CIRA
CHIROPRACTIC
& WELLNESS

Initial Consultation History

Today's Date_____

Name _____ Age _____ Date of Birth _____

Both Parent's names (if you are under 18)_____

Address_____

Cell Phone #_____Email_____

Occupation _____ Employer _____

Marital Status ❑ S ❑ M ❑ D ❑ W ❑ L/W Spouse/Partner _____

Names and Ages of Children_____

Whom may we thank for referring you to our office? _____

Your Main Complaint: _____

Any other Complaints: _____

_____

How long have you suffered with this problem? _____

What have you tried to do to get rid of this problem that **DID NOT** work? _____

Have you become discouraged about handling this problem? _____

When your problem is at its worst, how does it make you feel? _____

_____

How does this problem interfere with the following areas of your life?

WORK: _____

FAMILY: _____

. *HOBBIES:*_____

LIFE: _____

Does handling this problem cause stress for you? _____

What do you do that makes this problem worse? _____

_____

How much older does this make you feel? _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem:_____

What gives you some temporary relief? _____

What is the pattern of this problem? Constant ___ Intermittent ___ Occasional ___ Cyclic ___

What is the effect it has on your body functions? _____

How did it start? _____

Are you on any type of medication?_____ Please list all: _____

_____

_____

Could your problem have been caused by an injury at work? _____

If yes, please give us the details: _____

_____

Have you been involved in an auto accident? _____

Date of accident: _____

Any difficulties from this? _____

_____

Have you ever had a head injury?_____

Date of injury: _____

Please describe the injury_____

_____

Please check all that apply:

❑ Irritability or aggression	❑ Sleep disorders	❑ Fatigue	❑ Nausea
❑ Poor memory	❑ Speech difficulties	❑ Brain fog	❑ Tinnitus
❑ Poor word recall	❑ Visual disturbance	❑ Headache	❑ Speech problems
❑ Anger, anxiety, depression	❑ Apathy or lack of spontaneity		

Do any of your children have health problems that you are aware of? _____

If yes, please give us the details: _____

_____

Past or present history of cancer?_____

Have you ever received Chiropractic care? ❑Y ❑ N Name of D.C. _____

How long under care? ❑ _____days ❑_____weeks ❑_____months ❑_____ years

Date of last visit: _____Why did you stop care?_____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

❑ Medical Physician	❑ Naturopath	❑ Acupuncturist	❑ Homeopath
❑ Massage Therapist	❑ Psychotherapist	❑ Dentist	

Reason:_____

_____

Is there any other information you would like us to know?_____

_____

FOR WOMAN

Are you pregnant? Y N Date of last menstrual period: _____

If x-rays are recommended, your signature is required (below) to verify that you are **not pregnant**.

Signature: _____Date:_____

If **pregnant**, Due Date: _____ Name of OBGYN or Midwife_____

Payment in full is expected on all FIRST VISIT services (whether you have insurance coverage or not.) All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card

First Visit Fees: Comprehensive Exam:$175 time of service fee
$270-350 insurance/customary fee

INSURANCE INFORMATION

Insurance coverage varies greatly. We cannot predict whether your policy will cover the services we provide in our office. It is your responsibility to contact your insurance company to determine the amount and extent of coverage.

Please indicate below the type and name of your Insurance**

If you have coverage, our staff will need a copy of your insurance card.

Insurance type: ❑ Medicare ❑ Auto Accident ❑ Workers Comp. ❑ Other (e.g., Aetna, Cigna, Blue Shield, etc.)

Insurance name:_____

Is this an Auto Accident or a Work-Related Injury? ❑ Yes ❑ No

If **yes**, please provide us with the following information:

Have you been treated elsewhere? ❑ Yes ❑ No

If **yes**, where? ❑ Emergency Room ❑ Primary Care ❑ Other _____

What services were provided? ❑ MRI ❑X-Rays ❑ Medication ❑ Therapy ❑ Other

(details)_____

Patient Name: (Printed) _____

Signature _____ **Date:** _____

PLEASE READ AND SIGN

1. I have been informed that a copy of Cira Chiropractic's *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review both in the office and on the website at www.cirachiropractic.com.
2. I consent to receive communication from Cira Chiropractic via email, postal mail, text and telephone messaging in connection with my care. ❑ Yes ❑ No If I should withdraw my consent, I will notify the office in writing.
3. I clearly understand and agree that all services rendered are ultimately charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.
4. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policyholder. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered to myself.

The information I have provided on this case history form is true and accurate to the best of my knowledge.
I give Dr. Cathy Cira permission to render care to myself today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Patient Name: (Printed) _____

Signature _____ Date: _____

Thank you for choosing Cira Chiropractic and Wellness