CURRENT COMPLAINTS

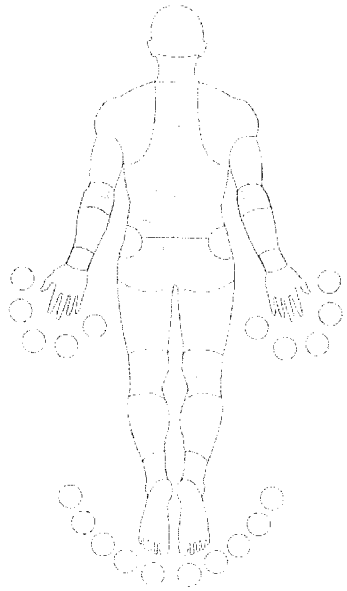
Patient's Name: _____ Date: _____

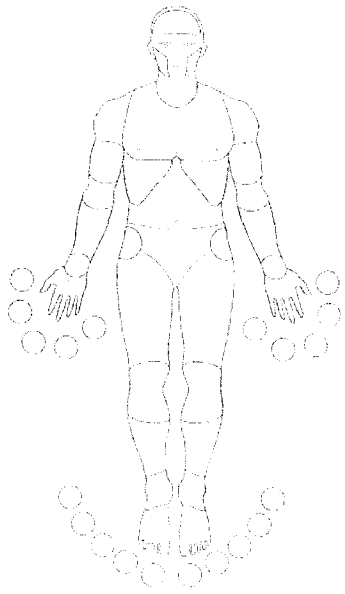
Please indicate the current complaints you are experiencing by marking the areas on the images below—please draw as specific to the area as is possible with these images. Then...

Using the 0-10 pain scale where 0 is no pain and 10 is excruciating, please draw a line from the appropriate pain level number to the area(s) with that pain level.

PAIN SCALE:

(Excruciating) 10
9
8
7
6
5
4
3
2
1
(No Symptom) 0





If the area is not a pain but another symptom or concern such as numbness, tingling, pins/needles, throbbing, burning, spasm, weakness--please write the type of symptom next to the body area with that symptom.

_____ I am here because of symptoms/problems.

_____ I am not here for symptoms, I am here for a wellness visit non-symptomatic spinal check-up.

Dr. Comments:

The following page(s) are what are called the HISTORY. Each separate/non-related condition may have its own set of answers, so a separate HISTORY form will be required for each condition. This will allow us to distinguish the characteristics relative to each area of concern that you would like addressed by our office.

CONFIDENTIAL PATIENT HISTORY

Please write in or circle answers on the following HISTORY form. A separate history page should be completed for each area that you would like to have addressed by our office. (examples: Lower back pain with tingling that radiates down the leg would need only this 1 HISTORY form. Completion of 3 HISTORY forms would be required for back pain PLUS neck pain PLUS headaches.)

MY MAIN REASON FOR THIS VISIT IS:

_____

_____

_____

_____

_____

_____

(please include types of symptoms—pain, ache, tingling, numbness, nausea, odd sweats, etc., and if symptoms radiate to any particular body part)

THIS BEGAN ON (specific date if known): _____

THIS IS DUE TO: _____

WHAT SEEMS TO HELP?: _____

_____

WHAT SEEMS TO AGGRAVATE?: _____

_____

SYMPTOMS WORSEN WITH: Coughs Sneezes Exerting for bowel movements None of these

THE WORST TIME—symptoms noticed the most: Morning Afternoon Evening Bed Time

FREQUENCY—WHAT % OF THE TIME DO YOU NOTICE THIS?: _____%

DOES THIS KEEP YOU AWAKE/FROM GETTING TO SLEEP? Yes No
If it does, please explain including number of hours of sleep lost: _____

_____

DOES THIS WAKE YOU FROM SLEEP? Yes NO
If it does, please explain: _____

ANY LOSS OF BOWEL OR BLADDER CONTROL JUST SINCE SYMPTOMS BEGAN? YES NO
Any other comments:

Patient Signature: _____ Today's Date: _____

IF YOU HAVE MORE THAN 1 AREA TO BE EVALUATED/TREATED, PLEASE CONTINUE THE HISTORY ON ANOTHER HISTORY SECTION FOR THE NEXT AREA OF CONCERN. THANK YOU FOR YOUR PATIENCE IN COMPLETING OUR FORMS.

Marco Chiropractic Clinic 291 S. Collier Blvd. Unit 109 Marco Island, FL 34145 Ph (239) 394-7221 Fax (239) 394-0528
This office is a HIPAA/HITECH compliant office

SARAH CHESTER DC

Medical History Information

Last Name:

First Name: Middle:

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Dr.

Marital status (circle one)
Single / Mar / Div / Sep
Widow Widower

Email: BIRTHDATE: Age: Sex:

Primary Address: City: State/Zip:
Secondary Address: City: State/Zip:

Home Phone: Social Spouse Name:
Cell Phone: Security # : Emergency Phone:

Occupation: Employer: Employer phone:

Medical Care Information

Do You Have a Family Medical Physician?: ☐ No ☐ Yes, Name of Medical Physician:

Address: City: State: ZIP:

Date of last Visit: / / Date of last General Physical Exam: / /

Previous Chiropractor?: ☐ No ☐ Yes, Name of Chiropractor:

Address: City: State: ZIP:

Date of last Visit: / /
Reason for last visit? X-rays or MRI available? Areas:

Have you had any surgeries? ☐ Yes ☐ No If yes, List ALL surgeries and respective dates in the next box

Surgeries and Surgical Dates:

PACEMAKER DEFIBRILLATOR JOINT REPLACEMENTS (which joints) ANY OTHER METAL IMPLANTS?

Current illness /Conditions: (PLEASE CHECK the box if an illness/condition is currently present. PLEASE CIRCLE any past illness/condition)

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble ☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S

Other:

Type(s) of Cancer (if applicable) and your current status:

Family History of illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	☐ Ulcer
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Polio
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Scoliosis
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Diverticulitis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	

Other:

Type of FAMILY MEMBER Cancer: ☐ Breast ☐ Lung ☐ Other:

Name: Date:

Alcohol? ☐ No ☐ Yes Drinks per week? Cigarettes? ☐ No ☐ Yes Packs per day? Caffeine? ☐ No ☐ Yes Drinks per day? Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous

My exercise program consist of: Tai Chi YOGA Pilates Biking Walking Running Other:

Smoking

☐ Current every day smoker ☐Current some day smoker ☐Former smoker ☐ Never Other tobacco use?

START DATE

Medication Allergies

☐ ACE Inhibitors	☐ Cephalosporin's	☐ HMG-COA Reductase Inhibitors	☐ Macrolides	☐ Paxil	☐Sertraline Derivatives
☐ Amoxicillin	☐ Cipro	☐ Ibuprofen	☐ Mepridine	☐ Penicillin	☐ Sulfa
☐ Aspirin	☐ Codeine	☐ Iodine	☐ Metronidazole	☐ Percocet	☐ Tetracycline
☐ Bactrim	☐ Darvon	☐ Keflex	☐ Morphine	☐ Pravachol	☐ Ultram
☐ Benadryl	☐ Demerol	☐ Levaquin	☐ NSAIDS	☐ Propoxyphene	☐ Zestril
☐ Biaxin	☐Erythromycin	☐ Lipitor	☐ Opioid Analgesics	☐ Quinolones	☐ Zocor
☐ Cefaclor	☐Flagyl	☐Lisinopril	☐ Peroxitine Derivatives	☐ Salicylates	☐ Zoloft

Allergy to what, when discovered, and the reaction that occurred:

Other Substances: Airborne Substances Foods Chemicals Mold Pet Dander

Medications

Medication Name	Dose	Form	Route	Frequency	Date Started
Name: (example) Zyrtec Reason: (list reason)	10 mg	Tablet	By mouth	once per day	10/24/2008
Name: Reason:					
Name: Reason:					
Name: Reason:					
Name: Reason:					
Name: Reason:					
Name: Reason:					

(PLEASE ASK FOR A LARGER MEDICATION LIST SHEET IF YOU NEED IT TO COMPLETE YOUR LIST)

If you are 65 years old or older, have you ever had a pneumonia/pneumococcal vaccination in the past? YES NO

Nutritional Supplements that you are currently taking and purpose for taking each supplement:

Name: **Date:**

(Please note—the following 4 questions are asked because we are required to ask them for the Electronic Health Record)

Race: ❑ White ❑African American ❑Asian ❑ Am Indian or AK Native ❑Native Hawaiian or other Pacific Islander ❑Decline

Ethnicity: ❑Non-Hispanic or Latino ❑Hispanic or Latino ❑Decline

Preferred Language: ❑English ❑Spanish ❑Portuguese ❑Italian ❑French ❑Chinese ❑Russian ❑Japanese

Preferred Contact: ❑Phone ❑Email ❑Text ❑Fax ❑Postal Mail ❑Other: _____

FEMALES: Are you pregnant? YES NO Date of onset of your last menstrual period?_____

PAST INJURIES WITH DATES: (work, falls, crashes, etc. Please note any permanent effects of past injuries)

INSURANCE INFORMATION: (Circle) Medicare (primary) Medicare (secondary) Auto/PIP Worker' Comp

Blue Cross/Blue Shield None Other:_____

(PLEASE PRESENT YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE TO THE RECEPTIONIST FOR COPYING)

PLEASE NOTE: IF MEDICARE OR A MEDICARE ADVANTAGE PLAN IS YOUR PRIMARY OR SECONDARY INSURANCE, WE MUST BE INFORMED PRIOR TO YOUR SEEING THE DOCTOR.

ELECTRONIC RECORDS AND BILLING:

Our office/patient records are predominantly stored on a computer and electronic backup data storage devices. Some insurance companies that we bill for patients are billed by electronic means. If you are using insurance with our office do we have your permission to use electronic billing? YES NO

I understand that if I am accepted as a patient at Marco Chiropractic Clinic, I am authorizing that they proceed with any evaluation and treatment that may be necessary and I may request information on the purpose of any test or procedure performed by this office, furthermore, any risks regarding chiropractic treatment will be explained upon my request.

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Marco Chiropractic Clinic 291 S. Collier Blvd. Unit 109 Marco Island FL 34145 Ph (239) 394-7221 Fax (239) 394-0528

Dr. **SARAH CHESTER** This office is a HIPAA/HITECH compliant office

REVIEW OF SYSTEMS

Patient's Name _____ Date _____

Treating Physician _____

Please check the appropriate "yes" or "no" responses to the following questions. If the answer is "yes", please identify if this is a problem that you currently have.)

		Yes	No	Current	Explain
Constitution:	Sudden weight loss or gain?				
Eyes:	Changes in vision?				
	Watering, itching, burning?				
	Pain or pressure?				
Ears,	Changes in hearing?				
Nose,	Bleeding or discharge?				
Mouth,	Blisters in mouth?				
Throat:	Throat pain?				
Cardio-	Chest pain?				
vascular:	Palpitations?				
	Ankle swelling?				
Respiratory:	Difficulty breathing?				
	Coughing?				
Gastro-	Abdominal pain?				
intestinal:	Blood in stool?				
	Any color changes in stool?				
Genito-	Frequent urination?				
urinary:	Blood in urine?				
	Painful urination?				
Musculo-	Joint pain?				
skeletal:	Muscle pain?				
Neurologic:	Headaches?				
	Numbness, Tingling?				
Hematologic/	Swollen glands?				
Lymphatic:	Bleeding problems?				
Endocrine:	Increase thirst?				
	Changes in temperature?				
Skin:	Rashes?				
	Itching?				
Allergic/	Allergies?				
Immunologic:	Immune disorders?				

OFFICE POLICY REGARDING INSURANCE, ACCOUNT BALANCES, *FEES FOR SERVICES, and APPOINTMENTS*

Our office is dedicated to your health. We have created this Office Policy to prevent misunderstandings and to help make your experience in our office a pleasant one.

1. For the comfort of all of our patients with allergies and lung conditions, please avoid wearing heavy colognes/perfumes in the office.
2. For the comfort of all of our patients, smoking is not permitted in the office.
3. Please do not bring food/beverages into the office (water is acceptable).
4. The first office visit is to be paid in full. Payments are due when services are provided, unless prior arrangements are made.
5. Most insurance plans pay for chiropractic. After the Receptionist has completed your billing records, if your insurance qualifies, we will bill your insurance company directly, however, what your insurance company does not pay in 75 days, you are obligated to pay.
6. If you have insurance that is accepted by this office and you decide to use it in this office, you understand that the use of your insurance is a contract between your insurance company and yourself, and is not a contract between the insurance company and the doctor's office. This means that you are ultimately responsible for any of your fees incurred in this office that become due because of non-payment by your insurance company, or have not been paid within an acceptable time period as determined by this office (ie., 75 days). This office will abide by payment agreements in accordance with your insurance company's managed care contract if this office also maintains a managed care contract with your insurance company.
7. SCHEDULE 1 is our regular fee schedule. Certain factors such as carrying an account balance, the use of insurance assignment, or requiring more than a simple receipt in a doctor's office creates greater paperwork demands on staff and increases overhead costs. For those patients/fees that qualify, our SCHEDULE 2 fees may apply which reflects our PAPERWORK REDUCTION DISCOUNT.
8. For our patients insured by Medicare, we are now accepting assignment. (Please note that Medicare only covers the fee for "the adjustment of the spine" in Florida chiropractic offices, and Medicare only pays 80% of that fee, and only after the deductible requirements have been fulfilled.)
9. For best results, keep all appointments that the Doctor has recommended, and make up any missed appointments. If it is necessary to miss an appointment, we kindly request that you try to give 24 hours notice. We reserve the right to charge a $20.00 fee for appointments that are missed without advance notice.
10. We reserve the right to charge interest at a rate on 1-1/2 % per month (18% APR) on fees that are determined to be past due, according to #5 and #6 above.

I have read and acknowledge and understand the above office policy.

PATIENT SIGNATURE_____ DATE_____

SARAH CHESTER
MARCO CHIROPRACTIC CLINIC *D.C., 291 S. Collier Blvd., Suite 109*
Marco Island, FL 34145 (239) 394-7221

SARAH A. CHESTER D.C.

291 South Collier Blvd. Unit 109
Marco Island, FL 34145
(239) 394-7221

SIGNATURE ON FILE

☐ I authorize the use of this form on all my insurance submissions either by mail and/or electronic submission.

☐ I authorize the release of information to all my Insurance Companies.

☐ I understand that I am responsible for my bill.

☐ I authorize Dr. Chester and her staff to act as my agent in helping me to obtain payment from my Insurance Companies.

☐ I authorize payment directly to Dr. Chester .

☐ I permit a copy of this authorization to be used in place of the original.

Name _____

Signature _____ Date _____

MARCO CHIROPRACTIC CLINIC
291 S. Collier Blvd. Unit 109 MARCO ISLAND FL 34145

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____
Patient Name (please print) Date

_____
Parent, Guardian or Patient's legal representative

_____
Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names, relationship, and phone # of people to whom you authorize our office to release PHI.

Name:_____Relationship:_____Phone#:_____

Name:_____Relationship:_____Phone#:_____

Name:_____Relationship:_____Phone#:_____

MY WE LEAVE A DETAILED MESSAGE ON YOUR HOME ANSWERING MACHINE? YES NO
MAY WE PHONE YOU AT HOME AND LEAVE A MESSAGE TO CALL OUR OFFICE BACK? YES NO
MAY WE PHONE YOU AT WORK AND LEAVE A MESSAGE TO CALL OUR OFFICE BACK? YES NO

Electronic Means of transmitting information cannot always be determined to be completely secure/encrypted--if records/PHI are to be sent by electronic means I understand this, and if requested by me or my representative to electronically send my PHI, I give consent to MARCO CHIROPRACTIC CLINIC to transmit these records via fax, email, or other electronic means that may be available. This is affirmed by me by my or my representative's signature below.

Signature_____Date_____

Service Provided	Schedule 1	Schedule 2	Medicare
Limited Initial Examination OV (15 min)	90	90	90
Intermidiate Initial Examination OV (20 Min)	100	100	100
Limited Examination OV (15 min)	40	40	40
Intermidiate Examination OV (20 Min)	60	60	60
Spinal Adjustment 1-2 Regions	55	50	55
Spinal Adjustment 3-4 Regions	57	52	57
Spinal Adjustment 5+ Regions	60	55	60
Extremity Adjustment without Spinal Adjustment	55	50	55
Extremity Adjustment with Spinal Adjustment	29	24	29
Trigger Point Therapy	26	21	26
Neuromuscular Re-Education	26	21	26
Deep Tissue therapy	35	30	35
All other Physical Therapy Modalities (Ultra Sound/ Electric Stem)	26	21	26
Supplies/ Supplements	Prices Vary	Prices Vary	Prices Vary
Acitivites of Daily Living	25	20	25
Rehab Exercise Instructions	55	50	55
X-ray Imaging	104	99	104
Computerized Inel per region	29	24	29
SEMG Per Region	58	53	58
Computerized Muscle Testing	29	24	29

Schedule 2 is a paperwork reduction discount. It applies to spinal adjustments and therapies if performed in conjunction with the spinal adjustment. You must maintain a zero balance by the end of the day. No insurance billing will be filed. If you qualify for schedule 2 and at a later date request further billing paperwork beycnd a simple receipt, the fee for the extra paperwork will equal the discount you received for those services.

Medicare will only pay for adjustment to the spine.

If our office is contracted with your insurance company, the amount that you and your insurance company owe will likely be less than the fees shown on the insurance claim or walk-out statement.

If you have any questions regarding our fees, please ask.

Our main concern is your health and well-being, and we will do our best to help and serve you.

Sincerely,

Dr. Sarah Chester

Effective JAN 16, 2018

Last revision to fee schedule 2/7/13

Our office reserves the right to update this fee schedule without formal notification to others, other than posting for view within our office.