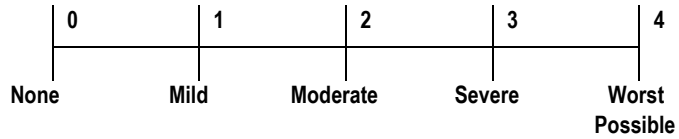
Date:_____ Print Name:_____ DOB:_____

For office use only
DX:_____
ETP: _____

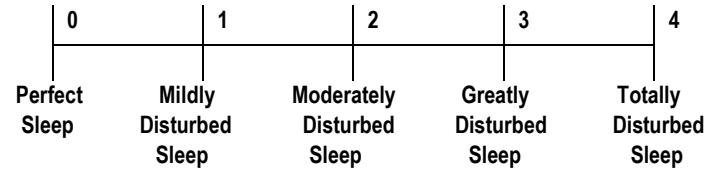
Functional Rating Index

In order to properly asses your condition, we must understand *how much* your problem(s) have *affected your ability to manage everyday activities*. For each item below, PLEASE CIRCLE ONE NUMBER which most closely describes your condition right now.

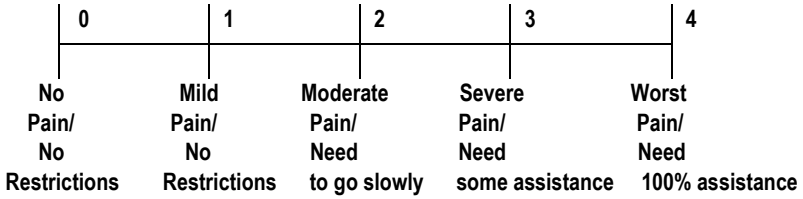
1. Intensity of problem



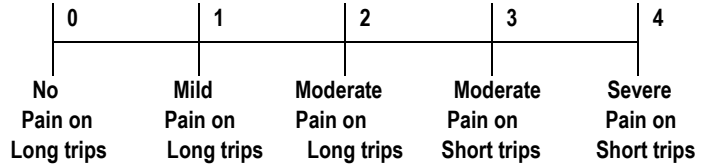
2. Sleeping



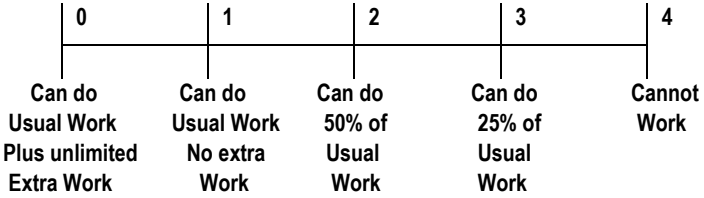
3. Personal Care (washing, dressing, etc.)



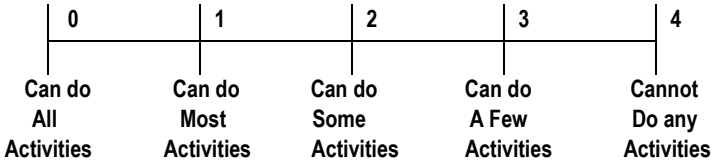
4. Travel (store, appointments, vacations, etc…)



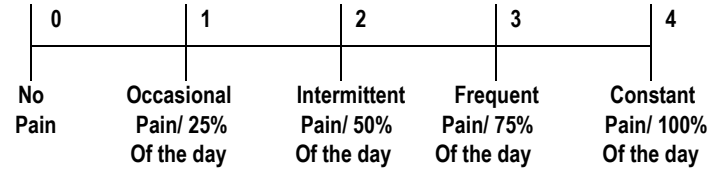
5. Work (washing dishes, sweeping, lawn care, etc.)



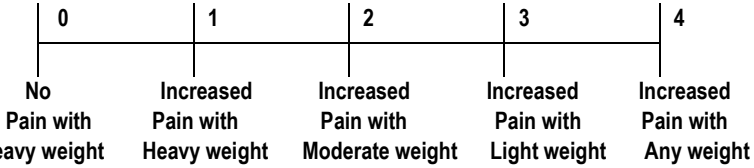
6. Recreation



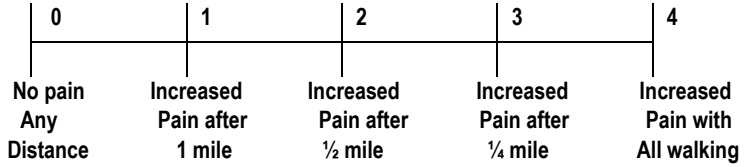
7. Frequency of Pain



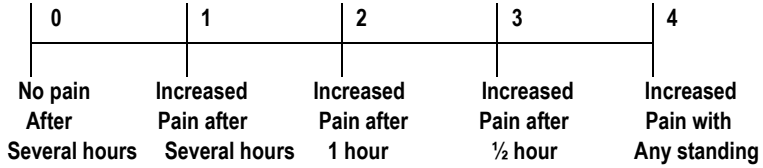
8. Lifting (grocery bags, laundry basket, pots, etc.)



9. Walking (from car to inside, exercise, etc.)



10. Standing



For office use only: Score _____(F) Score _____(30) Score _____(60) Score _____(90

S/C
12/27/2016

Surprise Chiropractic

14545 West Grand Avenue, Suite A106, Surprise, AZ 85374
623-544-9111 – Office / 623-544-9333 - Fax

Dr. Louis V. Verloop, D.C.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of therapeutic procedures, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here Dr. Louis V. Verloop and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Louis V. Verloop, D.C. and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the chiropractic physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the chiropractic physician to exercise judgment during the course of the procedure which the chiropractic physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my chiropractic physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the *Patient*:

_____ _____

Print Name of Patient *Signature of Patient*

To be completed by the *Patient's Representative*, if patient is a minor or is physically or mentally incapacitated:

_____

Print Name of Patient

_____ _____

Print Name of Representative *Signature of Representative*

Form to be maintained in the patient's health record.

INTRODUCTION PATIENT CASE HISTORY

Name: _____ **Date:** _____

Preferred Name: _____ **Email:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____

Home Phone: _____ **Mobile #:** _____

Gender: ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Other

Social Security #:_____ **Date of Birth:** _____

Referred By: _____ ☐*Family* ☐ *Friend* ☐ *Co-Worker* ☐ *Doctor* ☐*Other Source*

EMERGENCY CONTACT INFORMATION

Name: _____ **Home:** _____ **Mobile:** _____

Relationship: ☐ Child ☐ Parent ☐ Spouse ☐ Other: _____

Primary Care Physician: _____ **Doctor's Phone:** _____

FINANCIAL INFORMATION

☐ Insurance ☐ Worker's Comp ☐ Self-Pay *(Cash)* ☐ Personal Injury/Auto ☐ Other:_____

SYSTEMS REVIEW **Please check all of the following that apply to you.**

- ☐ Stroke *Date:*_____
- ☐ Dizziness / Fainting
- ☐ Numbness in Groin / Buttocks
- ☐ Epilepsy / Seizures
- ☐ Visual Disturbances
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Corticosteroid Use (Cortisone, prednisone, etc.)
- ☐ Osteoporosis
- ☐ Recent Fall *Date:*_____
- ☐ Recent Fever
- ☐ Currently Pregnant, # weeks _____
- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Marked Morning Pain/Stiffness
- ☐ Pain at Night
- ☐ Cancer / Tumor (explain)_____ _____
- ☐ **Medications**:_____ _____
- ☐ **Surgeries**:_____ _____
- ☐ **Other Health Problems (explain)**_____ _____

PLEASE FEEL FREE TO USE REVERSE SIDE OF PAPER – Copies of Medications/Surgeries Welcome

FAMILY HISTORY

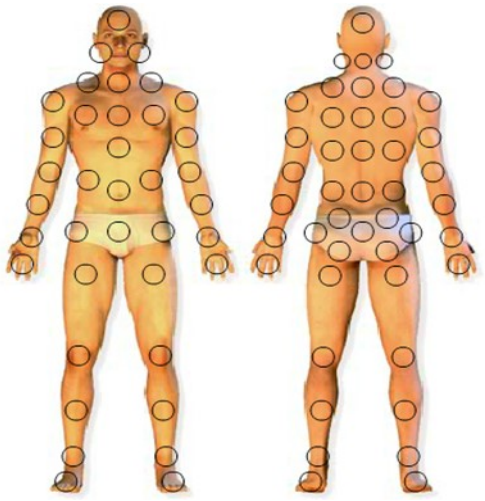
- ☐ Cancer
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Problems/ Stroke
- ☐ Rheumatoid Arthritis

IT IS USUAL AND CUSTOMARY TO PAY FOR SERVICES AS RENDERED UNLESS OTHERWISE ARRANGED

HISTORY OF CURRENT CONDITION

NAME:_____ **DATE:**_____

Mark on this diagram WHERE your #1 COMPLAINT is located



What type of complaint?
☐ *New Complaint*
☐ *Recurring (Gets Better and Comes Back)*

On a pain scale of 1-9 how would you rate the discomfort?
☐ *None (0)*
☐ *Mild- Moderate (2-4)*
☐ *Moderate (4-6)*
☐ *Moderate- Severe (6-8)*
☐ *Severe (8-9)*

***WHAT AGGRAVATED* this discomfort/flare up today?**_____

Recently *WHEN* did this DISCOMFORT FLARE UP? DATE (or approx.): _____

Is complaint getting? ☐ *Better* ☐ *Worse* ☐ *Same*

Frequency of discomfort? ☐ *16+ Hours* ☐ *10-16 Hours* ☐ *7-10 Hours* ☐ *3-7 Hours* ☐ *1-3 Hours*

Quality of discomfort? (√ all that apply) ☐ *Aching/ Dull* ☐ *Burning* ☐ *Sharp* ☐ *Stabbing* ☐ *Stiff* ☐ *Numbness/Tingling*

Does this complaint radiate/shoot to any areas?
☐ *No* *IF* ☐ *Yes* ***(INDICATE WITH A LINE WHERE DISCOMFORT radiates on BODY DIAGRAM ABOVE)***

What makes it BETTER? (√ all that apply) ☐ *Ice* ☐ *Heat* ☐ *Rest* ☐ *Massage* ☐*Stretching* ☐ *OTC* *Other*: _____

Have you had this condition *before*? ☐ *Yes* ☐ *No*

Have you received other treatment for this episode? ☐ *None* ☐ *DC* ☐ *PT* ☐ *Massage* ☐ *ER* ☐ *MD* ☐ *Other:* ____

Recent diagnostic images or tests performed? ☐ *Yes* ☐ *No* **Where?**_____ **When?** _____

Tell us which *TWO* activities makes it worse and tell us *HOW LONG BEFORE YOU FEEL DISCOMFORT.*

	Immediately	After 5 min.	After 10 min.	Other		Immediately	After 5 min.	After 10 min.	Other
Standing	☐	☐	☐	☐	*Sit*	☐	☐	☐	☐
Walking	☐	☐	☐	☐	*Household Chores*	☐	☐	☐	☐
Drive Car	☐	☐	☐	☐	*Reach overhead*	☐	☐	☐	☐
Cooking	☐	☐	☐	☐	*Use computer*	☐	☐	☐	☐
Lie Down	☐	☐	☐	☐	_____ ***(other)***	☐	☐	☐	☐

Where is your #2 COMPLAINT located??? and DESCRIBE IT

_____

_____

Surprise Chiropractic

14545 West Grand Avenue, Suite A106, Surprise, AZ 85374

623-544-9111 – Office / 623-544-9333 - Fax

Dr. Louis V. Verloop, D.C.

- **INSURANCE INFORMATION**

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and that the fees for the professional services rendered to me will be immediately due and payable.

***Initial*: _____**

- **ASSIGNMENT OF BENEFITS**

I hereby authorize Surprise Chiropractic, LLC to release any information necessary to process this claim and assign ALL BENEFITS payable directly to Surprise Chiropractic, LLC.

I waiver the Statute of Limitations regarding my chiropractic physician's right to recover.

I understand that whatever amount is not collected from insurance proceeds, (whether it be all or part, when insurance benefits exhaust or are denied for whatever reason), I am personally responsible.

If collection or legal action should become necessary in payment of services rendered by Surprise Chiropractic,LLC, I understand that I will be personally responsible for all fees incurred by Surprise Chiropractic, LLC, made to collect that payment due.

***Initial*: _____**

- **CONSENT OF PROFESSIONAL SERVICES & RELEASE OF INFORMATION**

I hereby authorize and release the chiropractic physician and whomever he/she may designate as his/her assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person of corporation which is or may be liable under a contract to the clinic or to the patient or to the family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, workers compensation carriers, welfare funds, or the patient's employer.

***Initial*: _____**

- **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and accreditation.
- We can accommodate your need for further privacy or information if you deem necessary, please let us know.

***Initial*: _____**

By initialing the above and signing this document, I acknowledge and understand my rights as a patient.

Printed Name:_____ DOB:_____

Patient/Guardian Signature:_____ DATE:_____

AUTOMOBILE ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI)_____ **Today's Date: _____**

Name of Driver, *if not self*: _____

Car Make_____ **Car Model**_____ **Year**_____

Name of Driver of *other* vehicle: _____

Car Make_____ **Car Model**_____ **Year**_____

Date of Accident: _____/_____/_____ Time _____:_____AM/PM

AUTO INSURANCE INFORMATION

***Your* Auto Ins:** _____ **Policy #:** _____

Claim #: _____ **Phone #:**_____

Address: _____ **City:** _____

State: _____ **Zip:** _____

***Other's* Auto Ins:** _____ **Policy #:**_____

Claim #: _____ **Phone #:**_____

Address: _____ **City:** _____

State: _____ **Zip:** _____

ACCIDENT INFORMATION (PLEASE ANSWER ALL QUESTIONS)

Briefly Explain what happened: _____
_____

WHERE were you sitting in vehicle?
□ *Front seat –* ***Driver/Passenger*** □ *Rear Seat–* ***Behind Driver*** □ *Middle* □ *Behind Passenger* □ *2nd Row* □ *3rd Row*

Were you using a seatbelt? □ *No* □ *Yes* **Did the airbags deploy?** □ *No* □ *Yes*

Height of your headrest? □ Top of head □ Mid head □ Below head

Where were you looking at the time of impact? □ *Ahead, but not certain* □ *Down* □ *Over the left shoulder* □ *Over the right shoulder* □ *Straight ahead* □ *To the left* □ *To the right* □ *Other*

Did your body contact the interior of the car? □ *No* □ *Yes* **What part of the body?** _____

What part of the interior of the vehicle did your body contact? _____

Did you receive an injury to the head? □ *No* □ *Yes* **Knocked unconscious?** □ *No* □ *Yes (How long?)* _____

Where was your vehicle impacted? □*Front* □ *Rear* □ *Passenger Side* □ *Driver's Side* *Other*: _____

Was your vehicle moving? □ *No* □ *Yes (What was your estimated speed?)* _____

Were you aware of the impending collision? *(Were you surprised?)* □ *No* □ *Yes*

AUTOMOBILE ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI)_____ **Today's Date: _____**

What was the visible damage to your vehicle? ☐ *High* ☐ Moderate ☐ *Slight* ☐ None

Was the other vehicle's moving? ☐ *No* ☐ *Yes* (*What was the estimated speed?)* _____

How much visible damage is estimated to the other vehicle? ☐ *High* ☐ Moderate ☐ *Slight* ☐ None

Was your vehicle towed from the scene? ☐ *No* ☐ *Yes*

Did Police arrive? ☐ *No* ☐ *Yes* **Was there an accident report taken?** ☐ *No* ☐ *Yes*

Was EMS at the scene? ☐ *No* ☐ *Yes* **Were you taken to the hospital?** ☐ *No* ☐ *Yes (How)* _____

What treatment was received in hospital? ☐ *Exam* ☐ *Admitted* ☐ *Released* ☐ *Imaging* ☐ *Referral to:* _____ ☐ *Prescription*

Did you receive treatment? ☐ ***Primary Care*** ☐ ***Self Treated @ Home with:*** ☐ *rest* ☐ *elevation* ☐ *heat* ☐ *ice*

Describe the discomfort AT THE TIME of the accident. ☐ *Aching* ☐ *Burning* ☐ *Dull* ☐ *Sharp* ☐ *Stiff* ☐ *Tingling*

***Where* were symptoms felt AT THE TIME of the accident?** ☐ *Neck* ☐ *Upper back* ☐ *Lower back* ☐ *Other* _____

Additional symptoms at the time of the accident? ☐*Anxiety* ☐ *Exhaustion* ☐ *Stunned* ☐ *Other*: _____

Status of your symptoms since the accident? ☐ *Better* ☐ *Worse* ☐ *Same*

BEFORE THE ACCIDENT

Have you ever had any complaints in the involved area before? ☐ *No* ☐ *Yes*
***If yes* - Were they present at the time of the accident/injury?** ☐ *No* ☐ *Yes*
***If yes* - Summarize these complaints prior to the accident:** _____

Were you capable of performing all your work activities without restriction? ☐ *No* ☐ *Yes*

AT THE TIME OF THE ACCIDENT

Did you feel pain immediately after the accident? ☐ *No* ☐ *Yes* ☐ *Later that day* ☐ *Next day* ☐ *When?* _____

SINCE THE ACCIDENT

Are your symptoms? ☐ *Improving* ☐ *Getting Worse* ☐ *Same*

Are your work activities restricted because of this accident/injury? ☐ *No* ☐ *Yes*
(How?) _____

Have you missed any work since this accident? ☐ *No* ☐ *Yes* (*Dates?)* _____

Have you retained an Attorney? ☐ *No* ☐ *Yes*

Name: _____ **Phone:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____

SURPRISE CHIROPRACTIC
Dr. Louis Verloop, D.C.

14545 W Grand Ave suite # A106, Surprise, AZ 85374
Phone : 623-544-9111 Fax : 623-544-9333

Authorization and Assignment of Benefits

You, Surprise Chiropractic are authorized to release any information that you, Surprise Chiropractic, deem appropriate concerning my physical condition for reimbursement of charges incurred.

In that this office is waiting for payment of some of its fee, I agree to provide Surprise Chiropractic with information and forms regarding any potential source of fee payment to assist in any way I can, and I hereby assign to Surprise Chiropractic my rights to receive payment from negligent parties and from insurance companies. Payment should be payable to and mailed to surprise Chiropractic at the above address. If my policy prohibits assignment, then checks should be made jointly to me and Surprise Chiropractic and mailed to the above address. I authorize the direct payment to you (Surprise Chiropractic) of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to me or you based in whole or in part upon the charges made for services.

I understand that if Surprise Chiropractic receives more than their fees, Surprise Chiropractic will pay the credited amount to me, the patient.

I permit Surprise Chiropractic to endorse co-issued remittance for the convenience of credit to my account.

In the event any insurance company, obligated by contractual agreement, to make payment to me or towards your services refuse to make such payment upon demand, I hereby assign and transfer to you, Surprise Chiropractic the cause of action that exits in my favor against any such companies, the names of which is believed to correctly set forth under pertinent data and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort had been made to collect the sums due from any insurance company or companies contractually obligated, you Surprise Chiropractic will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance company's proceeds, whether it be all or part of what is due, I personally owe and agree to pay you.

In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in the state of AZ.

I further agree that this authorization and assignment is irrevocable and ongoing until all monies owed are paid in full.

This authorization for assignment will be in continual effect until revoked by both parties.

This document shall not be superseded by any other document sent to you, if any, by my attorney pertaining to disbursement of funds for my medical bills.

A photocopy of this form shall be valid as the original.

In the event of default, I agree to pay for collections and/or attorney fees.

Notice of Medical County Lien **(For patients who have an auto accident or other personal injury claim) In order to ensure that the parties liable for payment of your claim are fully aware of the fact that Surprise Chiropractic is extending credit to you for your care in our office, we will be filing a medical county lien. This lien will be released once payment has been paid by all responsible parties.**

Signature of Patient _____ **Date** _____