ALL NATURAL CHIROPRACTIC AND SPINAL DECOMPRESSION

Dr. Ronald Reeb

3685 Southwestern Blvd.
Orchard Park, NY 14127
(716) 662-0906

9366 Transit Rd.
East Amherst, NY 14051
(716) 639-3791

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ (c/h) Secondary Phone: _____ (c/h)

Date of Birth: _____ Social Security Number: _____

Email Address: _____ Marital Status(circle): Single Married Divorced Widowed

Primary Doctor's Name: _____ How did you hear about our office? _____

Insurance Company: _____

Insurance ID #: _____ Insurance Group Number: _____

Primary Insurance Holder: _____ Date of Birth: _____

Employer: _____ Employer Phone: _____

Employer Address: _____

Employer City: _____ State: _____ Zip Code: _____

What is this visit primarily for?(circle): Chiropractic Spinal Decompression Laser Therapy Unsure

Have you ever seen a Chiropractor in the past?: _____ Date of last visit: _____

Is this visit due to an automobile accident? **O** Yes **O** No Date of accident: _____

Is this visit for Worker's Comp.? **O** Yes **O** No Date of incident: _____

1. When did your symptoms start? _____

2. Describe your symptoms and how they began:

_____

_____

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Patient Health Questionnaire

3. How often do you experience your symptoms?

a. Constantly (78-100% of the day)
b. Frequently (51-75% of the day)
c. Occasionally (26-50% of the day)
d. Intermittently (0-25% of the day)

4. What describes the nature of your symptoms?

a. Sharp b. Shooting
c. Dull Ache d. Burning
e. Numb f. Tingling

5. How are your symptoms changing?

a. Getting Better
b. Not Changing
c. Getting Worse

6. Who have you seen for your symptoms?

A. No One B. Medical Doctor
C. Chiropractor D. Physical Therapist
E. Other

What/when was your most recent treatment? :_____

7. How bad are your symptoms at their: (circle)

	None									Unbearable
worst	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
best	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

8. How do your symptoms affect your ability to perform daily activities? (circle)

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No Complaints	Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, no activity possible	

9. What activities make your symptoms worse:

_____

10. What activities make your symptoms better:

_____

11. What tests have you had for your symptoms and when were they performed?

a. X-rays date: _____ **c. MRI date:**_____

b. CT scan date: _____ **d. Other date:** _____

12. What do you hope to get from your visit/treatment (circle all that apply):

1. Reduce Symptoms
2. Resume/Increase Activities
3. Explanation of condition/treatment
4. Learn how to take care of this on my own
5. How to prevent this from occurring again

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What type of regular exercise do you perform? **O** None **O** Light **O** Moderate **O** Strenuous

Please list any dietary restrictions: _____

What is your occupation: _____

What is your height and weight? Height: _____ Weight: _____

For each of the following conditions listed below, place a check in the 'Past' column if you have had the condition in the past. If you currently have a condition listed below, place a check in the 'Present' column.

Past	Present		Past	Present		Past	Present	
O	O	Headaches	O	O	High Blood Pressure	O	O	Diabetes
O	O	Neck Pain	O	O	Heart Attack	O	O	Excessive Thirst
O	O	Upper Back Pain	O	O	Chest Pains	O	O	Epilepsy
O	O	Mid Back Pain	O	O	Stroke	O	O	HIV/AIDS
O	O	Lower Back Pain	O	O	Angina	O	O	Drug/Alcohol Abuse
O	O	Shoulder Pain	O	O	Kidney Stones / Disorders	O	O	Allergies
O	O	Elbow/Upper Arm Pain	O	O	Systemic Lupus	O	O	Depression
O	O	Wrist Pain	O	O	Bladder Infection	O	O	Dermatitis / Eczema
O	O	Hand Pain	O	O	Painful/ Frequent Urination	O	O	Bloating / Diarrhea
O	O	Hip/Upper Leg Pain	O	O	Loss of Bladder Control	O	O	Constipation / Hemorrhoids
O	O	Knee/Lower Leg Pain	O	O	Prostate Problem	O	O	Difficulty concentrating
O	O	Ankle/Foot Pain	O	O	Abnormal Weight Gain/Loss	O	O	Low energy
O	O	Jaw Pain	O	O	Loss of Appetite	O	O	Mood swings / Irritability
O	O	Joint Swelling/Stiffness	O	O	Ulcer	O	O	Seasonal allergies
O	O	Arthritis	O	O	Hepatitis	O	O	Weakened Immune System
O	O	Rheumatoid Arthritis	O	O	Liver/Gallbladder Disorder	O	O	Do you use tobacco products?
O	O	General Fatigue	O	O	Cancer	*Female Patients Only*		
O	O	Muscular Incoordination	O	O	Tumor	O	O	Birth Control Pills
O	O	Visual Disturbances	O	O	Asthma	O	O	Hormone Replacement
O	O	Dizziness	O	O	Chronic Sinusitis	O	O	Pregnancy

List all prescription and over-the-counter medications, nutritional supplements, and herbal supplements you are currently taking:

_____

_____

List all surgical procedures you have had done, and any times that you have been hospitalized in the last ten years:

_____

_____

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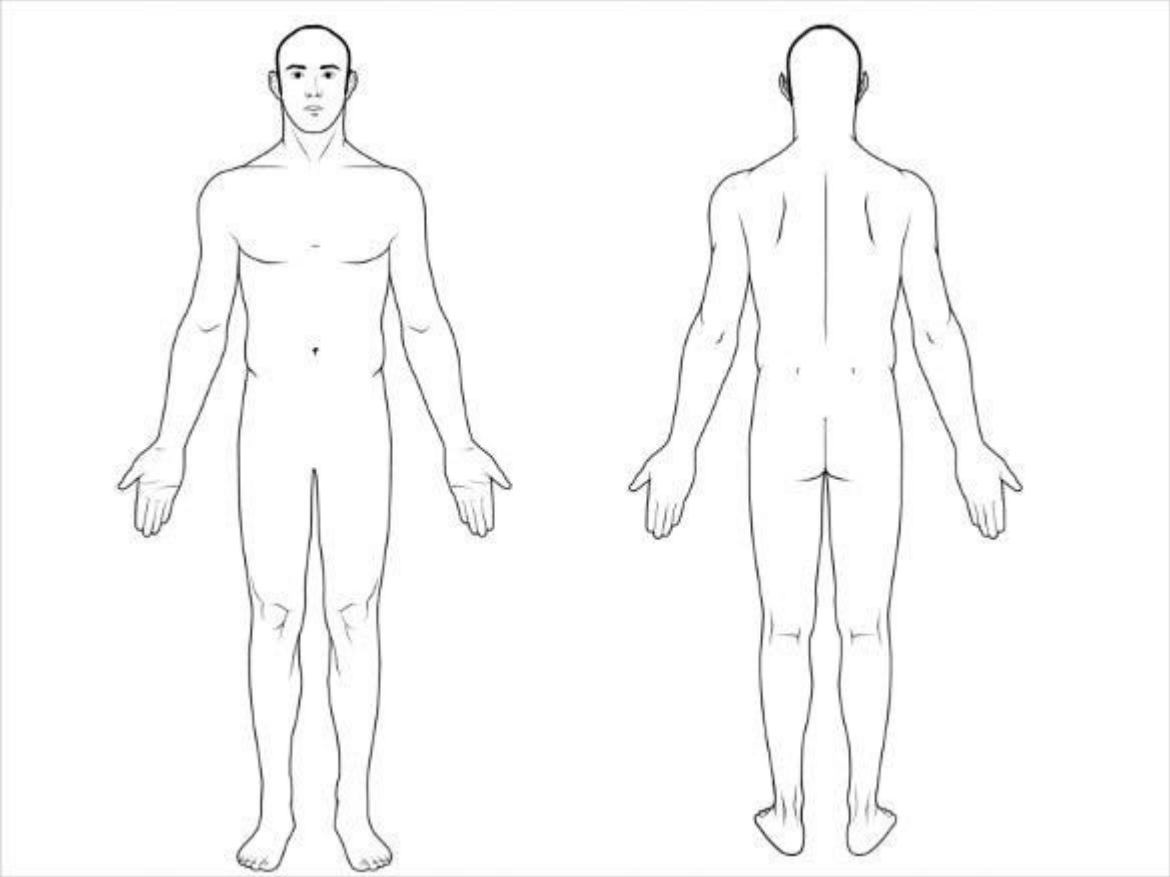
Please Indicate the Following Areas:

B - Burning D – Dull Ache S – Sharp/Stabbing
N – Numbness T – Tingling P – Pins & Needles



Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY:

_____

_____

_____

_____

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CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments, cold laser therapy, hydromassage, massage chair and/or massage performed by a licensed massage therapist and other chiropractic procedure, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff 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 below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there no promise of cure. I further understand and am informed that, as in practice of medicine, the practice of chiropractic there are some risks of 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 wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedure. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other options if I have concerns as to the nature of my symptoms and treatment options.

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 procedure. 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.

Name of Chiropractor Treating: _____Dr. Ronald Reeb_____

PATIENT SIGNATURE: _____ Date: _____

(or signature of parent / guardian if under 18)

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General Release of Information

I hereby authorize any hospital, Physician or other person who has examined or attended me, _____ to furnish to Dr. Ronald M. Reeb D.C., or a representative thereof, any and all information with respect to any illness, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. Further, I hereby authorize Dr. Ronald M. Reeb D.C., to release to authorized persons any and all records pertaining to my treatment in said clinic. A photostatic copy of this authorization shall be considered effective and valid as the original. It shall remain effective until I revoke it with written authorization for revocation.

Date:_____ Signed:_____

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Dr. Ronald M. Reeb D.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure payment.

Date:_____ Signed:_____

Female Patients Only

This is to certify that to the best of my knowledge I am NOT pregnant and that Dr. Ronald M. Reeb D. C has my permission to take x-rays. Date of last menstrual cycle: _____

Date:_____ Signed:_____

Privacy Practice Acknowledgement

I acknowledge that I have received or viewed a copy of the All Natural Chiropractic HIPPA Privacy Notice.

Date:_____ Signed:_____

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Billing Policies

All Natural Chiropractic participates with some insurance companies and the insurance card(s) will be taken at the time of service. At that time we will notify the insurance company to see what the benefits cover. We are required to follow rules as designated by your insurance carrier, in order to be paid on your behalf. Our policies are as follows:

CO-PAYS are paid at the time of visit, if not, there is an additional $5.00 charge for us to bill you.

MISSED APPOINTMENTS: We understand there are times when appointments cannot be kept. We ask that you call to cancel, so that we might be able to use that allotted time for other patients. If not cancelled within 24 hours, there will be a $45.00 charge for routine chiropractic appointments, a $225.00 charge for missed spinal decompression appointments, and a $65.00 charge on cold laser appointments.

REFUND POLICY: If a refund is requested at any time during a treatment plan, the refund will be pro-rated based on the standard per visit fee.

We will file your No Fault and Workers Compensation claims as long as you give us the information at the time of service. If you do not, you need to provide payment in full at the time of visit. Then you can submit it to the proper insurance carrier for reimbursement.

If you do not have insurance, payment is expected at the time of service. If this is a problem please contact the office and make payment arrangements with the staff. (662-0906)

Thank you for your cooperation in this matter. We look forward to a long and healthy relationship.

All Natural Chiropractic Services,

Date:_____ Signed:_____