

**BOWMAN CHIROPRACTIC and REHABILITATION
107 SHILOH DR. SUITE B
MT. VERNON, IL 62864
(618) 242 - 2440**

**BOWMAN CHIROPRACTIC, P.C.
202 S. BROADWAY
SALEM, IL 62881
(618) 548 - 5252**

SIGNATURE ON FILE STATEMENT

The above provider is allowed to enter "Signature on file" (on line 12 of the HCFA-1500 form). This shall be acceptable in lieu of the beneficiary's or a representative's signature authorizing the release of medical record information necessary to process the claim.

This disclosure and assignment authorization is for the beneficiary's lifetime, or until such time as the beneficiary or beneficiary's representative has renounced this allowance by written document.

**BENEFICIARY'S
Or REPRESENTATIVE'S
SIGNATURE:**

Signature

Date

TO THE **NEW PATIENT**

OUTLINE OF PROCEDURES FOR CARE.

STEP ONE: All new patients are requested to fill out this personal health history questionnaire.

STEP TWO: A consultation with the doctor to discuss your health problems and to determine the precise cause of your problem.

STEP THREE: A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem.

STEP FOUR: The doctor will advise you if additional laboratory tests or other tests including x-rays if needed.

STEP FIVE: You will be given a Report of Findings at which time the cause of your problem will be discussed. You will be given a thorough explanation of how chiropractic works and how results can be obtained. You will also be advised concerning how our office procedures work.

STEP SIX: If you are accepted as a patient, chiropractic care will begin. The type of care you need will be explained to you. Also, additional explanations will be given on the different types of care available in our office.

STEP SEVEN: An estimate of the future care that is needed will be given and upon your acceptance, adjustments will begin and continue until a maximum correction for you have been obtained.

STEP EIGHT: After maximum correction, a schedule of care will be recommended to help prevent future problems and maintain good health
Confidential Patient Health Record

Personal History

Name _____ Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Birth Date _____ Age: _____ Sex M _____ F _____

Social Security # _____

Drivers License # _____

Employer: _____

Type of Work _____

Employer Phone # _____ Cell Phone # _____

Spouse's Social Security # _____

Spouse's Name _____

Spouse's Employer _____ Business Phone _____

Type of Work _____

Name and Ages of Children _____

Referred to this office by: _____

Name and Number of Emergency Contact _____

Relationship _____

Who is responsible for your Bill, You and Spouse _____

Workers Comp. _____ Auto Ins. _____ Medicare _____

Personal Health Ins. (Name) _____

Health Card # _____

Current Health Condition

Purpose of this Appointment

Other Doctors seen for this condition Yes _____ No _____

Who? _____

Type of Treatment: _____

Results: _____

When did this condition begin? _____

Has this condition occurred before? Yes _____ No _____

Is Condition Job Related _____ Auto Accident _____ Home Injury _____

Fall _____ Other _____

Date of Accident _____ Time of Accident _____

Have you made a report of your accident to your Employer? Yes _____ No _____

Drugs you now take: Nerve Pills _____ Pain Killers/Muscle Relaxers _____ Blood Pressure Meds _____

Insulin _____ Other _____

Do you wear a shoe lift? Yes _____ No _____ Do you suffer from any condition other than that

Which you are now consulting with Us? _____

Past Health History

Please check and describe:

Major Surgery/Operations: Appendectomy _____ Tonsillectomy _____ Gall Bladder _____

Hernia _____ Back Surgery _____ Broken Bones _____ Other _____

Major accidents or falls: _____

Hospitalization (Other than the above): _____

Previous Chiropractic Care: None _____

Doctor's name & approximate date of last visit _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Please Check Any of The Following Diseases You Have Had:

_____ Pneumonia _____ Mumps _____ Influenza _____ Rheumatic Fever _____ Small Pox

_____ Pleurisy _____ Polio _____ Chicken Pox _____ Arthritis _____ Tuberculosis

_____ Diabetes _____ Epilepsy _____ Cancer _____ Whooping Cough _____ Anemia

_____ Measles _____ Thyroid _____ Eczema _____ Heart Disease _____ Mental Disorder

Have you been tested HIV positive Yes _____ No _____

Please Check Any of The Following You Have Had The Past 6 Months:

Musculo-Skeletal Code

_____ Low Back Pain _____ Pain Between Shoulders _____ Neck Pain _____ Arm Pain _____ Walking Problem

_____ Joint Pain/Stiffness _____ Difficult Chewing/Clicking Jaw _____ General Stiffness

Nervous System Code

_____ Nervous _____ Numbness _____ Paralysis _____ Dizziness _____ Forgetfulness

_____ Confusion/Depression _____ Fainting _____ Convulsions _____ Cold/Tingling Extremities

_____ Stress

General Code

_____ Fatigue _____ Allergies _____ Loss of Sleep _____ Fever _____ Headaches

Gastro-Intestinal Code

Poor/Excessive Appetite Excessive Thirst Frequent Nausea Vomiting
 Diarrhea Constipation Hemorrhoids Liver Problems Weight Trouble
 Gall Bladder Problems Abdominal Cramps Gas/Bloating After Meals Colitis
 Heartburn Black/Bloody Stool

Genito-Urinary Code

Bladder Trouble Painful/Excessive Urination Discolored Urine

C-V-R Code

Chest Pain Short Breath Blood Pressure Problems Irregular Heartbeat
 Heart Problems Lung Problems/Congestion Varicose Veins Ankle Swelling
 Stroke

EENT Code

Vision Problems Dental Problems Sore Throat Ear Aches Stuffed Nose
 Hearing Difficulty

Male/Female Code

Menstrual Irregularity Menstrual Cramps Vaginal Pain/Infection
 Breast Pain/Lumps
 Other Problems

Females Only

When was your Last Period? _____

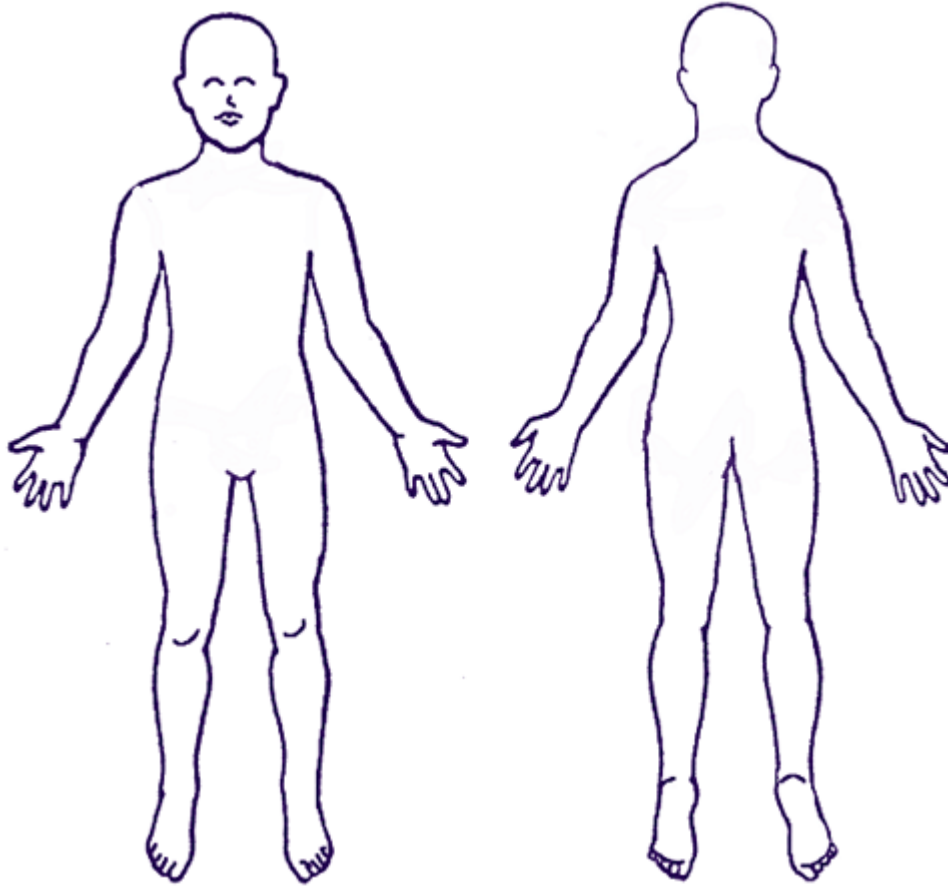
Are you Pregnant? Yes No Not Sure

Family History

The following members have a same or similar problem as I do:

Mother Father Brother Sister Spouse Child

Please outline on the diagram the area of your discomfort.



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0000
XXXX
++++

**SHARP
STABBING
DULL
BURNING**

PLEASE DO NOT WRITE BELOW THIS LINE

Chiropractic Analysis:

Diagnosis:

Patient Accepted: ___ Yes ___ No ___ Referred

Doctor's Signature:
