CHIROPRACTIC HEALING ARTS CENTER
2345 Fletcher Parkway • El Cajon, California 92020 • (619) 460-4465

PLEASE REVIEW AND COMPLETE THIS PATIENT QUESTIONNAIRE. DOING THIS WILL SIGNIFICANTLY REDUCE YOUR TIME IN THE OFFICE. THE AMOUNT OF TIME, WHICH HAS BEEN SCHEDULED FOR YOUR APPOINTMENT, DOES TAKE INTO CONSIDERATION THAT THIS PACKET HAS BEEN COMPLETED. THANK YOU VERY MUCH!

PATIENT INFORMATION

(*Please present ID & insurance card*)

First Name: _____ Last Name: _____ Nickname: _____
Address: _____ City: _____ State: _____ Zip: _____
Social Security #: _____ **Sex:** ◯ male ◯ female **Pronouns** *(optional)* _____
Date of Birth: _____/_____/_____ **Age:** _____
Marital Status: ◯ single ◯ married ◯ divorced ◯ widowed Spouse: _____

Language Preference: ◯ English ◯ Spanish ◯ other _____
Race: ◯ Declined to specify ◯ American Indian/Alaska Native ◯ Asian ◯ Black/African American
◯ Native Hawaiian/Other Pacific Islander ◯ White
Ethnicity: ◯ Declined to specify ◯ Hispanic/Latino ◯ Not Hispanic/Latino

Cell Phone: (_____) _____--_____ **Work Phone:** (_____) _____--_____
Home Phone: (_____) _____--_____ which is primary contact? ◯ Cell ◯ Home ◯ Work
Email address: _____
Occupation: _____ **Employer:** _____
Emergency Contact: _____
Relationship: _____ Phone: (_____) _____--_____
How did you hear about us? / Who referred you? _____
Do you have special communication needs due to vision, hearing or language (interpreter, etc.)? ◯ No ◯ Yes
If yes, please explain _____

Is care self-pay or covered by Insurance? ◯ Self-Pay ◯ Health Insurance ◯ Medicare ◯ Other _____

Cause of this problem? ◯ Auto Accident ◯ Work Related Injury ◯ Unknown ◯ other injury _____
DATE OF INJURY: ___/___/_____

PRIMARY Insurance: _____ Address: _____
ID/Claim #: _____ Group #: _____
Name of Insured: _____ Insured Date of birth: _____
Relationship to Insured: ◯ Self ◯ Spouse/Partner ◯ Child ◯ Other _____

SECONDARY Insurance: _____ Address: _____
ID/Claim #: _____ Group #: _____
Name of Insured: _____ Insured Date of birth: _____
Relationship to Insured: ◯ Self ◯ Spouse/Partner ◯ Child ◯ Other _____

Patient Signature _____ **Date** _____

Gianfranco Calafiore, DC / Chiropractic Healing Arts Center

HEALTH HISTORY

Patient Name (First, Last) _____

Cause of this problem? ◯ Auto Accident ◯ Work Related Injury ◯ Unknown ◯ other injury _____

DATE of Current Symptoms: ___/___/_____

How did symptoms start? _____

Describe current symptoms: _____

☐ Headaches ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain ☐ Other_____

Average pain intensity:

Last 24 hours: no pain=⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩=excruciating 10

Past week: no pain=⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩=excruciating 10

How often are symptoms present?

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

How much have your symptoms interfered with your daily activities?

◯ Not at all ◯ A little bit ◯ Moderately ◯ Quite a bit ◯ Extremely

In general, would you say your overall health right now is...

◯ Excellent ◯ Very good ◯ Good ◯ Fair ◯ Poor

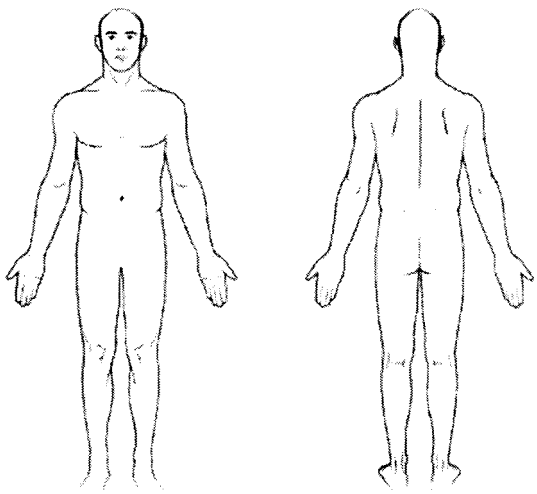
Have you had X-rays, MRI, CT Scan for areas of complaint? ◯ No ◯ Yes

If yes, please indicate: Date taken: _____/_____/_____

What areas? _____

At what facility? _____

Indicate below where you have pain or symptoms



Please check all of the following that apply to you:

☐ Abdominal pain
☐ Abnormal weight gain/loss
☐ Alcohol/Drug dependence
☐ Birth control
☐ Chest Pain
☐ Corticosteroid use (Cortisone, Prednisone, etc.)
☐ Currently pregnant, # weeks _____
☐ Diabetes
☐ Disability rating _____
☐ Dizziness/Fainting
☐ Epilepsy/Seizures
☐ High blood pressure
☐ Irregular bowel habits/Constipation
☐ Loss of bladder control/Frequent painful urination
☐ Numbness in extremities
☐ Osteoporosis
☐ Prostate problems
☐ Recent fever
☐ Rheumatoid Arthritis
☐ Heart Attack/Stroke, date _____/_____/_____
☐ Tinnitus/Ear noises
☐ Tobacco (type) _____, frequency ____/day
☐ Visual disturbances
☐ Cancer/Tumor (explain) _____
☐ Medications _____
☐ Previous accidents _____
☐ Surgeries _____
☐ Other health problems (explain) _____

Family Health History:

☐ Cancer ☐ Diabetes ☐ Heart problems/Stroke ☐ High blood pressure ☐ Rheumatoid Arthritis ☐ Other_____

I certify, to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature _____ **Date** _____

Gianfranco Calafiore, DC / Chiropractic Healing Arts Center

INSURANCE VERIFICATION

If you have insurance, as a courtesy, our office will attempt to verify chiropractic benefits with your insurance company. We will also try to determine your co-pay or co-insurance that is due during each visit based on the information provided to us by your insurance company. When verifying benefits, insurance companies always have a disclaimer stating that, **"telephone verification of benefits are NOT a guarantee of payment"** and that **"actual payment will be determined after a bill is received."**

It has been our experience that insurance companies often misquote benefit information. **Therefore, please be aware that our office or staff members are not responsible for any misquoted benefits**. The amount originally determined may be subject to change based on insurance statements/explanation of benefits that we receive from your insurance company.

FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for all charges incurred by me, regardless of whether my insurance pays or not, or my claim status. I also understand that the Chiropractic Healing Arts Center, as a courtesy to me, will prepare and send billing and any necessary reports to assist me in making collections from the insurance company in such cases. Any benefits authorized will be paid directly to the doctor and credited to my account upon receipt. **I fully realize that my insurance is a contract between me, my employer and the insurance company and that the doctor or office is not a liable party to that contract.**

I am aware that payments for services are due at the time services are rendered, unless previous arrangements have been made and approved in writing by the office manager. I understand and agree that if I suspend or terminate my care with this office, the remaining balance for services rendered to me will be immediately due and payable. I further agree that in the event of nonpayment, I will bear the cost of collection and/or court costs and reasonable legal fees should such court action be required. I am also aware of the following policies:

Please Initial boxes below:

- Balances older than 45 days may be subject to late fees and interest charges of 2% per month ($2 min). _____
- A fee of $35 will be charged for missed appointments without 24-hour cancellation notice. _____
- All returned checks will be subject to a $25 service charge. _____

By signing this form, I am acknowledging the fact that I have read, or have had read to me, the above Financial Responsibility and Insurance Verification Sections and that I understand and agree to the above policies.

Patient's Signature _____ Date ____/____/_____

Patient's Name _____

Gianfranco Calafiore, DC / Chiropractic Healing Arts Center