PATIENT INTRODUCTION CARD

Name_____Phone (Home)_____
(Last, First, Mi)

Mailing Address_____
City State Zip code

Phone (Cell)_____ Phone (Work)_____

Married_____ Single_____ Other_____ Date of Birth_____ Age_____

Email Address_____

Occupation_____ Employer_____

Office Address_____

Previous Chiropractic Care ___Yes ___No Doctor's Name:_____

Please present your insurance card to the front desk: Insurance Company_____

Major Complaint_____ Social Security No._____

Who (or what source) referred you?_____

Emergency Contact/Number

Assignment of Benefits, Authorization for Release of Information and Consent

1. **Assignment of Benefits**: I hereby direct my insurance carrier(s) or attorney to pay by check made and mailed directly to Eastland Chiropractic D C 1126 Eastland Drive N # 300 Twin Falls Id
2. I also understand that I am personally responsible and agree to pay, in current manner, any balance due after payment or nonpayment by my insurance carrier(s) or attorney.
3. Authorization for Release of Information: I hereby authorize the release of any pertinent information to any doctor, insurance company, adjuster, or attorney involved in this claim.
4. A photocopy of this "Assignment of Benefits" and Authorization for Release of information's: shall be considered as effective and valid as the original.
5. Consent: I give permission to the doctor and his staff to administer treatment and preform such procedures as deemed necessary in the diagnosis and treatment of the named patient.

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

My signature below acknowledges that I have received a copy of the Provider's HIPAA Notice of Privacy Practice.
HIPAA EXEMPTION FOR DOCTOR SENECAL TREATMENT:

I give Dr. Senecal permission to display my Insight Nerve Scans and Digital X-rays in a treatment room during my visit. I understand that another patient in the office may inadvertently see my name, Nerve Scans and/or Digital X-rays. I understand that the doctor will not directly discuss or intestinally reveal any details of my case to another patients.

_____ _____

I have read and agree to the above statement. Date

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ **No.:** _____

MUSCULO SKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Spasms
- ❑ Broken bones
- ❑ Shoulder pain

GENITO-URINARY SYSTEM

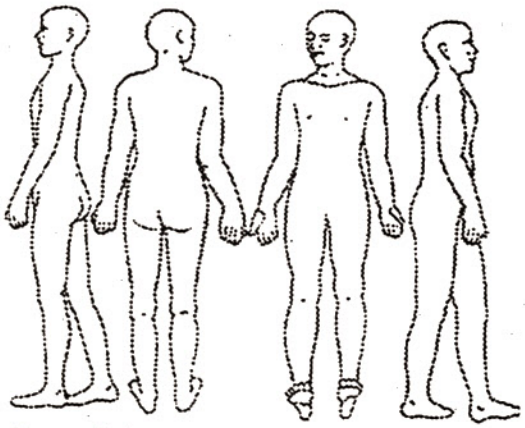
- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast

ARE YOU PREGNANT?
❑ YES ❑ NO

SYMPTOM LOCALIZATION



P ___ Pain
N ___ Numb
S ___ Spasm

T ___ Tender
H ___ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

GASTRO-INTESTIONAL SYSTEM

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Difficult swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting Blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscles jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia

HABITS

- ❑ Cigarettes
- ❑ Alcohol Abuse
- ❑ Coffee or Tea
- ❑ Drug Abuse
- ❑ _____

CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficult breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose veins

EYE, EAR, NOSE AND THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficult breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw Pain

Patient's Signature _____

•••••••••••••••••••• **DO NOT WRITE BELOW THIS LINE** ••••••••••••••••••••

Patient Accepted? ❑ Yes ❑ No Doctor's Signature _____