exodus international CHIROPRACTIC knoxville, TN

10910 Kingston Pike, Suite 101 Knoxville, TN 37934

Personal Information ***For office use only; File #:_____***

Name: Today's Date:

Date of Birth: Age: Social Security #:

Address:

City/State/Zip:

Home #: Work #: Cell #:

Preferred way to be reminded for appointments: ☐ Phone Call ☐ Text Message

Best Time to Call: If Text Message, Cell Phone Carrier:

E-mail Address: Gender: ☐ Male ☐ Female

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name:

Occupation: Employer's Name:

Names and Ages of Children:

How did you hear about our office?

Your Health Profile

	Health Concerns	Rating of Severity	Problem began on?	Was this due to an Injury?
1.		1 2 3 4 5 6 7 8 9 10		
2.		1 2 3 4 5 6 7 8 9 10		
3.		1 2 3 4 5 6 7 8 9 10		
4.		1 2 3 4 5 6 7 8 9 10		

If you are experiencing pain, how would you describe it?
□ Sharp □ Dull Ache □ Constant □ Numb □ Shooting □ Cramping □ Burning □ Stiffness □ Throbbing

Does the pain travel or radiate anywhere? □ No □ Yes If yes, please describe:

Circle each symptom that your health effects: Work Sleep Daily Routine Recreation Family

How would describe the problem since it started? About the same Getting Better Getting Worse

What makes it worse?

What makes it better?

Other Health Professionals seen for this condition: Chiropractor Medical Doctor Other

Name: Date: Diagnosis:

What was done?

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General Health History:

Please circle all symptoms you have had in the past year:

Headaches	Pins and needles in legs	Numbness in fingers	Buzzing in ears
Fainting	Pins and needles in arms	Numbness in toes	Loss of Balance
Neck Pain	Menstrual Irregularity	Urinary Problems	Ringing in Ears
Loss of Smell	Upset Stomach	Sleeping Problems	Tension
Nervousness	Difficulty focusing attention	Cold Sweats	Stiff Neck
Back Pain	Lights bother eyes	Mood Swings	Dry/cracked Skin
Dizziness	Cold Hands	Diarrhea	Hot Flashes
Depression	Menstrual pain	Dry Eyes	Poor Memory
Heartburn	Ulcers	Fever	Irritability
Constipation	Fatigue	Cold feet	

List all medications that you are currently taking and why: (Prescription and non-prescription): _____

_____

Please list all vitamins and supplements that you are currently taking: _____

_____

Have you ever had surgery?

1.Type: _____ Date:_____

2.Type:_____ Date:_____

3.Type:_____ Date:_____

Have you ever had an accident and/or injuries? Yes / No -If yes, please specify auto, work, or other:

1.Type: _____ Date:_____Hospitalized: Yes / No

2.Type:_____ Date:_____Hospitalized: Yes / No

3.Type:_____ Date:_____Hospitalized: Yes / No

On a scale of 0-10, Describe your psychological/emotional stress levels: (0=stress free, 10=full of stress)

Work Related Stress: _____ Personal Related Stress:_____

On a scale of 1-10 (1 being very poor and 10 being excellent), Describe your:

Eating Habits:_____ Exercise Habits: _____ Sleep: _____ General Health:_____

REGARDING XRAYS/IMAGING STUDIES → Please read carefully and check the boxes, then sign below if you understand and have no further questions, otherwise see our receptionist for more explanation.

FEMALES ONLY → □ I am pregnant and will not receive x-rays

□ I am not pregnant and I am able to receive x-rays

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays.

After careful consideration I therefore, do hereby consent to have diagnostic x-rays the doctor has deemed necessary in my case.

Signature: _____ Date:_____

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Insurance Information:

Patient's Name: _____Date of Birth: _____ Social Security #: _____

Insurance Company: _____ Are you responsible for this account? Yes / No

Subscriber's Name: _____Date of Birth: _____Social Security #: _____

Relationship to Patient (if not self):_____

Is patient covered by additional insurance? Yes / No Secondary Insurance Company:_____

Accident Information:

Is the patient's condition due to an accident? Yes / No Date of Injury: _____

Type of accident: □ Auto □Work □Home □Other:_____

At Fault for the accident? □You of your driver □ Other Drive

Do you have medical pay benefits on your auto insurance? Yes / No / Don't Know

Auto Insurance Company: _____ Claim Number:_____

Agent Name:_____ Phone Number:_____

Medicare Advanced Beneficiary Notice: All Medicare patients are responsible for their $147 yearly deductible for chiropractic care. Medicare does not cover exams, but requires them before any adjustments of the spine can be performed. Medicare does not cover x-rays, but they may be necessary for treatment to occur. Medicare provides coverage for chiropractic adjustment when Medicare rules are met. The patient is responsible for any services that are not covered by Medicare or supplemental insurance.

Assignment and Release: I agree to treatment by my doctor and such person's of the doctor's choosing, which may include interns, preceptors, Chiropractic Assistants, etc. And hereby provide my consent for treatment. I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Pete Sulack (Chiropractor) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of their signature on all insurance submissions.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-treatment for unusual findings, we will advise you. If you 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 the disease or health issue is classified, 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 vertebral subluxation.

Signature:_____ Date:_____