



DATE: _____

PATIENT INFORMATION

Name: _____
(LAST) (MI) (FIRST)

Address _____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

DOB: ____ / ____ / ____ Soc. Sec#: - -

Drive's License #: _____ State: _____

Marital Status: S M W P Spouse's Name: _____

Employer: _____ Occupation: _____

Employer Address: _____
(STREET) (CITY) (STATE) (ZIP)

Referred By: _____

INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto _____

Insurance Name: _____

Member #: _____ Group #: _____

Insurer's Name (If Different From Patient): _____

Insurer's DOB: ____ / ____ / ____ Insurer's Soc. Sec #: - -

Insurer's Employer: _____

Person responsible for account: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Chalmers all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance; I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Patient/Guardian Signature

Date:

IMPORTANT: Please circle all present symptoms:

HEAD

- Headache
Sinus(Allergy)
Entire Head
Back of Head
Fore Head
Temples
Migraine
Head Feels Heavy
Loss of Memory
Light headedness
Fainting
Light Bothers Eyes
Blurred Vision
Double Vision
Loss of Vision
Loss of Taste
Loss of Balance
Dizziness
Loss of Hearing
Pain in Ears
Ringing in Ears
Buzzing in Ears

NECK

- Pain In Neck
Neck Pain w/ Movement
Forward
Backward
Turn to Left
Turn to Right
Bend to Left
Bend to Right
Pinched Nerve In Neck
Neck Feels Out Of Place
Muscle Spasms in Neck
Grinding Sounds in Neck
Popping sounds in Neck
Arthritis in Neck

SHOULDER

- Pain In Shoulders Joint (L-R)
Pain Across Shoulders
Bursitis (L-R)
Arthritis (L-R)
Con't Raise Arm (L-R)
Above Shoulders
Over Head
Tension in Shoulder
Muscle Spasms (L-R)

ARMS & HANDS

- Pain in Upper Arm (L-R)
Pain in Elbow (L-R)
Movement Aggravated
Tennis Elbow (L-R)
Pain in Forearm (L-R)
Pain in Hands (L-R)
Pain in Fingers (L-R)
Pins & Needles Sensation - Arms (L-R)
Pins & Needles Sensation - Fingers (L-R)
Numbness in Arm (L-R)
Numbness in Fingers (L-R)
Fingers "Fall Asleep (L-R)
Hands Cold (L-R)
Swollen Joints in Fingers (L-R)
Sore Joints in Fingers (L-R)

ARMS & HANDS (cont'd)

- Arthritis In Fingers (L-R)
Loss of Grip Strength (L-R)

MID-BACK

- Mid-Back Pain
Location
Pain Between Shoulder Blades (Scapula)
Sharp Stabbing
Dull Ache
Pain From Front to Back
Muscles Spasms
Pain in kidney Area

CHEST

- Chest Pain
Shortness of Breath
Pain Around Ribs
Breast Pain
Dimpled or Orange Peel Breast
Irregular Heartbeat

ABDOMEN

- Nervous Stomach
Food Unable to Eat
Nausea
Gas
Constipation
Hemorrhoids

LOW-BACK

- Low Back Pain
Upper Lumbar
Lower Lumbar
Sacroiliac
Low Back Pain is Worse When:
Working
Lifting
Stooping
Standing
Sitting
Bending
Coughing
Lying Down (Sleeping)
Walking
Pain Relieves When
Slipped Disk (Herniated)
Low Back Feels Out of Place
Muscle Spasms
Arthritis

HIPS, LEGS & FEET

- Pain in Buttocks (L-R)
Pain in Hip Joint (L-R)
Pain Down Leg (L-R)
Pain Down Both Legs
Knee Pain
Inside
Outside
Leg Cramps (L-R)
Cramps in Feet (L-R)
Pins & Needles Sensation in Legs (L-R)
Numbness of Leg (L-R)
Numbness of Feet (L-R)
Numbness of Toes (L-R)
Feet Feel Cold (L-R)
Swollen Ankles (L-R)

WOMEN ONLY

- Menstrual Pain (Location)
Cramping
Irregularity
Cycle (Days)
Birth Control (Type)
Hysterectomy
Genital Cancer
Discharge
Color
Tumors
Abortions
Menopause
Miscarriage #
Are you pregnant

MEN ONLY

- Urinary Frequency
Difficulty in Starting
Night Urination
Prostate Pain / Swelling

GENERAL

- Nervousness
Irritable
Depressed
Fatigue
Feel Run Down
Normal Sleep (Hours Per Night)
Loss of Sleep (Hours Per Night)
Loss of Weight (lbs.)
Weight Gain (lbs.)
Coffee (Cups per Day)
Tea (Cups per Day)
Cigarettes (Packs Per Day)
Exercise (Times Per Week)
Alcohol (Drinks Per Week)
Diabetes
Hypoglycemia
Other

Remarks

Remarks section with multiple horizontal lines for text entry.

As a courtesy, Chalmers Wellness will verify and file my health insurance. However, verification of my insurance benefits does NOT guarantee payment for services rendered. As such, in the event of my health insurance non-payment or limitations, I am financially responsible for all charges incurred.

Patient Name (Printed)

Patient Signature

Staff Member

Date

Date

Patient Health History Form

Patient Name: _____

Date _____

Reason for your visit? _____

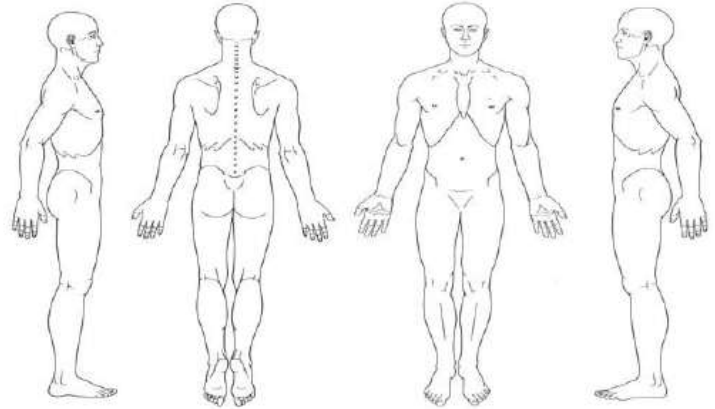
When did your symptom(s) first appear? _____

Is this condition getting progressively worse Yes No Unknown

Mark the best one below which describes your type of pain?

- Sharp Dull Throbbing Numbness
- Aching Shooting Burning Tingling
- Cramps Stiffness Swelling Other _____

Mark an (X) on the picture where you continue to have pain, numbness, or tingling.



How often do you have this pain? _____

Is it constant or does it come and go? _____

How often do you experience your symptoms?

- Constantly (76 -100% of the day) Frequently (51-75% of the day)
- Occasionally (26-50% of the day) Intermittently (0-25% of the day)

What treatment have you already received for your condition?

- Medications Surgery Physical Therapy Chiropractic Services
- None Other _____

No Pain	Unbearable
0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10	

Name and address of the doctor(s) who have treated your for this condition now or in the past.

Dates of Last: Physical Exam: _____ Spinal X-Ray: _____ Blood Test: _____

Spinal Exam: _____ Chest X-Ray: _____ Urine Test: _____

Dental X-Ray: _____ MRI, CT-Scan, Bone Scan: _____

Have you had any previous surgeries and what was the date and procedure? _____

What medications are you currently taking? _____

What Vitamins / Herbs / Minerals are you currently taking? _____

List any allergies you may have? _____

What is your occupation? _____

PHONE 214.446.5300 • FAX 214.446.5304

CHALMERS WELLNESS

6988 Lebanon Road • Suite 101 • Frisco • Texas 75034



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You may refuse to sign this acknowledgement ***

I, _____, have read and understand a copy of Chalmers Wellness Group notice of Privacy Practices.

(PLEASE PRINT NAME)

(Signature)

(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

CHALMERS WELLNESS GROUP

Matt Chalmers, DC

OFFICE POLICY

Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified by the responsible party. We will file your claim forms and assist you in every way we can.

It must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

1. **Payment for services is due at the time of the office visit.** Payment options include: cash, check, MasterCard, Visa or Discover. A credit card number is required to be kept on file to satisfy financial obligations and/or missed appointments.
 MC/VISA/DISC CC# _____

 Exp. Date _____ Name on card _____
2. Filing your insurance is a courtesy and may be withdrawn if circumstances warrant it.
3. If you discontinue care without the Doctor's authorization, the balance of your account is due and payable in full immediately, even if your insurance has been filed. If the insurance does pay, it will be refunded if you have a zero balance.
4. Your insurance should pay within 30 days. If your insurance has not paid within 60 days, you must pay the balance due and be reimbursed by your insurance company when and if it pays.
5. Our office does NOT guarantee that your insurance will pay. We will make every attempt, at the beginning of your healthcare, to receive verification of your policy and what it covers. However, if for some reason your insurance claim is denied, you are responsible for the full amount of your bill.
6. Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.
7. All special arrangements regarding finances must be signed by the Doctor and patient and/or other representative.
8. Missed Appointment Policy: If an appointment cannot be kept, please give 24 hours notice
9. Returned Check Policy: Our returned check fee is \$25.00

If you understand and agree to the above policies, please sign your name below.

Signature of Patient

Date

CHALMERS WELLNESS GROUP

CONSENT TO CHIROPRACTIC TREATMENT and/or NUTRITIONAL TESTING

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-rays, blood draws for laboratory test, and physical therapy techniques on me (or the patient named below for which I am legally responsible) which are recommended by Dr. Matt Chalmers, D.C., C.C.C.N.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications may include but are not limited to: Fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of the manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts known, and are in my best interest.

I have had the opportunity to discuss with the doctor and/or with the office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read () or have had read to me () the above explanation of chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Printed Name of Patient

Signature of Patient or Legal Guardian (if minor)

Date

I consent to QRA nutritional testing performed by Dr. Matt Chalmers

Signature of Patient or Legal Guardian (if Minor)

Date