BARNES FAMILY CHIROPRACTIC CASE HISTORY UPDATE

In order for us to better serve you, and so that we may bring your original case history up to date, please provide us with the following information.

PLEASE PRINT Date of last adjustment: ___________

Name:_______________________________________ Date: ___________________________

Mailing Address: ____

Physical Address: ____

Home Phone: _________________________ Work Phone: _____________________________

Cell Phone: ___________________________

Age: _____ Date of Birth: ____________ Social Security #: ____________________________

Occupation: _________________ Employer: _______________________________________

Spouse's Name & SS#: __________________________________

Are you insured with: ________Anthem Blue Cross ________Landmark __________ Medicare

1. List present complaints (describe fully):____
____

2. Duration of present condition: ___________________What do you believe caused this condition?____
____

3. Describe any falls, surgery, and/or accidents since your last visit:_______________________
____
____

5. Describe condition(s) for which you were previously treated in this office and your response to the treatment(s):____

6. Since your last visit here, have you consulted another Doctor? _____ If so, give Doctor's name and condition(s) you were treated for: ____
____
____

7. What type of treatment did you receive?____

(over)

Reviewed by Dr: ___________________

Activities of Daily Living (ADL) Information

Condition's Effect on Daily Activities*:*

No Effect	**Mild** Painful (Can do)
Mod Painful (limited ability)	**Mod/Sev** Limited Duty
Severe No Limited Duty	**Severe** (can't do= limited duty)

Please answer the following questions based on the following measurement scale.
***No Effect *Mild =Painful (Can do) *Moderate=Painful (Limited)**
***Severe=Unable to Perform**

Please check the answers that apply:

Bending:	**No Effect**	**Mild**	**Moderate**	**Severe**
Care –Infirm Family:	**No Effect**	**Mild**	**Moderate**	**Severe**
Carrying Groceries:	**No Effect**	**Mild**	**Moderate**	**Severe**
Change Position–Sit-Stand:	**No Effect**	**Mild**	**Moderate**	**Severe**
Climb Stairs:	**No Effect**	**Mild**	**Moderate**	**Severe**
Driving:	**No Effect**	**Mild**	**Moderate**	**Severe**
Extended Computer Use:	**No Effect**	**Mild**	**Moderate**	**Severe**
Feeding:	**No Effect**	**Mild**	**Moderate**	**Severe**
Household Chores:	**No Effect**	**Mild**	**Moderate**	**Severe**
Kneeling:	**No Effect**	**Mild**	**Moderate**	**Severe**
Lift Children:	**No Effect**	**Mild**	**Moderate**	**Severe**
Lifting:	**No Effect**	**Mild**	**Moderate**	**Severe**
Pet Care:	**No Effect**	**Mild**	**Moderate**	**Severe**
Reading (Concentration):	**No Effect**	**Mild**	**Moderate**	**Severe**
Self Care–Bathing:	**No Effect**	**Mild**	**Moderate**	**Severe**
Self Care–Dressing:	**No Effect**	**Mild**	**Moderate**	**Severe**
Self Care–Shaving:	**No Effect**	**Mild**	**Moderate**	**Severe**
Sleep:	**No Effect**	**Mild**	**Moderate**	**Severe**
Static Sitting:	**No Effect**	**Mild**	**Moderate**	**Severe**
Static Standing:	**No Effect**	**Mild**	**Moderate**	**Severe**
Walking:	**No Effect**	**Mild**	**Moderate**	**Severe**
Yard Work:	**No Effect**	**Mild**	**Moderate**	**Severe**

Recreational Activity: Effects of Current Condition on Performance

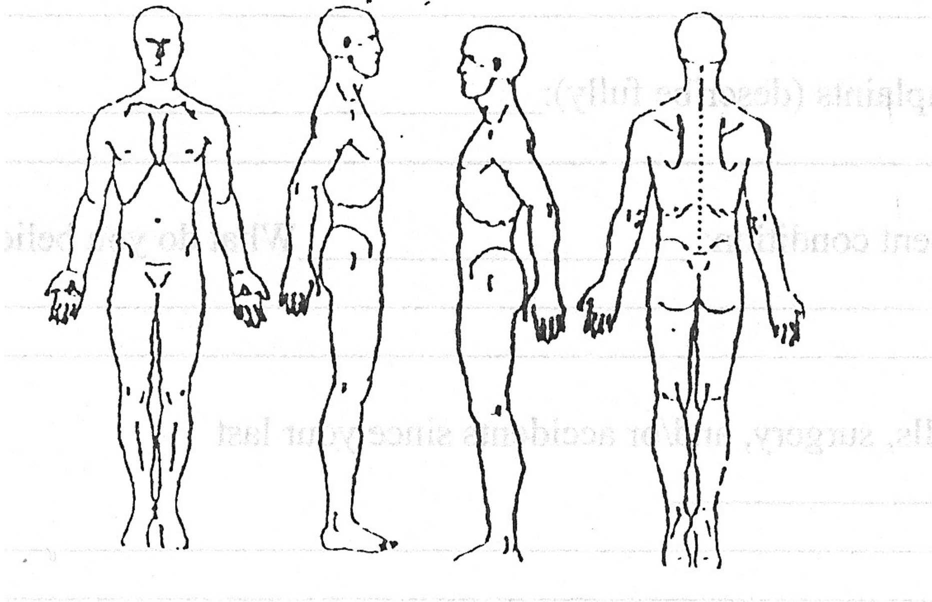
____________________________	**No Effect**	**Mild**	**Moderate**	**Severe**
____________________________	**No Effect**	**Mild**	**Moderate**	**Severe**
____________________________	**No Effect**	**Mild**	**Moderate**)	**Severe**

Reviewed by Dr: ___________________

Rate your pain:

0---1---2---3---4---5---6---7---8---9---10
no pain extreme pain

Circle the location of your pain:



Patient Signature: X________________________________

Reviewed by Dr: ___________________

(Over)

FINANCIAL POLICY

Financial responsibility is an important aspect of your health care. Just as Dr. Barnes respects your time as a patient you are expected to respect his time with your payments. In order to keep overhead costs to a minimum it is important that all services be paid for at the time of the office visit. Thank you.

Please initial

____ I understand that payment is due at the time of the office visit. The first office visit is payable in full at the time of service. If a payment schedule needs to be established, immediately notify the front desk staff.

Payment Plan Attached Staff initial: ____________

FORMS OF ACCEPTED PAYMENT:

***Cash *Check *Money Order *Credit Card: Master card, Visa, or Discover**

PENALTY'S

_____ I understand that unpaid fees for services beyond 60 days are subject to a 2.0 % finance charge (24% annually). I understand a minimum interest of $2.00 per statement may apply.

____Returned checks are subject to a $25 fee.

It is the policy of Barnes Family Chiropractic to assess a **$45.00** missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee. We reserve the right to charge for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

_____I understand the missed appointment policy.

Please choose one of the boxes below:

_____***PRIVATE PAY*****:** I have no insurance, I agree to assume all financial responsibility and to keep my account current by paying for services when they are rendered. Signature: _________________________

Landmark Healthcare/ Blue Cross Blue Shield Signature: _________________________

____I understand that as Barnes Family Chiropractic is a participating member of the Landmark Chiropractic Network (Blue Cross Blue Shield), I am responsible for any and all co-pay's, deductible or non-covered expense.

Attach copy of non-covered Landmark Charges staff initial: ______

Medicare Signature: _________________________

____I have read and understand the policy regarding Medicare's fee schedule, covered and non-covered items and payments as a Medicare patient.

Attach copies of Medicare Financial and Supplement Agreement's. Staff initial: __________