smoker: Quit how long ago_____ How much smoked_____

Do you drink alcoholic beverages?_____If yes, how often _____

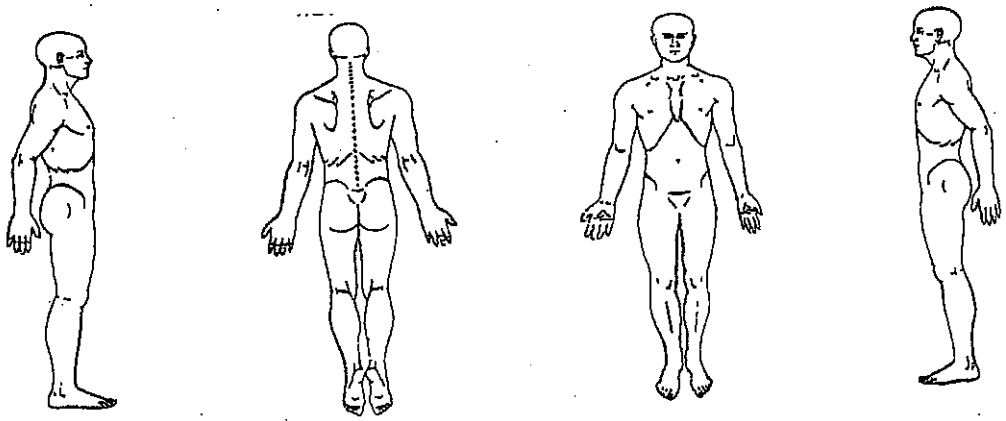
Have you had any other serious illness/ trauma (falls, accidents), surgeries or been hospitalized?____

_____

Please list all medications including birth control pills, aspirin, or vitamins that you are presently taking

_____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



MEDIA DISTRICT CHIROPRACTIC

JAY J. SHERY, D.C.
Chiropractic Physician
Qualified Medical Evaluator
Industrial Disability Examiner

10811 WASHINGTON BLVD., SUITE 250
CULVER CITY, CA 90232
PHONE: (310) 841-5000
FAX: (310) 841-5011

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays , on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named above, including those working at the clinic or office listed above or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic name above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

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, strokes, 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 on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, 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.

To be completed by patient:

_____
Patient name (print)

_____
Signature of patient / Date

_____
Witness signature /Date

To be completed by patient's representative:
(If necessary)

_____
Patient name (print)

_____
Name of representative/relationship

_____
Signature of representative / Date

Financial Agreement

In order to familiarize you with the financial policies of our office, I would like to explain how your medical bills will be handled. Charges for treatment in this office are due and payable at the time the service is performed. However, if this is inconvenient for you , we will be glad to set up a payment plan to assist you while you are under care in our office.

Payment Plan

_____CASH: I agree to make a minimum monthly/weeky payment of $_____. I agree to pay any outstanding balance within one month after termination of my care. I further agree to pay an interest charge of 1 ½% per month on any balance over 30 days past due.

_____INSURANCE: I understand that the terms of my insurance policy are between the insurance company and myself. Should my insurance company deny any charges incurred, I will be personally responsible for payment for those services in full. I agree to pay my yearly deductible amount and applicable co-payment per visit/ week/ month.

_____PERSONAL INJURY: I agree to allow MEDIA DISTRICT CHIROPRACTIC to submit all charges incurred for this accident to my automobile medical payment policy. I further agree that if no coverage is available, or if I exhaust my benefits, that I will be personally responsible to pay charges incurred on a daily/ weekly/ monthly basis (or at the time of settlement of my claim). *

_____3rd PARTY CLAIM: I understand that I am making a claim against a 3rd party insurance policy and that this policy does not reimburse the doctor directly for any services incurred as a result of my claim. I agree to be personally responsible to pay charges incurred on a daily/ weekly/monthly basis (or at the time of settlement of my claim).*

_____ATTORNEY LIEN: I understand that MEDIA DISTRICT CHIROPRACTIC has agreed to carry the balance of any unpaid charges on a lien with my attorney. I further understand that if I change attorneys or release this attorney prior to the settlement of my claim this agreement is void, and I agree to pay the full balance due immediately. *

_____MEDICARE: I understand that my Medicare insurance policy only covers 80% of allowed charges for spinal manipulation procedures performed by a chiropractor. Any and all other charges are considered not covered by Medicare. I agree to be personally responsible for payment of my deductible amount, my co-payment for covered services, and for all non-covered services on a daily/ weekly/ monthly basis.

I further understand that if I suspend or terminate my care with this office, my balance will be immediately due and payable.

I authorize payment of benefits be made directly to this healthcare provider.

I authorize the release of any information requested to process this claim.

I understand provider reserves the right to charge a billing fee of $10 per month on all outstanding charges.

* Any account balance remaining 6 months after termination of care will be considered past due and subject to interest charges (1.5%/mo) and may be subject to collection proceedings. Collection /Attorney fees payable to prevailing party.

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have bee accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____

Date Patient's signature

Jay J. Shery, D.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Dr. Jay J. Shery may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Please refer to Dr. Shery's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Shery reserves the right to revise its Notice of Privacy Practices anytime.

A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Shery's Privacy Officer at his Culver City location.

With my consent, Dr. Jay J. Shery may call my home or other designated location and leave a message on voice mail in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Dr. Jay J. Shery may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Dr. Jay J. Shery may e-mail to any email address I provide messages that assist the practice in carrying out TPO, such as appointment reminders. I have the right to request that Dr. Shery restrict how he uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by said agreement.

Signature of Patient (or Legal Guardian and if under 18)

Print Patient's Name Date

(Print Name of Legal Guardian, if applicable)