TESTER CHIROPRACTIC

Dr. Brandon P. Tester
Doctor of Chiropractic

CONFIDENTIAL PATIENT INFORMATION

First Name	Last Name	Date
SSN	DOB	Sex: ☐ M ☐ F
Marital Status	No. of Children	Occupation
Mailing Address		Height
City, State, ZIP		Weight
Email	Cell Phone	Other Phone
Emergency Contact	Emergency Relation	Emergency Phone

How did you hear about us?

Who is your Primary Care Physician?

Date and reason for your last doctor visit

Are you also receiving care from any other health professional? ☐ Yes ☐ No
If yes, please name them and their specialty

Please note any significant family medical history

YOUR HEALTH GOALS

Your Top 3 Health Goals

1.

2.

3.

What would you like to gain from chiropractic care?
☐ Resolve existing conditions ☐ Overall wellness ☐ Both

Have you ever visited a Chiropractor? ☐ Yes ☐ No
If Yes, what is their name? _____

What is their Specialty? ☐ Pain Relief ☐ Physical Therapy/Rehab ☐ Nutritional ☐ Subluxion based ☐ Other:

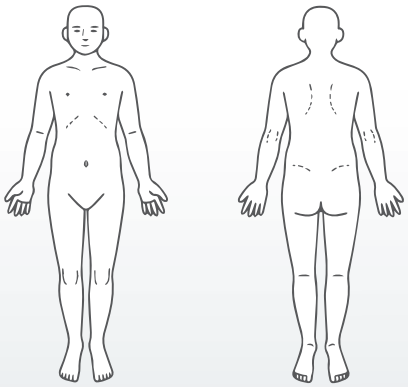
Do you have any health concerns for other family members today?

LOCATION OF PAIN

Where does it hurt?

Circle the areas on the illustration.

Use "O" for current condition
Use "X" for prior condition



PRIMARY COMPLAINT

Primary Complaint:
The primary symptom that prompted me to seek care today is:

And are the result of:
- ☐ An Accident or Injury
  - ☐ Work ☐ Auto
  - ☐ Other _____
- ☐ Worsening Long Term Problem
- ☐ An Interest In
  - ☐ Wellness ☐ Other _____

Onset:
When did you first notice your current symptoms?

Prior Interventions:
What have you done to relieve the symptoms?

- ☐ Prescription Medication
- ☐ Physical Therapy
- ☐ Massage
- ☐ Over the counter drugs
- ☐ Surgery
- ☐ Ice
- ☐ Homeopathic Remedies
- ☐ Accupuncture
- ☐ Heat
- ☐ Other: _____

Intensity
How extreme are your current symtoms?

ABSENT ——— UNCOMFORTABLE ——— AGONIZING

1 2 3 4 5 6 7 8 9 10

Radiation
Does it affect other areas of your body? To what areas does the pain radiate, shoot, or travel?

Duration and Timing
When did it start, and how often do you feel it?

☐ Constant ☐ Comes + Goes How Often? _____

Quality of Symptoms:
What does it feel like?

- ☐ Numbness
- ☐ Aching
- ☐ Burning
- ☐ Tingling
- ☐ Cramps
- ☐ Shooting
- ☐ Stiffness
- ☐ Nagging
- ☐ Throbbing
- ☐ Dull
- ☐ Sharp
- ☐ Stabbing
- ☐ Other: _____

Aggravating/Relieving Factors
What makes it better or worse?

SECONDARY COMPLAINT

Secondary Complaint:
The secondary symptom that prompted me to seek care today is:

And are the result of:
- ☐ An Accident or Injury
  - ☐ Work ☐ Auto
  - ☐ Other _____
- ☐ Worsening Long Term Problem
- ☐ An Interest In
  - ☐ Wellness ☐ Other _____

Onset:
When did you first notice your current symptoms?

Prior Interventions:
What have you done to relieve the symptoms?

- ☐ Prescription Medication
- ☐ Physical Therapy
- ☐ Massage
- ☐ Over the counter drugs
- ☐ Surgery
- ☐ Ice
- ☐ Homeopathic Remedies
- ☐ Accupuncture
- ☐ Heat
- ☐ Other: _____

Intensity
How extreme are your current symtoms?

ABSENT ——— UNCOMFORTABLE ——— AGONIZING

1 2 3 4 5 6 7 8 9 10

Radiation
Does it affect other areas of your body? To what areas does the pain radiate, shoot, or travel?

Duration and Timing
When did it start, and how often do you feel it?

☐ Constant ☐ Comes + Goes How Often? _____

Quality of Symptoms:
What does it feel like?

- ☐ Numbness
- ☐ Aching
- ☐ Burning
- ☐ Tingling
- ☐ Cramps
- ☐ Shooting
- ☐ Stiffness
- ☐ Nagging
- ☐ Throbbing
- ☐ Dull
- ☐ Sharp
- ☐ Stabbing
- ☐ Other: _____

Aggravating/Relieving Factors
What makes it better or worse?

ADDITIONAL COMPLAINT

Additional Complaint:
The additional symptom that prompted me to seek care today is:

And are the result of:
- ☐ An Accident or Injury
  - ☐ Work ☐ Auto
  - ☐ Other _____
- ☐ Worsening Long Term Problem
- ☐ An Interest In
  - ☐ Wellness ☐ Other _____

Onset:
When did you first notice your current symptoms?

Prior Interventions:
What have you done to relieve the symptoms?

- ☐ Prescription Medication
- ☐ Physical Therapy
- ☐ Massage
- ☐ Over the counter drugs
- ☐ Surgery
- ☐ Ice
- ☐ Homeopathic Remedies
- ☐ Accupuncture
- ☐ Heat
- ☐ Other: _____

Intensity
How extreme are your current symtoms?

ABSENT ——— UNCOMFORTABLE ——— AGONIZING

1 2 3 4 5 6 7 8 9 10

Radiation
Does it affect other areas of your body? To what areas does the pain radiate, shoot, or travel?

Duration and Timing
When did it start, and how often do you feel it?

☐ Constant ☐ Comes + Goes How Often? _____

Quality of Symptoms:
What does it feel like?

- ☐ Numbness
- ☐ Aching
- ☐ Burning
- ☐ Tingling
- ☐ Cramps
- ☐ Shooting
- ☐ Stiffness
- ☐ Nagging
- ☐ Throbbing
- ☐ Dull
- ☐ Sharp
- ☐ Stabbing
- ☐ Other: _____

Aggravating/Relieving Factors
What makes it better or worse?

276.328.7052 www.testerchiropractic.com testerchiropracticllc@gmail.com 724B Norton Rd. Wise, VA 24293

TRAUMAS: PHYSICAL INJURY HISTORY

Have you ever had any significant falls, surgeries, or other injuries as an adult? ☐ Yes ☐ No
If Yes, please explain:

Notable childhood injuries? ☐ Yes ☐ No If Yes, please explain:

Youth or college sports? ☐ Yes ☐ No If Yes, please explain:

Any auto accidents? ☐ Yes ☐ No If Yes, please explain:

Excercise Frequency: ☐ None ☐ 1-3x per Week ☐ 4-6x per Week ☐ Daily
What types of excercise:

How do you normally sleep? ☐ Back ☐ Side ☐ Stomach
Do you wake up: ☐ Refreshed and ready ☐ Stiff and tired

Do you commute to work? ☐ Yes ☐ No If Yes, how many minutes per day?

List any problems with flexibility (ex. putting on socks and shoes, etc)

How many hours per day do you typically spend sitting at a desk or on a computer, tablet, or phone?

TOXINS: CHEMICAL & ENVIRONMENTAL EXPOSURE

Please rate your CONSUMPTION for each

	NONE		MODERATE		HIGH
	1	2	3	4	5
Alcohol	☐	☐	☐	☐	☐
Water	☐	☐	☐	☐	☐
Sugar	☐	☐	☐	☐	☐
Dairy	☐	☐	☐	☐	☐
Gluten	☐	☐	☐	☐	☐

	NONE		MODERATE		HIGH
	1	2	3	4	5
Processed Foods	☐	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐	☐
Sugary Drinks	☐	☐	☐	☐	☐
Cigarettes	☐	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐	☐

How many hours per day do you typically spend sitting at a desk or on a computer, tablet, or phone?

THOUGHTS: EMOTIONAL STRESS & CHALLENGES

Please rate your STRESS for each

	NONE		MODERATE		HIGH
	1	2	3	4	5
Home	☐	☐	☐	☐	☐
Work	☐	☐	☐	☐	☐
Life	☐	☐	☐	☐	☐

	NONE		MODERATE		HIGH
	1	2	3	4	5
Money	☐	☐	☐	☐	☐
Healthy	☐	☐	☐	☐	☐
Family	☐	☐	☐	☐	☐

Acknowledgement and Consent

Patient Signature _____ Date _____

276.328.7052 www.testerchiropractic.com testerchiropracticllc@gmail.com 724B Norton Rd. Wise, VA 24293

REVIEW OF SYMPTOMS

PLEASE CHECK ALL THAT APPLY

GENERAL

- [ ] Lethargy/Weakness
- [ ] Recurring fever
- [ ] Recent weight loss/gain
- [ ] Diziness
- [ ] Fever
- [ ] Chills
- [ ] Other:

HEENT

- [ ] Headaches
- [ ] Visual changes
- [ ] Sinus problems
- [ ] Nose bleeds
- [ ] Hearing loss
- [ ] Ear pain
- [ ] Ringing in ears
- [ ] Sore throat
- [ ] Hoarseness
- [ ] Swollen glands
- [ ] Bleeding gums
- [ ] Other:

SKIN/HAIR

- [ ] Rashes
- [ ] Itching
- [ ] Lesions
- [ ] Hives
- [ ] Psoriasis
- [ ] Mole changes
- [ ] Changes in skin color
- [ ] Change in hair
- [ ] Nail problems
- [ ] Other:

CARDIO

- [ ] Chest pain
- [ ] Heart attack
- [ ] Shortness of breath
- [ ] Palpitations
- [ ] Swelling of feet/hands
- [ ] High blood pressure
- [ ] High cholesterol
- [ ] Heart murmur
- [ ] Blood clots
- [ ] Pacemaker
- [ ] Mitral valve prolapse
- [ ] Other:

RESPIRATORY

- [ ] Chronic/frequent cough
- [ ] Spitting up blood
- [ ] Asthma or wheezing
- [ ] Shortness of breath
- [ ] Excercise intolerance
- [ ] Sleep apnea
- [ ] Emphysema
- [ ] Other:

GASTROINTESTINAL

- [ ] Loss of appetite
- [ ] Nausea or vomiting
- [ ] Diarrhea
- [ ] Constipation
- [ ] Abdominal pain
- [ ] Stomach ulcer
- [ ] Bloating/Cramping
- [ ] Heartburn
- [ ] Rectal bleeding
- [ ] Hemorrhoids
- [ ] Hepatitis
- [ ] Cirrhosis
- [ ] Other:

NEUROLOGICAL

- [ ] Frequent headaches
- [ ] Migraines
- [ ] Dizziness
- [ ] Fainting
- [ ] Memory loss
- [ ] Poor balance
- [ ] Numbness or tingling
- [ ] Pins and needles
- [ ] Limb weakness
- [ ] Seizures
- [ ] Stroke
- [ ] Tremors
- [ ] Head injury
- [ ] Other:

MUSCULOSKELETAL

- [ ] Arthritis
- [ ] Muscle pain
- [ ] Muscle cramps
- [ ] Muscle stiffness
- [ ] Joint pain or swelling
- [ ] Neck pain
- [ ] Back pain
- [ ] Trauma
- [ ] Other:

276.328.7052 www.testerchiropractic.com testerchiropracticllc@gmail.com 724B Norton Rd. Wise, VA 24293

REVIEW OF SYMPTOMS

PLEASE CHECK ALL THAT APPLY

BLOOD / LYMPH

- [ ] Anemia
- [ ] Bleeding
- [ ] Bruising
- [ ] Blood clots
- [ ] Past transfusions
- [ ] Leukemia
- [ ] Lymphoma
- [ ] HIV/AIDS
- [ ] Sickle cell
- [ ] Other:

ALLERGIES

- [ ] Seasonal
- [ ] Medication
- [ ] Food
- [ ] Other:

PSYCHIATRIC

- [ ] Alzheimer's Disease
- [ ] Insomnia
- [ ] Difficulty concentrating
- [ ] Memory loss/confusion
- [ ] Depression
- [ ] Anxiety
- [ ] Agitation/Irritability
- [ ] Suicidal thoughts
- [ ] Chemical dependency
- [ ] Other:

ENDOCRINE

- [ ] Diabetes
- [ ] Thyroid disease
- [ ] Sweating
- [ ] Heat Intolerant
- [ ] Cold Intolerant
- [ ] Weight loss
- [ ] Weight gain
- [ ] Frequent urination
- [ ] Excessive thirst
- [ ] Change in appetite
- [ ] Hair changes
- [ ] Other:

URINARY

- [ ] Frequent urination
- [ ] Burning/painful urination
- [ ] Incontinence
- [ ] Hesitancy
- [ ] Urgency
- [ ] Blood in urine
- [ ] Other:

FEMALE

- [ ] Painful sex
- [ ] Vaginal discharge
- [ ] Breast pain or lumps
- [ ] Hot flashes
- [ ] Menstrual irregularity
- [ ] Loss of libido
- [ ] Menopause
- [ ] Sexually transmitted disease
- [ ] Other:

MALE

- [ ] Dribbling
- [ ] Loss of libido
- [ ] Erectile dysfunction
- [ ] Sexually transmitted disease
- [ ] Testicular pain or lumps
- [ ] Prostate disease
- [ ] Penile discharge
- [ ] Other:

276.328.7052 www.testerchiropractic.com testerchiropracticllc@gmail.com 724B Norton Rd. Wise, VA 24293

Dr. Brandon P. Tester
Doctor of Chiropractic

FINANCIAL POLICY SUMMARY

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan
- If you are covered by a State or Federal program with a mandated fee schedule.
- Patients who are uninsured, or underinsured (limited benefits for chiropractic care), will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our team for more information.
- Patients who meet state and/or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount as determined by the clinic. Verification will be required.

As part of our compliance plan, as of December 1st, 2018 our office will be unable to extend any type of discounts other than those listed above.

PATIENT HIPPA CONSENT FORM

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days of the request. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights of privacy regarding my protected health information. I understand that this information can and will be used to: conduct, directly and indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how your personal information is used and disclosed.

AUTHORIZATION FOR CARE

i hereby authorize doctors and staff at Tester Chiropractic to treat my condition as deemed appropriate. At Tester Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff memeber of Tester Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as other types of health care, is associated with potential reisks in the delivery of treatment. While Chiropractic treatment is remarkably safe, you need to be iformated about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as weith any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

By signing below you agree to the Patient Financial Responsibility Policy and give your consent to all of the above information.

Patient Signature _____ Date _____