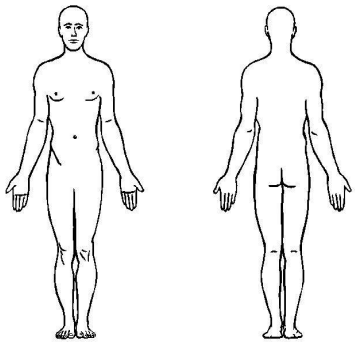
Signature_____Patient Name_____Date_____

Have you performed your daily exercises? Yes/ No New Injury? Yes/ No Explain:_____

Overall, has your problem gotten: Much Worse Little Worse Same Little Better Much Better

Tell us how you feel:_____

Patient Reports Difficulty In: Standing Sitting Walking Sleeping Lifting Bending_____(other)

Patient Reporting:	**Rate:**	**Pain Radiates To:**	**Associated Symptoms:**
Headache	/10	Shoulder **L R Both**	**Tell us about your pain**
Neck Pain/ Stiffness	/10	Arm/ Elbow **L R Both**	**Circle:** Sharp, Burning, Dull, Tingling, Throbbing, Cramps, Numbness, Stiffness, Aching, Swelling, Shooting
Upper back pain/ Stiffness	/10	Wrist/ Hand **L R Both**	
Mid-Back Pain/ Stiffness	/10	Chest/ Ribs **L R Both**	
Low Back Pain/ Stiffness	/10	Hip/ Gluteal **L R Both**	
TMJ/ Clicking	/10	Leg/ Knee **L R Both**	
Other		Ankle/ Foot **L R Both**	

Rehabilitation to:

- Cupping
- Acupuncture
- Manual Therapy
- Howat Sweep L-R
- Tens
- PP/IST
- Cryo/MH
- Ther Ex

Additional Notes from doctor: _____

_____

_____

_____

Doctor Signature

Objective	**Restricted ROM**	**Muscle Spasm/ Dysf.**	Vertebral Tenderness/Fixation	Misc./ Ortho Test
Physical Therapy	_____	Mild Mod Severe	L/R _____	
Active Rehab time:	Cervical Spine	Mild Mod Severe	Occ C1 2 3 4 5 6 7	
Clinical assessment & Care	Thoracic Spine	Mild Mod Severe	T1 2 3 4 5 6 7 8 9 10 11 12	
	Lumbar Spine	Mild Mod Severe	L1 2 3 4 5	
	Pelvic Region	Mild Mod Severe	LSac Rsac L Ilium R Ilium	

Assessment & Plan

Same

Chiropractic care (98940 98941 98942 98943) Wellness/ Maint.

Necessity: Medically Necessary Treatment Was Provided

Patient is Progressing: As Expected Slow, limited by: _____

Improvement Minimal None Moderate Poor

Prognosis/Potential None Minimal Moderate Marked Worsened

Treatment Tolerated: Exellent Good Fair Poor None

Relief Therapeutic(Sub Acute) Supportive Rehab Palliative Wellness

Frequency of Duration 4 3 2 1 xWeek Week/Month (Other:)

_____ _____

Patient Information

Date:_____Name:_____
Full Address:
_____
_____

Home Phone:_____
Cell Phone: _____
Email:_____
Sex: **M F** Age: _____ DOB: _____
Employer: _____
Hours/Week Worked: _____

Is condition due to an accident? **Yes No**

Auto Work Home

IN CASE OF EMERGENCY
Name:_____Relation:_____
Phone#:_____

Primary Physician: _____

How did you hear about us?_____

Insurance Information

Health Insurance (primary)
Insurance Company:_____
Policy Holders Name:_____
Policy Holders DOB_____
Relation to PT: _____
Policy# _____Group: _____

Health Insurance (Secondary)
Insurance Company_____
Policy Holder_____
Relation to PH_____
Policy# _____
Group:_____

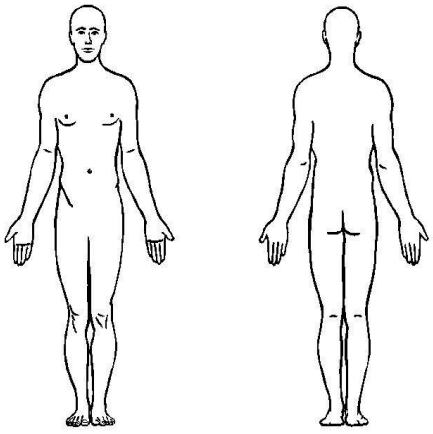
Complete the following if injury is related to an auto accident.

Motor Vehicle Insurance (Your PIP Info)
Owner of vehicle in which you were injured:
_____
Insurance Company: _____
Phone: _____
Policy#: _____
Claim#: _____
Have you retained an attorney? **Yes No**
Name: _____Phone: _____

Current Complaints

What are your present complaints? (location of pain)

_____



Use an "X" on the drawing to mark where you are experiencing pain.

When did these symptoms first appear? _____

Do your symptoms interfere with: (circle)

Sleep Daily Routine Work Recreation

Are you working less hours/days as a result of your injuries?(circle)

Yes No

If yes, explain _____

Activities or movements are painful: (circle)

Sitting Standing Walking Bending Lying Down

How would you rate your symptoms?(circle) **Mild Moderate Severe**

How would you rate your current symptoms: (Circle) **1 2 3 4 5 6 7 8 9 10**

Since incident, if applicable, are your symptoms: **Improving Unchanged Worsening**

HOSPITALIZATION/ EXAMINATION HISTORY

Have you been to the hospital for this condition? **Yes No** If yes, name of hospital _____

When did you go?_____ How did you get there? **Ambulance Self Others**

Were x-rays taken**? Yes No** If yes, what areas? _____

Were you prescribed any medications? **Yes No** If yes, What medications? _____

Have you seen any other doctor or received any other treatment for your condition? **Yes No**

If yes, explain _____

Doctors name: _____ Phone: _____

Date last seen:_____ Diagnosis: _____

HEALTH/ HISTORY/ INJURIES/ TREATMENT

Injuries you may have had in the past Date

Auto Accidents _____ _____

Work Injuries _____ _____

Broken Bones _____ _____

Other _____ _____

Have you ever been diagnosed as having or suffering from: ***Please Circle***

Muscle Disorder	**Lungs, Asthma**	**Osteoarthritis**	**Nervous system**	**GI Trouble**
Broken Bones	**Epilepsy**	**Bone Disorder**	**Eating Disorder**	**Kidney/Bladder**
Alcoholism **RA**	**Pace Maker**	**Drug Addiction**	**Poor Circulation**	**Tumors**
Allergies	**Seizures**	**Stroke**	**Depression**	**Ears/Eyes/Nose/Throat**
Gallbladder	**Excessive Bleeding**	**Cancer**	**Ulcer**	**Coughing Blood**
Congenital Disease	**Diabetes**	**High/Low Blood Pressure**	**HIV**	**Hernias**

Surgeries you may have had for *this* condition: _____

Nonsurgical treatments you may have received for *this* condition: ***Please Circle***

Medication **Injections** **Physical Therapy** **Massage** **Chiropractic**

Acupuncture **Other** _____

Female Clients: Start date of most recent menstrual cycle: _____ Are you Pregnant? **Yes No**

Financial Arrangement Policy

The established financial policy of this office is that payment in full is due at time of service. We accept payment in the form of cash, check, money order, Debit, and debit card. Please read the following explanation of our financial arrangements policy and select the one that would be easiest and most appropriate for you.

Patients without insurance

If you do not have insurance, we request you pay in full at the time of service. We will charge $50 if you do not call within 24 hours of your scheduled appointment. If an acupuncture package is purchased, (five acupuncture sessions for the price of four) it is non-refundable.

Patients with insurance

If you have qualifying insurance, we will prepare and file your insurance claims for you. Patients who carry health insurance should remember that professional services are rendered and charged to the patient and not the insurance companies. You are responsible for all charges regardless of whether or not they are covered by insurance. We will wait up to Ninety days for insurers to pay their portion of the claim. Under this arrangement you are responsible for paying a co-pay and/or any non-covered portions and any deductible that you may have to satisfy at the time the services are rendered. If statements are not fully paid within ninety days after their dates, you are responsible to pay Dr. Chamein Clark-Witter any and all reasonable costs incurred. You are required to present a valid Insurance card for us to make a photocopy of along with a valid photo ID for us to bill your insurance.

Our practice is dedicated to providing chiropractic, and health care to as many patients as possible. Our charges are well within the range considered "usual and customary" by most insurance carriers; however, some insurance companies have arbitrarily determined their own "schedule of payment," which may be more or less than our regular fees. Please note that some services may be considered as non-covered under some policy limitations

We charge $50 if you do not call within 24 hours of your scheduled appointment. For no show appointments, the charge will go directly to you, not your insurance. If your check is returned, you will be charged a $30 return check fee.

Please check one of the following payment plans

With Insurance

- ○ 1. I prefer to pay on each visit and bill my insurance carrier myself.
- ○ 2. I prefer to have you bill my insurance company and I will pay my co-pay on each visit.

Without Insurance

- ○ 1. I prefer to pay the office in full on each visit.
- ○ 2. I prefer to pay an upfront annual fee of $2000 for one full year of adjustments only.

I have read, understand, and agree to the above financial arrangement.

Patient's Signature_____ Date_____

Consent To Treatment

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

I. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment.

II. There have been very rare reported cases of disc injuries following cervical and lumbar spinal adjustments although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation and treatment.

III. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility or such injuries resulting from cervical spine manipulation is extremely rare.

Osseous and soft tissue manipulation have been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches, and/or other related symptoms. Musculoskeletal care contributes to your overall wellbeing. *The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.*

I acknowledge I have discussed the following with my healthcare prover:

The condition that the treatment is to address

The nature of the treatment

The risks and benefits of the treatment

Any/All alternatives to that treatment

I have had the opportunity to ask and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with Dr. Chamein Clark-Witter DC FIAMA DIPL.A.C.

Signature _____ **Date** _____

Time of Service Price List

Prices as of June 1 2023

Adjustment only	$50
Pediatric Adjustment (up to age 5)	$40
Acupuncture only	$55
Auricular Acupuncture	$55
Children's Acupressure	$25
Acupuncture and Adjustment together	$90
New Patient Consultation	$75
New Patient Consultation without treatment	$100
Taping	$20
Cupping	$25
Sports/School Physicals	$50
Acupuncture Package	$225
Annual Adjustment Package	$2000

Initial_____