Pain Drawing

Name:____ Date:____________________

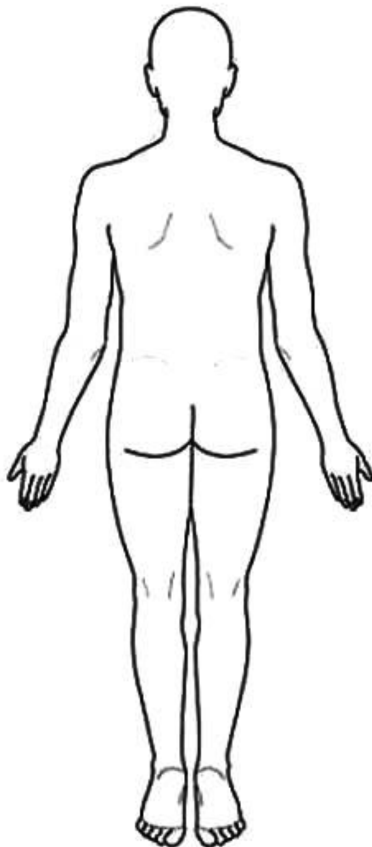
Date of Birth:_________________________ Examiner:_________________________________

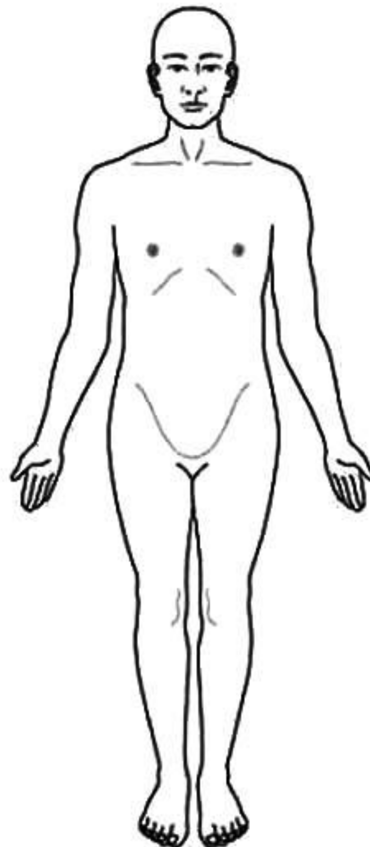
TELL US WHERE YOU HURT.

Please read carefully: Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > >   Numbness = = = = = =   Pins & Needles o o o o

Burning x x x x   Stabbing / / / /   Throbbing ~ ~ ~ ~





Please Circle the number below how bad your pain is now.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

CHIROPRACTIC CASE HISTORY

Name____ Sex: Male Female Date_______________

Address______________________________________City_________________State_____Zip________

Home Phone__________________Cell Phone__________________D.O.B._____________Age______

Marital Status: Single Married Divorced Separated Widowed

Referred By______________________________Social Security #_______________________________

Occupation_______________________________________Employer___________________________

Have you ever received chiropractic Care? Yes No If yes, When________________________

1. **Chief Complaint:**_______________________________Location of complaint________________

Circle any that describe complaint/pain: Dull Aching Sharp Shooting Burning Deep

Throbbing Nagging Other (describe)____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Yes No

If yes, Where?____________________________

Do you have any numbness or tingling in your body? Yes No If Yes, Where?______________________

Circle the intensity/severity of the complaint/pain: (**0 = no complaint/pain; 10 = Worst pain/complaint imaginable): 1 2 3 4 5 6 7 8 9 10**

How frequent is complaint present?__________________________How long does is last____________

Describe actions that aggravate the complaint:____

Describe actions that make the complaint feel better:____

2. **Describe previous interventions, treatments, medications, surgery, or care you have sought for complaint**:____
____

3. **Past Health History:**

Previous illness:____________________________Previous Injury or Trauma_____________________

Have you ever broken any bones? Yes No If Yes, Which?__________________________________

Allergies?____

Medications? Reasons for Taking?

_______________________________________ ____________________________________

_______________________________________ ____________________________________

Describe any surgeries which you had: Date:

____ __________________

____ __________________

Females: Describe pregnancies and outcomes: Date of Delivery:

____ __________________

____ __________________

Date of the beginning of your last menstrual period?____

4.**Family Health History:**

Associated health problems of relatives?____

____

Deaths in immediate family? (Who) Cause? Age at death

___________________________ ____________________ ______________

___________________________ ____________________ ______________

4. Social and Occupational History:

Circle Level Of Education: High School/GED Some College College graduate Post graduate

Job Description:______________________________Work Schedule:_______________________________

Describe any recreational/extra-curricular activities and/or hobbies:______________________________

____

Describe Your Diet:____

Circle each of the following in terms of use:

Exercise: Never Seldom Occasionally Frequently Daily

Alcohol: Never Seldom Occasionally Frequently Daily

Tobacco: Never Seldom Occasionally Frequently Daily

Drugs: Never Seldom Occasionally Frequently Daily

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patients Signature:____Date:________________

Parent/Guardian's Signature:_______________________________________Date:________________

Doctor's Signature:____Date:________________

Nature of Accident/MVA IF APPLICABLE

1. Date of accident___________________________Time of Day________________________

2. Were you: Driver Passenger Front seat Back Seat

3. Number of people in your vehicle?________________Were you wearing seatbelts?_________________

4. What direction were you heading? North East West South

5. What direction was other vehicle headed? North East West South

6. Were you struck from: Behind Front Left Side Right Side

7. Approximate speed or our car:______________________ MPH of other car:_____________________

8. Were you knocked unconscious? Yes No If yes, How long_____________________

9. Were police notified? Yes No

10. In your own words describe accident.

____

____

____

____

____

11. Did you have any physical complaints before the accident? Yes No If yes, Please describe complaints.

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OFFICE/FINANCIAL POLICIES

VEHICLE ACCIDENTS: If your visit is related to a vehicle accident, in addition to your private insurance information, the responsible party's claim number is required prior to your first visit. Also, if you are represented by an attorney concerning the vehicle accident you are required to provide your attorney's name, address, and telephone number prior to your first visit.

OUTCOME OF CLAIM: If, for any reason, the result your personal injury claim or personal injury lawsuit is not favorable or you do not receive any funds or you do not receive sufficient funds to satisfy your account with this office, then you are responsible to pay in full and satisfy your account with this office.

INTEREST: The office of Dr. Jonathan J. Boudreaux, D.C. shall charge interest in the amount of 1.5% per month on the total outstanding account balance if the full outstanding account balance is not paid within 75 days of the date of treatment.

RETURN CHECK CHARGE: If you make a payment with any check, draft, or negotiable instrument of any type, on a bank or other depository institution and such instrument is not paid or is dishonored for any reason you agree to pay The Office of Dr. Jonathan J. Boudreaux, D.C. an amount equal to the greater of 5% of the amount of the negotiable instrument or $25.00. You may be placed on a "Cash Only" basis following any returned negotiable instrument.

ATTORNEY FEES AND COLLECTION COSTS: If your account is placed in the hands of an attorney at law for collection, to prosecute claims in bankruptcy, to institute legal proceedings to recover the amount of the account or any part, in principal or interest, or any other action to protect the interests of The Office of Dr. Jonathan J. Boudreaux, D.C. then you shall pay the fees of the attorney who may be employed for that purpose in the amount of 33% of the total amount due or $250.00, whichever is greater, plus all court costs and other expenses incurred in the collection of your account.

COMMERCIAL HEALTH INSURANCE: As a courtesy to me the physician at Boudreaux Spine and Joint will file claims for healthcare services provided on my behalf directly to my health insurance carrier. I hereby assign directly to my physician and all health insurance benefits to which I am entitled and which are payable to me for any such services rendered. I understand that independent of my health insurance policy, I assume personal financially responsibility for all charges incurred for services provided by my physician on my behalf.

MEDICARE: The physician at Boudreaux Spine and Joint accepts Medicare assignment on Medicare approved charges. I understand that I am personally financially responsible for any required deductible(s) and or copayments(s). As a courtesy to me, the physician at Boudreaux Spine and Joint will file claims for healthcare services provided on my behalf directly to my Medicare supplemental insurance carrier. I hereby assign directly to my physician and any and all supplemental health insurance benefits to which I am entitled and which are payable to me for any such services rendered.

NO INSURANCE: If there is no health insurance or other such coverage for the charges incurred on this account. I agree to pay the full balance of such charges AT THE TIME OF SERVICE. IF YOU DO NOT HAVE INSURANCE NOTIFY RECEPTIONIST PRIOR TO SEEING PHYSICIAN!

RELEASE OF INFORMATION: I authorize my physicians to release any and all medical information, including but not limited to a photocopy of my medical records, which may be requested by my insurance company and/or which is necessary to process my insurance claim(s) or to secure the payment of health insurance benefits. Further, I authorize the use of my signature below on all insurance submissions made by my physician for healthcare services provided on my behalf.

I authorize Boudreaux Spine and Joint (or their designated staff under the physician's direction) to verbally give my test results to people listed below from this day forward until otherwise notified.:

____

____

I have agreed and understand the above and agree to abide by these financial policies of Boudreaux Spine and Joint. I understand and agree that such policies may be changed from time to time at the sole discretion of Boudreaux Spine and Joint.

____ ___________________

Signature of Patient or Responsible Party Date