The following information is needed in order to serve you to the best of our ability. Please complete all questions to the best of your knowledge. If you need help, please ask the receptionist. PLEASE PRINT AND USE BLACK INK.

Today's Date: _____

Name: _____ _____ _____ Home Phone: _____
First Name *Middle Initial* *Last Name*

Address: _____ City: _____ State: _____ Zip: _____

Age: 61 Birth Date: _____ Marital Status: ☐M ☐S ☐W ☑D No. of Children _____

Referred by: _____ E-mail Address: _____

Please Check Type of Payment: ☑ Cash ☐ Check ☐ MasterCard/Visa

Your Employer: _____ Occupation: _____ Years on Job: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Office Phone: _____ Cell Phone: _____ Patient's SS#: _____

Do You Have Health Insurance? ☐Yes ☐No Insurance Company: _____

Insurance ID #: _____ Insurance Group #: _____ Your Work Hours:_____

Do You Have Medicare? ☑Yes ☐No Medicaid? ☑Yes ☐No

Name of Spouse or Parent: _____ Birth Date: _____

Spouse's Employer: _____ Occupation: _____

Office Phone: _____ Cell Phone: _____Spouse's SS#:_____

Describe the Major Complaints That Bring You to Our Office:

Insurance Co Name:_____ Insurance Co Phone Number:_____ Claim #:_____

Is Your Condition Due To An Accident? ☐Yes ☑No Date of Accident: _____

Type of Accident? ☑Auto ☐Work/Job ☐At Home ☐Other: _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature (For Minors): _____Date: _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

Health History

Name: _____ Date: _____

List All Current Health Problems:

List Any Other Doctors Seen, Treatments and Results Obtained:

Your Current Physician(s)/Therapist(s):

List All Surgeries And Their Dates:

List Any Medications You Are Taking:

List Any Traumas And Their Dates:

List Any Family History (Parents, Siblings, and Grandparents):

Please Check The Conditions You Have Or Have Had:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Cancer
- ☐ Chronic fatigue
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Hypoglycemia
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Rheumatoid arthritis
- ☐ Tuberculosis
- ☐ Venereal disease

Review Of Systems

Town and Country Specific Chiropractic

Please Check All Present Symptoms:

CARDIOVASCULAR

- ☐ General swelling
- ☐ Swelling in legs
- ☐ Swelling in face
- ☐ Swelling around eyes
- ☐ Chest pain
- ☐ Pounding heart beat
- ☐ Rapid heart beat
- ☐ Irregular heart beat
- ☐ Blue or purple skin
- ☐ Blue or purple nail beds
- ☐ Cold hand/feet

VERTEBROBASILAR

- ☐ Double vision
- ☐ Loss of coordination
- ☐ Loss of memory
- ☐ Ringing in ears
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Muscle weakness
- ☐ Dizziness
- ☐ Blurred vision
- ☐ Stroke
- ☐ Hypertension

- ☐ Inability to form words
- ☐ Burning sensations
- ☐ Blindness
- ☐ Previous head injury
- ☐ Previous neck injury
- ☐ Taking birth control pills
- ☐ Family history of stroke
- ☐ Blood vessel disease
- ☐ Check if you smoke
- ☐ Fainting
- ☐ Area of numbness

Mental

- ☐ Nervousness
- ☐ Irritability
- ☐ Fatigue
- ☐ Depression
- ☐ Panic attacks
- ☐ Problems sleeping
- ☐ Generally feel run-down

Skin, Hair, Nails

- ☐ Eczema
- ☐ Itchy skin
- ☐ Rough, scaly skin
- ☐ Dry skin
- ☐ Oily skin
- ☐ Yellow skin
- ☐ Bruise easily
- ☐ Baldness
- ☐ Paper thin nails
- ☐ Nail biting

Eyes

- ☐ Blurred vision
- ☐ Double vision
- ☐ Eye fatigue
- ☐ Excessive tearing
- ☐ Lack of tearing
- ☐ Light bothers eyes
- ☐ Excessive itching
- ☐ Pain in eyeball

Ears

- ☐ Loss of hearing
- ☐ Discharge from ears
- ☐ Not sufficient
- ☐ Vertigo
- ☐ Pain in ears
- ☐ Ringing in ears

Nose & Sinuses

- ☐ Nose bleeds
- ☐ Pressure over eyes
- ☐ Nose obstruction
- ☐ Frequent colds
- ☐ Sinusitis
- ☐ Loss of smell
- ☐ Allergies

Mouth & Throat

- ☐ Pain in throat
- ☐ Bleeding gums
- ☐ Abscessed teeth
- ☐ Dentures
- ☐ Difficulty swallowing

Respiratory

- ☐ Shortness of breath
- ☐ Dry cough
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Productive cough

Gastrointestinal

- ☐ Poor appetite
- ☐ Constant nibbling
- ☐ Difficulty swallowing
- ☐ Indigestion
- ☐ Nausea & vomiting
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids

Genitourinary

Urination is

- ☐ Frequent
- ☐ Not sufficient

The amount is

- ☐ High
- ☐ Moderate
- ☐ Low
- ☐ Frequent urination at night
- ☐ Intense desire to urinate
- ☐ Difficulty urinating
- ☐ Lack of control
- ☐ Pain with urination
- ☐ Dribbling
- ☐ Bloody urine
- ☐ Cloudy urine

Venereal Disease

- ☐ Syphilis
- ☐ Gonorrhea

Other

Women Only

- ☐ Painful periods
- ☐ Spotting
- ☐ Premenstrual symptoms
- ☐ Irregular periods
- ☐ Lumps in breast
- ☐ Vaginal discharge

# of pregnancies: ☐

# of deliveries: ☐

Musculoskeletal System

Please Check All Present Symptoms:

Head

- ☐ Frequent headaches
- ☐ Severe headaches
- ☐ Head feels heavy
- ☐ Vertigo
- ☐ Dizziness

Shoulders

- ☐ Pain in shoulders
- ☐ Pain across shoulders
- ☐ Muscle spasms
- ☐ Can't raise arm
- ☐ Above shoulder

☐Light headedness
☐Loss of taste
☐Loss of smell

☐Above head

Arms & Hands

☐Loss of hearing
☐Loss of balance
☐Pain in hands
☐Loss of grip strength

☐Pain in upper arm
☐Pain in forearm
☐Pain in fingers

☐Pins & needles
☐In arms
☐In fingers

☐Fingers go to sleep
☐Cold hands
☐Swollen fingers

Neck

☐Pain in neck
☐Pinched nerve in neck
☐Grinding sounds in neck

☐Pain with movement
☐Neck feels out of place
☐Popping sounds in neck

☐Swelling in neck
☐Muscle spasms in neck
☐Limited neck movement

☐Stiffness in neck

Hips, Legs & Feet

☐Pain in buttocks
☐Leg cramps
☐Cold feet

☐Pain in hip
☐Pins & needles in legs
☐Pain over kidney area

☐Pain down leg
☐Numbness in legs
☐Swollen ankles

☐Knee pain
☐Numbness in toes
☐Swollen feet

Mid-Back

☐Mid-back pain
☐Dull ache

☐Pain between shoulder blades
☐Pain from front to back

☐Sharp stabbing pain
☐Muscle spasms

Lower Back

☐Lower back pain

☐Lower back feels out of place

☐Muscle spasms

Social History

Town and Country Specific Chiropractic

Please Check All Present Symptoms:

☐Smoking
☐Other tobacco use
☐Alcohol use
☐Drink coffee or tea

Diet is: ☐Balanced ☐Not balanced
Rest is: ☐Sufficient ☐Not sufficient
Recreation is ☐Sufficient ☐Not sufficient
Family stress is:

☐Severe ☐High ☐Moderate ☐Minimal ☐None

My job stress is

☐ Severe ☐ High ☐ Moderate ☐ Minimal ☐ None

My role in your care is to remove the interference that is preventing you from being the self developing, self maintaining and self healing organism that we were intended to be so that homeostasis may be restored. Many conditions are resolved through Upper Cervical Specific Corrections but I do not specifically treat any conditions. The body needs time to heal and will do so from above, down, from the inside out. It doesn't need any help just no interference.

On a scale of 1-10, How committed are you to restoring your health to its maximum potential?

☒1, ☐2, ☐3, ☐4, ☐5, ☐6, ☐7, ☐8, ☐9, ☐10

Town and Country Specific Chiropractic, LLC

Dr. Kristine Strawniak:

Terms of Acceptance

Welcome to our office! Our goal is to administer exceptionally friendly and prompt service, while providing the family health care available. In return, you will receive restored health. It is our experience that patients who understand the purpose, procedures and policies of our care and who follow these simple guidelines obtain the best results and greatest benefits to their health.

Definitions: INITIAL_____

Vertebral Subluxation: A misalignment of the vertebra in the spinal column which causes alterations of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum heal potential.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or Infirmity.

Purpose: INITIAL_____

The purpose of specific chiropractic is to promote natural health through the release of maximal nerve energy. This gives the body maximum opportunity to heal itself. Specific chiropractic utilizes specific analysis (instrumentation and specific x-rays) to detect vertebral subluxation. In a subluxation is detected, a specific chiropractic adjustment will be rendered to correct the vertebral subluxation and restore maximum amour of nerve energy to the body.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct the vertebral subluxation.

I _____have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

_____ _____

Signature **Date**

COLLECTIONS CRITERIA

PLEASE READ AND SIGN BELOW.

If you have insurance, we will submit the claim in a timely manner. Once we receive an Explanation of Benefits from your insurance company, your account will then be placed in a 0 to 30 day range. You have 30 days to pay your responsibility in full or finance charges will be added to your account each month until your balance is paid or you reach the appropriate collections criteria. In the event we have not received an ***EOB*** from your insurance company within 90 days, the charges become your responsibility, regardless of the nature of service. It will be you're responsibly to contact your insurance company and address why non-payment was made. Our office follows up on each claim that is sent and refiles only when deemed necessary. We will NOT charge of falsify any CPT or diagnosis code so that insurance will cover your visit or procedure. We will only Submit correct and accurate medical information evaluated by the doctor. **We are not in network with any insurance except Medicare!**

PLEASE DO NOT ASK US TO CHANGE ANY CODES

****After 120 days and we do not hear from your insurance or a balance has not been paid on your account; your account will be forwarded for collection activity. Failure to cooperate to make good on your account my also result in dismissal from this practice.** We would like to encourage you to check with our office and see if payment has been made by your insurance or if you have been sent a statement that you pay the amount do ***promptly.*** If nonpayment of any account results in turning your account over to an outside collection agency; you will also be responsible for your original amount plus any collection fees assessed in the pursuit of collection of this debt.

*****ALL patients that do not have their account up to date may not make an appointment until paid in full.*****

BANKRUPTCY ACCOUNTS MAY RESULT IN DISSMISSLE FROM THIS PRACTICE

RESCHEDULED OR MISSED APPOINTMENTS

Please understand that our office works by a schedule and we have reserved the appropriate time slot so that so you may speak to Dr. Strawniak and that she may be of service to you during the time allotted. It is our policy that if you do not contact us within 24 hours in advance of your scheduled appointment date and time that you will be subject to a $25.00 no call / no show fee and your noncompliance will be recorded in your chart.

Repeated no shows may result in dismissal from our practice. **Please be advised that if you have received this charge that payment will be collected before you are seen again in our office.** Occasionally our schedules may be disrupted and not run on time. We understand our patients have busy lives and we will do our best to keep you informed of these delays and will ask that you also keep us informed of your time constraints. Communication is a vital key to a successful healthcare provider-patient relationship.

RECORDS RELEASE

Our office reserves the right to charge a fee for release of medical records. This fee includes: paper, postage and man-power. This fee must be paid before the release of records. Our medical records department requires48-72 hours to produce these documents. If you have any questions regarding this policy, please ask the front office.

COMPLETION OF FORMS

A fee may be charged for completion of any forms pertaining to your care to your place of employment, Insurance company and/or attorney. *Please* allow approximately 48-72 hours for completion of forms.

Please note that our office policy regarding x-rays is that the originals must remain in our office. However, copies can be made for a fee. Any fees for completion of forms or reproduction of x-rays are due and payable by you the patient in the event they are not paid by your insurance company / attorney.

Thank you for understanding and signing our policies. Again, if you have any questions or concerns, .please let the front office know and we will be happy to address them accordingly. We look forward to establishing a relationship with you and meeting all or you future healthcare needs

_____ _____

PATIENT SIGNITURE **STAFF WITNESS**

_____

DATE

Town and Country Specific Chiropractic, LLC

Dr. Kristine Strawniak:

X-Ray Consent Form

Dr. Strawniak will explain that the purpose of the X-rays about to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If Dr. Strawniak discovers a non-chiropractic unusual finding when reviewing this X-ray, I will be informed. I then must determine if I should seek the services of an additional health care provider for advice, diagnosis, or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation correction care provided by this office.

I fully understand the above and consent to chiropractic spinal X-rays.

_____ _____

Patient's Signature **Date**