

# SUMMER AVENUE CHIROPRACTIC CLINIC

4239 Summer Avenue • Memphis, Tennessee 38122 • 901-763-2225

If you need any assistance completing this form, please ask the receptionist.

Visit us at: [www.summeravechiro.com](http://www.summeravechiro.com)

What type of care do you want?  Relief Care  Correction Care  Wellness Care

## PATIENT INFORMATION

Today's date: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Name: \_\_\_\_\_ Called Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Beeper #: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Driver License #: \_\_\_\_\_  
Age: \_\_\_\_\_  Male  Female  
Marital Status  Married  Single  Divorced  Separated  Other: \_\_\_\_\_  
Name of spouse or nearest relative: \_\_\_\_\_  
Number of children: \_\_\_\_\_ Ages of children: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
How did you hear about us?  yellow pages  friend  sign or location  web site  
Weight frequently required to lift is under: 10 20 30 40 50 60 70 80 90 100  
Payment for service will be by  cash  check  credit card  health insurance  Worker's Compensation  
 automobile insurance  attorney: \_\_\_\_\_  
Name of insurance company or attorney: \_\_\_\_\_  
Insured's employer: \_\_\_\_\_  
Insured's ID # or Claim #: \_\_\_\_\_  
Adjuster's or Attorney#: \_\_\_\_\_  
Address: \_\_\_\_\_  
Does more than one insurance company cover you?  yes  no Name: \_\_\_\_\_

## MEDICAL/FAMILY HISTORY

S-Self M-Mother F - Father

(Please indicate which conditions the above has experienced by marking appropriate boxes.)

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dislocated Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reproductive Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone Fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serious Injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Control Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease

Have you been treated by a physician for any health condition in the last year?  yes  no

Describe condition: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

## **SURGICAL HISTORY**

1. \_\_\_\_\_ Date: \_\_\_\_\_  
2. \_\_\_\_\_ Date: \_\_\_\_\_  
3. \_\_\_\_\_ Date: \_\_\_\_\_  
4. \_\_\_\_\_ Date: \_\_\_\_\_

## **ACCIDENT HISTORY**

- Job  Auto  Other: \_\_\_\_\_ Date: \_\_\_\_\_  
 Job  Auto  Other: \_\_\_\_\_ Date: \_\_\_\_\_

## **PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS**

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

Symptoms are worse in:  Morning  Afternoon  Evening  
When and how occurred? \_\_\_\_\_

Symptoms developed from:  Job related  Auto accident  other: \_\_\_\_\_

Symptoms have persisted for # \_\_\_\_ Hour(s) \_\_\_\_ Day(s) \_\_\_\_ Week(s) \_\_\_\_ Month(s) \_\_\_\_ Year(s)

Symptoms/complaints  Come and go  Are constant

Have you ever had this before?  No  Yes When? \_\_\_\_\_

If you were to guess, what do you think is causing your complaints? \_\_\_\_\_

Name and location of doctors previously seen for present conditions: \_\_\_\_\_

Are you allergic to any medications?  No  Yes What kind? \_\_\_\_\_

Are you taking any medications?  No  Yes What kind? \_\_\_\_\_

Are you pregnant?  No  Yes Date of last period? \_\_\_\_\_

### **PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:**

- Bending  Reaching  Coughing  Sitting  Turning head  
 Lifting  Sneezing  Walking  Lying down  Standing  
 Straining at stool

### **PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:**

- Bending  Sitting  Lifting  Standing  Lying down  
 Reaching  Walking  Turning head

### **PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:**

- |                                                       |                                          |                                                    |                                     |                                              |
|-------------------------------------------------------|------------------------------------------|----------------------------------------------------|-------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Blurred vision               | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Cold feet                 | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Constipation        |
| <input type="checkbox"/> Diarrhea                     | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Face flushed              | <input type="checkbox"/> Fever      | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Headaches                    | <input type="checkbox"/> Cold sweats     | <input type="checkbox"/> Fatigue                   | <input type="checkbox"/> Insomnia   | <input type="checkbox"/> Light bothers eyes  |
| <input type="checkbox"/> Loss of balance              | <input type="checkbox"/> Loss of smell   | <input type="checkbox"/> Loss of taste             | <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Numbness in fingers |
| <input type="checkbox"/> Concentration loss/confusion |                                          | <input type="checkbox"/> Ringing in ears           |                                     |                                              |
| <input type="checkbox"/> Stomach upset                |                                          | <input type="checkbox"/> Pins and needles in legs  |                                     |                                              |
| <input type="checkbox"/> Head seems to be heavy       |                                          | <input type="checkbox"/> Depression/weeping spells |                                     |                                              |
| <input type="checkbox"/> Head seems to be heavy       |                                          | <input type="checkbox"/> Low resistance to colds   |                                     |                                              |
| <input type="checkbox"/> Numbness in toes             |                                          | <input type="checkbox"/> Shortness of breath       |                                     |                                              |
| <input type="checkbox"/> Pins and needles in arms     |                                          | <input type="checkbox"/> Muscle jerking            |                                     |                                              |

**MAJOR COMPLAINTS**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

	<b>SEVERITY</b>	<b>FREQUENCY</b>	<b>DURATION</b>
	Grade pain on a scale of 1 –10 Mild pain - Extreme pain	Percent of time pain or numbness is present	How long has the pain or numbness been present
<u>CHECK MAJOR COMPLAINTS</u>			
Headaches	_____	_____	_____
Neck Pain L/R/B/C	_____	_____	_____
Arm Pain L/R/B	_____	_____	_____
Arm Numbness L/R/B	_____	_____	_____
Hand Pain L/R/B	_____	_____	_____
Hand Numbness L/R/B	_____	_____	_____
Shoulder Pain L/R/B	_____	_____	_____
Mid Back Pain L/R/B/C	_____	_____	_____
Low Back Pain L/R/B/C	_____	_____	_____
Hip Pain L/R/B	_____	_____	_____
Leg Pain L/R/B	_____	_____	_____
Foot Pain L/R/B	_____	_____	_____
Leg Numbness L/R/B	_____	_____	_____
Foot Numbness L/R/B	_____	_____	_____
Other	_____	_____	_____

# CONSENT TO EXAMINE AND TREAT

The undersigned consents to any examination (x-ray or otherwise) including, but not limited to physical, orthopedic and neurological evaluation, visual inspection and palpation.

The undersigned also consents to observation of the therapeutic or diagnostic procedures by staff personnel or medical personnel in training as permitted by the attending practitioner and allowed by clinic policy. Treatment procedures that may be used in your treatment include, but are not limited to, manipulative therapy, joint mobilization, myofascial release, trigger point therapy, ultrasound, electrical stimulation, rehabilitative exercise and massage.

Cases will be managed with all due concern and with the evaluation of response to previous care provided. Home care instructions will be given as appropriate to enhance your treatment program. Compliance with the recommendations for home care and follow-up care is necessary for the resolution of your complaint.

Because of modern techniques and equipment, examination and therapeutic procedures carry with them a low risk of complication. Even though problems seldom arise during these procedures, risks must be recognized and considered. Any procedure intended to help may also do some harm. While examination and therapeutic procedures used in this clinic are considered remarkably safe and effective, understand that occasionally there may be adverse reactions that occur. Although the chances of experiencing any of these complications are extremely small, it is the practice of this office to fully inform and educate our patients. These complications include but are not limited to pain, swelling, bruising, discoloration, inflammation, disc injury, sensory changes, bleeding, fracture, fainting, irregular heart beat, heart attack, spinal cord damage, nausea, burns, soft tissue injury, stroke, dizziness, or weakness. No guarantee or warranty for a specific cure or result is implied by the acceptance of your case. All patients respond differently to the treatment procedures and each case must be evaluated separately.

If you do not fully understand the above or have any questions about anything mentioned in this document, please do not sign until these matters have been resolved with further discussion.

I have read the above explanation of treatment and diagnosis procedures used in this clinic and have myself decided that it is in my best interest to submit to these procedures.

Printed Name \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

## CONSENT OF TREATMENT OF MINOR CHILD

I hereby authorize Summer Ave Chiropractic Clinic (ABCG Incorporated) to administer treatment, as they so deem necessary to my Son/Daughter

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_

**Summer Ave Chiropractic Clinic**  
**4239 Summer Ave Memphis, Tn 38122**  
**901 -763-2225**

**FINANCIAL and INSURANCE POLICY**

1. It is the policy of this office that ALL services rendered are charged directly to you, the patient, and that ultimately, the patient is responsible for ALL services, including those not reimbursed by third party payer.
2. The privilege of insurance assignment begins when our office receives your insurance form. If it is after hours or we are unable to verify prior to you leaving the office, you are responsible for the entire balance until we are able to verify. You are considered a "cash patient" until it can be verified.
3. If the insurance company tells us that your deductible had not been met, that is what we go by. You will be responsible for paying for the deductible. When we file the claim and if the filed claim comes back that your deductible had been met, we will reimburse you at that time.
4. All co-payments, deductibles or %'s are due at time of service or at the end of your scheduled week, e.g.: if he wants to see you three times a week, on the 3rd visit you will be responsible for your balance then. A patient balance may not exceed \$200.00 at any time.
5. Returned checks will have a \$20.00 fee added to their balance and any balance over 30 days old will have an additional collection fees and a 1.5% interest added to their total balance.
6. All accounts not paid within 90 days will be turned over to a collection agency and the patient/guardian will be responsible for any court costs, attorney fees and the 33% or more that we are charged for turning you over, along with any other charges that may occur during your time in the collection agency.
7. If you have an attorney, you have one year from the date of accident to have our bill paid. If there is no settlement prior to the year then you will be responsible for 5% of your total balance every month. If you neglect to pay this 5% then you will be responsible for the 1.5% interest monthly until the case settles. (You will be responsible for the interest, NOT the attorney), then # 6 will take into effect.
8. All patients whose visitation is once a month will not be eligible for insurance assignment (If policy does not cover maintenance). Charges for services rendered will again be due as they are received.
9. Since we do not pay for your policy, and occasionally, we experience difficulty in collecting from the carrier, we may ask for your active assistance in rectifying the situation.
10. Lastly, it is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We look forward to your referral and to a doctor-patient relationship that works for our mutual benefit.

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Patients Signature/ SS#