Welcome to Pepperell Chiropractic

First Name________________MI____Last______________________Birth Date___/___/___Age____Today's date___/___/___

Address____City________________________State________Zip_______________

Home# (   )______________________Work#(   )______________________ Mobile#(   )____________________________

Email: ____

_____Male ______Female   # of children______   ☐Single ☐ Married ☐ Widowed ☐Separated ☐ Divorced

Names & Ages of Chidren: ____

Social Security #: ________-________-________   Women: Are you pregnant? ☐ Y ☐ N

Place of Employment: ____ Occupation: ___________________________

Name of Spouse (Parent if under 18): _________________________ Birth date of spouse (Parent if patient under 18): ___/___/___

Place of Employment: ____ Occupation: ___________________________

Primary Care Physician Name/Address/Phone: ____

____

Prior Doctor of Chiropractic Name/Address/Phone: ____

____

Last time you went to previous Doctor of Chiropractic:____

What have you heard about chiropractic care? ____

____

Do you know what a subluxation is? If yes, please describe: ____

____

On a scale from 1-10 with 10 being the highest, what is your level of commitment to correcting the problem? ___________________

Whom may we thank for referring you? ____

Race (Circle only 1):	American Indian	Native Hawaiian	Hispanic
	Asian	Alaska Native	Other
	African American	Caucasian	Decline to State

Preferred Language: ____

Smoking Status (Circle only 1):	Current Smoker	Smoking Start Date: ______________________
	Former Smoker	Smoking End Date: ______________________
	Never Smoker	

Do you have any allergies to medication? Yes No

If yes, please indicate the following:

Allergy: ______________________ Allergy: ______________________
Reaction: ______________________ Reaction: ______________________
Start Date: ______________________ Start Date: ______________________
End Date: ______________________ End Date: ______________________

PRESCRIPTION MEDICATIONS:

Medication: ______________________
Route: Oral Intravenous Other: __________
Frequency: ______________________
Began Use: ______________________

Medication: ______________________
Route: Oral Intravenous Other: __________
Frequency: ______________________
Began Use: ______________________

OVER THE COUNTER MEDICATIONS:

Medication: ______________________
Route: Oral Intravenous Other: __________
Frequency: ______________________
Began Use: ______________________

Medication: ______________________
Route: Oral Intravenous Other: __________
Frequency: ______________________
Began Use: ______________________

PLACE X NEXT TO CURRENT CONDITIONS

_____Numbness/Tingling/Pain in Arms/Hands/Fingers
Right Left Both

_____Numbness/Tingling/Pain in Buttocks/Leg/Feet/Toes
Right Left Both

_____Headaches/Migraines	_____Hip Pain R/L	_____Neck Stiffness/Pain	_____Back Stiffness/Pain
_____Fractured Bones	_____Arthritis	_____Frequent Colds/Flu	_____Diabetes
_____Swollen/Painful Joint s	_____Convulsions/Epilepsy	_____Skin Problems	_____Cancer
_____Anemia	_____Tremors	_____Blurred Vision (R/L)	_____Double Vision (R/L)
_____Pain with cough/sneeze	_____Chest Pain	_____Lung Problems	_____Loss of Taste
_____Heart Problems	_____Stroke	_____Gall Bladder Problems	_____Digestive Problems
_____Prostate Problems	_____Kidney Problems	_____Loss of Smell	_____Loss of Balance
_____Dizziness/Vertigo	_____Buzzing/Ringing in ears	_____Sinus Problems/Allergies	_____Nervousness/Anxiety
_____Fatigue	_____Depression	_____Irritability/Mood Swings	_____Tension/Stress
_____Sleeping Problems	_____Cold Hands	_____Upset Stomach	
_____Cold Feet	_____Bed Wetting	_____Recurring Infections	_____Diarrhea/Constipation
_____Foot Problems	_____Shortness of Breath	_____Hot Flashes	_____Jaw/TMJ Problems
_____Cold Sweats	_____Light bothers eyes	_____Problems Urinating	_____Heartburn/Reflux
_____High Blood Pressure	_____PMS	_____Menopause	_____Ulcers

_____Other:____

Current Health Condition:

***PLEASE MARK THE AREAS OF DISCOMFORT ON THE DIAGRAM BEL**

Chief Complaint (why are you here today): ____

____

Date this condition begin? _______________________ Has it ever occurred before? Y/N

Is there anything that makes it worse? ____

Is there anything that makes it better?____

Quality (mark all that apply):

☐ Burning ☐ Diffuse ☐ Dull/ Aching ☐ Localized

☐ Sharp ☐ Shooting ☐ Stabbing ☐ Tingling

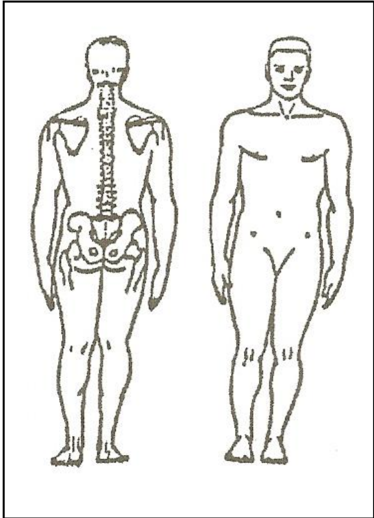
☐ Radiating ☐ Other: __________________________________

Does this pain travel or radiate? Y / N If so, where? _________________________________

Severity: Mild 1 2 3 4 5 6 7 8 9 10 Severe

How often does the pain occur?

☐ Occasional (0-25%) ☐Intermittent (25-50%) ☐ Frequent (50-75%) ☐ Constant (75-100%)



Do you have health insurance? ___________ Name of Company: ____

Method of payment for first visit:

_______ Cash _______ Check _______ Credit Card

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation. I understand that I am responsible for payment of all services rendered.

____ Signature

____________________________ Date

Informed Consent for Chiropractic Care

Chiropractic has only one goal. It is important that each patient understand both the objective and method that will be used to attain this goal. This will prevent confusion or disappointment. Please review the following terms:

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 to the spine.

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

VETEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spine column which causes alteration of nerve function and interferes with the transmission of nerve impulses, resulting in the body's inability to optimally express it's innate given maximum health potential.

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 evaluation, we encounter unusual findings outside of the realm of subluxation, we will refer you to the appropriate professional or specialist for specific diagnosis or treatment of those findings. Regardless of the disease, we do not offer to treat you or offer advice for that condition. Our only objective is to eliminate interference to the nerves of the spine and to allow your body to function as optimally as your given potential allows. Our method is specific adjustments to the spine to correct vertebral subluxation.

Additional treatment modalities may be utilized in conjunction with adjustments in our office for the use of pain management, postural and spinal strengthening or conditioning and increasing range of motion in order to improve function during daily activities of living. These modalities may include ice, electrical muscle stimulation, therapeutic activities and exercises, traction and recommendation for use of nutritional supplementation.

I understand the nature and purpose of chiropractic adjustments and other mentioned treatment modalities. I request and consent to these chiropractic adjustments, therapeutic modalities and other chiropractic related procedures by Dr. Kurt M. Pepperell or other licensed doctors of chiropractic who may be employed or engaged in practice at Pepperell Chiropractic. I have been advised that although the incidence of complications associated with chiropractic care is very low, the rare possible complications that may occur include, but are not limited to, fractures, disc injuries, dislocations, sprains, irritation of a disk condition or other musculoskeletal or neurological injury. One of the rarest complications associated with chiropractic care, occurring at a rate of one instance in one million to one instance per two million cervical spine or neck adjustments may be a vertebral artery injury that could lead to stroke.

I, ____ have read and fully understand the above statements.
(Print Patient Name)

I understand and accept the risks associated with chiropractic care and give my consent to the evaluations and chiropractic care, including spinal adjustments, that I may receive in this office. I therefore give informed consent to begin my chiropractic evaluation and any further care on this basis.

______________________________________ ______________________________

Signature of Patient or Legal Guardian | Date

I authorize Dr. Kurt M Pepperell or any other licensed Doctor of Chiropractic to take x-rays. I do not suspect nor know positively that I am or may be pregnant at this time. I release Dr. Kurt M. Pepperell and other doctors in this office from any and all liability from complications from the diagnostic or treatment procedures utilized in the office.

______________________________________ ______________________________

Signature of Patient or Legal Guardian | Date

______________________________________ ______________________________

Witness Signature (Office Staff) | Date

Kurt M. Pepperell, D.C.

3530 W. Willow Knolls Rd.
Peoria, IL 61614
309-839-8358

PRIVACY POLICY INFORMATION

This document describes how Chiropractic and medical information about you may be used and disclosed, and how you can get access to this information. Please read it carefully.

In the course of your care as a patient at Pepperell Chiropractic, we may use and disclose personal and health related information about you in the following ways:

-personal health information including your clinical records may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnostic assessment or treatment

-health and billing records may be disclosed to another party such as an insurance carrier or your employer if they are responsible for payment of your services

-personal information, health records and billing records may be disclosed to an outside collection agency if needed in an effort to collect payment on overdue unpaid accounts with an outstanding balance

Your name, address, phone number and your health care records may be used to contact you regarding appointment reminders or other health related information that may be of interest to you. If you do not answer your phone to receive an appointment reminder, a message may be left on your answering machine or person taking a message in your absence. You have the right to inspect or obtain a copy of the information that we will use for these purposes. You have the right to refuse to provide us with authorization to contact you regarding these matters. Refusal to provide authorization will not affect the care provided to you or the reimbursement avenues associated with your care.

If required, statements regarding the outstanding remaining balance of your account may be mailed to the address you provided on your intake paperwork.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

-if we are providing health care services based on orders from another health care provider

-if we provide health care services in an emergency

-if there are substantial barriers to communicating with you, but it is in our professional judgment that we believe you intend for us to provide care

-if we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than outlined above will only be made upon your written authorization.

If you would like additional information regarding our privacy practices, would like to make a complaint regarding our privacy practices or have additional questions, please contact Dr. Kurt Pepperell.

You have the right to inspect and/or have a copy of your health information for seven years from the date that the record was created or as long as the information remains in our files. Requests must be provided to our office in writing,

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ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, HAVE RECEIVED, REVIEWED AND

UNDERSTAND THE PRIVACY POLICIES OF PEPPERELL CHIROPRACTIC.

____
Signature

____
Print Name

____
Date

____
____

(Office use only)

We attempted to obtain written acknowledgement of receipt of our Privacy Policy Information, but acknowledgement could not be obtained because:

○ Individual refused to sign

○ Communication barriers prohibited obtaining the acknowledge

○ An emergency situation prevented us from obtaining acknowledgement

○ Other (Please specify)

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OFFICE POLICY

Payments and Statements

Payment for office visits and x-rays are requested at the time of service. Responsibility for all bills remains with the patient. If you have a financial problem, please ask to speak with the insurance administrator.

Insurance and Medicare

Our office will bill your insurance company for all services. Our insurance administrator will confirm your insurance benefits with your insurance carrier/payer. If we are unable to confirm benefits, you will be asked to pay for services until we can confirm.

If you have MEDICARE, we will send charges to MEDICARE for you. **WE DO NOT ACCEPT MEDICARE ASSIGNMENT.** If you have supplementary insurance, we will be happy to file a claim for you (we need a copy of the MEDICARE Explanation of Benefits in order to do so.)

Credit Policy

Health insurance is designed to help you meet the cost of medical care. However, the responsibility for payment is yours. Your insurance contract defines the extent to which the company will reimburse you. There is no contract between the insurance payer and your doctor. It is your obligation to notify our insurance administrator of any insurance changes.

Collection Fee

You should be aware that your insurance carrier may not pay these medical charges in full. You will have to pay any charges not paid by your insurer within 90 days of our first statement and all our expenses which we may incur in connection with efforts to collect the charges. In the event we must enforce our rights under this Agreement after your failure to pay all charges due within 90 days of our first statement, you must pay all charges to include collection agency fees, which are typically 33% to 50% of the unpaid balance, reporters fees, for depositors and at trial expenses we incur enforcing our rights under this Agreement. Also, in the event that you have not paid all charges due within 90 days of our first statement, a finance charge will begin to accrue at the rate of nine percent (9%) per annum. I also agree to release all necessary information in order for the collection agency to reach me. This authorization will remain in effect until revoked by me in writing.

Please indicate below that you understand it is your responsibility to pay your account. If your insurance does not pay, you are responsible for the amount due.

Signature: ____ Date: __________________________