Financial/Treatment Consent Form

Please sign and complete for treatment. Thank you.

Manchester Family Chiropractic

Patient Information

Date: _____

Name:_____ Date of Birth _____/_____/_____
Last First MI

Address: _____ City:_____ State_____

Zip: _____ Responsible Party (If different): _____

Soc. Security # _____ / _____ / _____ Home Phone _____ Cell _____

Primary Contact Number Preferred: _____ Work Phone _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? Friend/Family Patient Health Fair Internet Other_____

Circle One: Insurance Self-Pay

Insurance Company _____ Effective Date _____

Member ID# _____ Group # _____

Policy Holder Name (if self, note self) _____ Policy Holder's Birthdate _____

Relationship to Insured: Self Spouse Child

Statement of Financial Responsibility and Authorization to Treat

I understand that I am financially responsible for all services rendered to me or my dependant at the Chiropractic Care & Wellness Center. I hereby authorize the Chiropractic Care & Wellness Center or its successors to submit claims to my insurance company or other third party on my behalf. If my insurance company denies payment on my behalf, I understand that I am financially responsible for any remaining balance.

I further authorize my insurance company to direct payment to the Chiropractic Care & Wellness Center on my behalf.

I authorize the physician to diagnose and treat me or my dependent/minor child and to use any diagnostic modality needed to make a clinical diagnosis and develop a treatment plan.

Signature _____ Date _____ / _____ / _____

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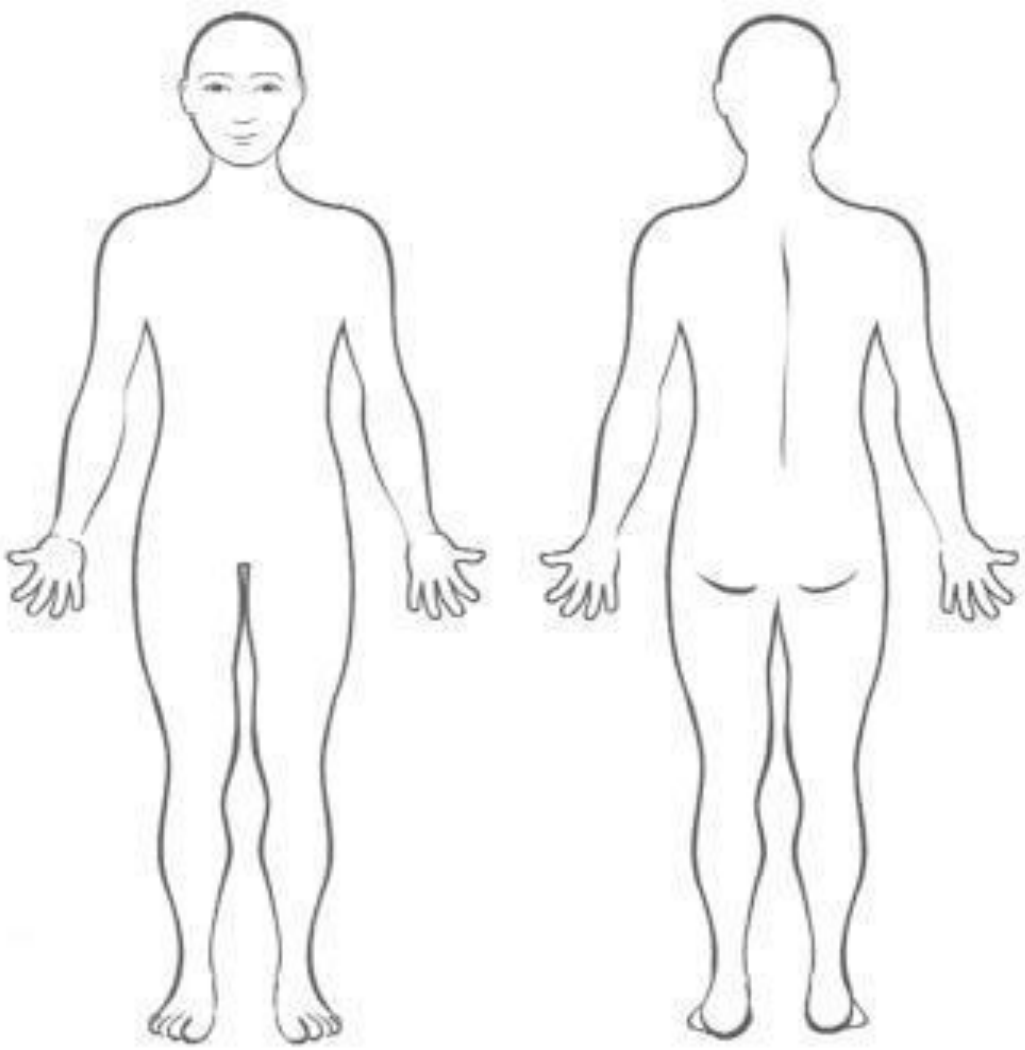
Patient: _____ DOB: _____ Date: _____

Mark the areas on the diagram where you feel the described sensations. Use the indicated symbols and include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
----------	OOOOOOOO	XXXXX	*****	///////



_____

Patient Signature

Numeric Rating Scale

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Patient: _____ DOB: _____ Date: _____

Please indicate the area or region of the body, then circle the corresponding numerical value that indicates how much pain or discomfort you feel in that area.

Area #1: _____

No Discomfort 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Area #2: _____

No Discomfort 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Area #3: _____

No Discomfort 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Area #4: _____

No Discomfort 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

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Name: _____ **Date:** _____

CHIEF Complaints or Symptoms:

☐**Neck pain**	☐none ☐left shoulder ☐left arm ☐left forearm ☐left hand
select the areas of radiation, if any	☐right shoulder ☐right arm ☐right forearm ☐right hand
☐headache	
☐Migraine Headache	
☐upper back pain	

Ringing in Ears	☐Yes	☐No	☐Left	☐Right	☐Both Ears
Blurry Vision	☐Yes	☐No	☐Left	☐Right	☐Both Eyes
Wrist Pain	☐Yes	☐No	☐Left	☐Right	☐Both Wrists
Jaw Pain	☐Yes	☐No	☐Left	☐Right	☐Both Sides

☐Dizziness ☐nervousness ☐fatigue ☐anxiety ☐depression ☐excessive irritability
☐fear of driving in a car ☐a loss of concentration ☐jaw clenching ☐grinding of teeth at night
☐nightmares ☐difficulty with sleeping at night

☐**Low Back Pain**	☐none ☐buttocks ☐left buttock ☐left thigh ☐left knee
select the areas of radiation, if any...	☐left foot ☐right buttock ☐right thigh ☐right knee ☐right foot

Hip Pain	☐Left	☐Right	☐Bilateral
Knee Pain	☐Left	☐Right	☐Bilateral
Foot Pain	☐Left	☐Right	☐Bilateral

Numbness:

☐ Left Hand	☐Left Upper Arm	☐Right Hand	☐Right Upper Arm
☐ Left Foot	☐Left Leg	☐Right Foot	☐Right Leg

Additional Symptoms/ Complaints:

Have You lost any time from work due to your injuries? ☐Yes ☐No
If yes please give dates: _____
Type of employment:
_____