Welcome to Peak Performance Chiropractic Clinic

Cody Hopson, D.C.

First Name_____ MI ____ Last Name_____ Date ____/____/_____

Address_____ City _____State _____ Zip _____

Birth Date____/____/_____ Age____ Male ____ Female_____ Single Married Widowed Separated Divorced

# of Children _____ Social Sec. No. _____-_____-_____ Email Address:_____

Home #: (_____) _____ Cell #: (_____) _____Work# (____) _____

Place of Employment: _____Occupation: _____

Spouse (Parent if under 18):_____

Who may we thank for referring you to our office?_____

Have you ever been to a chiropractor before? Yes / No If yes, Name of Chiropractor: _____

Insurance Provider: _____ **Member ID #**:_____

Insured Member Name & DOB:_____ **Group #**:_____

Peak Performance Chiropractic will make every effort to verify your Chiropractic insurance benefits and explain them to you within the first two visits. However, as your insurance policy is a contract between you and your insurer, we strongly advise you to call and personally confirm your benefits.

Mark "X" for Present Conditions or "PA" for Past Conditions (3 months or longer). Please "Circle" if necessary to be more specific.

__Headaches/Migraines	__Hip Pain R/L	__ Neck Stiffness/Pain	__ Back Stiffness/Pain
__Fractured Bones	__ Arthritis	__ Frequent Colds/Flu	__Diabetes
__Swollen Painful Joints	__Convulsion/Epilepsy	__ Skin Problems	__ Cancer
__Anemia	__Tremors	__Blurred Vision R/L	__Double Vision R/L
__Pain w Cough/Sneeze	__Chest Pain	__Lung Problems	__Loss of Taste
__Heart Problems	__Stroke	__Gallbladder Problems	__Digestive Problems
__Prostate Problems	__Kidney Trouble	__Loss of Smell	__Loss of Balance
__Dizziness/Vertigo	__Buzzing/Ringing in Ear	__Sinus Problems	__Nervousness/Anxiety
__Fatigue	__Depression	__Allergies	__Tension/Stress
__Colon Trouble	__Sleeping Trouble	__Irritability/Mood Swing	__Stomach Upset
__Cold Feet	__Bed Wetting	__Cold Hands	__Diarrhea/Constip/Gas
__Foot Problems	__Shortness of Breath	__Recurring Infection	__Jaw/TMJ Problems
__Cold Sweats	__Light Bothers Eyes	__Hot Flashes	__Heartburn/Reflux
__High Blood Pressure	__PMS	__Problems Urinating	__Ulcers
__Other	__Cancer (Type)_____	__Menopause	

__Numbness, Tingling/Pain in (Arms/Hands/Fingers) R/L/ Both

__ Numbness/Tingling, Pain in (Buttocks/Thighs/Legs/ Toes) R/L

Additional Information: _____

DAILY ACTIVITIES DISCOMFORT: Effects of Current Condition on Performance

Walking	□ No Pain	□ Little Pain	□ Pain	□ Almost Unbearable	□ Unbearable
Sitting	□ No Pain	□ Little Pain	□ Pain	□ Almost Unbearable	□ Unbearable
Bending	□ No Pain	□ Little Pain	□ Pain	□ Almost Unbearable	□ Unbearable
Standing	□ No Pain	□ Little Pain	□ Pain	□ Almost Unbearable	□ Unbearable
Sleeping	□ No Pain	□ Little Pain	□ Pain	□ Almost Unbearable	□ Unbearable
Lifting	□ No Pain	□ Little Pain	□ Pain	□ Almost Unbearable	□ Unbearable
Running/Jogging	□ No Pain	□ Little Pain	□ Pain	□ Almost Unbearable	□ Unbearable
Climbing Stairs	□ No Pain	□ Little Pain	□ Pain	□ Almost Unbearable	□ Unbearable

CASE HISTORY

Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	**Severity**	**Frequency (% of week)**
	Minimal Severe	Occasional Constant
_____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
_____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
_____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
_____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

Please circle/mark the areas on the figures where you experience pain.

2. Symptoms are worse in the (circle what applies):

- morning - increase during the day
- afternoon - same all day
-night - decrease during the day

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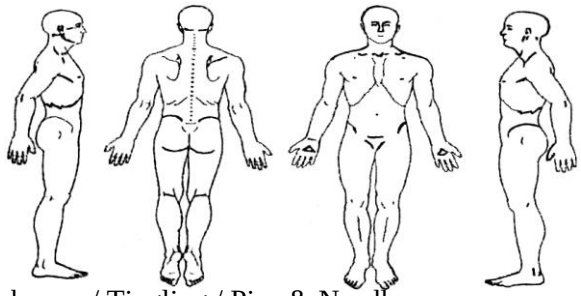

3. Symptom (a) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
   Symptom (b) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. When did your symptoms begin (onset date)? _____
5. How did your symptoms begin? _____
6. Have you experienced these symptoms before? _____
7. Do your symptoms raditate?_____
8. Has your condition…? Improved___ Gotten Worse ___ Stayed the same since its onset ___
9. Circle the things that make your problems worse:
   Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting
10. Is there anything you can do to relieve the problems? No ___ Yes ___ Describe: _____
    If No, what have you tried that has not helped? _____
11. Have you been treated for this before? No ___ Yes ___ How long ago? _____
12. What treatment did you receive? _____
13. Results of previous treatment? Good ___ Poor ___ Comments _____
14. Is this condition interfering with Work ___ Sleep ___ Daily Routine ___ Recreation ___
15. Approximate date of last Chiropractic treatment? _____
16. Approximate date of last MD / DO treatment? _____
17. List any other major injuries you have had, other that those that might have been mentioned above: _____

_____

18. Any other musculoskeletal problems? No ____ Yes ___ 19. Neurological Problems? No ____ Yes _____

I certify that the above information is accurate to the best of my knowledge.

Patient / Guardian Signature _____ Date: _____

Patient Signature _____ Date: _____

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Health & Social History

Tobacco Use -

__ Never Smoked
__ Former Smoker
__ Current Every Day Smoker
__ Current Some Day Smoker
__ Smoker, Current Status Unknown
__ Unknown if Ever Smoker
__ Light Smoker
__ Heavy Smoker

__ 1-5
__ 6-10
__ ½ a pack /day
__ 1 pack / day
__ 1 ½ pack /day
__ 2 packs /day
__ 3 packs /day

__Chews Plug Tobacco
__Chews Twist Tobacco
__ User of moist powered
__ Ex-user of moist powered
__Never used moist powered
__ Do not use moist powered tobacco products
__ Chews Fine Tobacco

__Chews Tobacco
__ Snuff User
__ Intolerant non-smoker
__Never chewed tobacco
__ Tolerant ex-smoker
__ Tolerant non-smoker
__Chews Loose Leaf Tobacco

Smoking Start Date: _____ Smoking End Date: _____

Alcohol Consumption:

__ No __ Yes: __ Daily __ Weekly __ Less __ Former/Quit

Type: __ Beer __ Wine __ Liquor __ Other: _____

Exercise Activity:

__ None __Sedentary __ Light __ Moderate __Vigorous Active Days/Week: _____

Sleep Pattern:

___ Sleep all night ___ Trouble falling asleep ___ Fall asleep but wake during night/cannot return to sleep

___ Change in sleep only due to recent pain ___ No change in sleep pattern

Vitamins/Supplements:

___ No ___ Yes

List:_____

_____

Caffeine Use:

___ No ___ Yes: __ Daily __ Weekly __ Less __Former/Quit

Type: ___Chocolate ___ Soda ___ Coffee ___ Tablets ___ Tea __Other:_____

Who is your Family doctor /Location? _____

Are you currently under the care of any other physician? Y / N Dr. _____ Date of Exam _____

Have you been treated by a physician for any other health condition in the past year? Y / N Reason? _____

What medications are you currently taking (prescription and OTC)? For what conditions? _____

_____

_____

Are you allergic to anything? If so what? _____

Patient/Guardian Signature_____ Date_____

Patient Name _____ Date_____

Peak Performance Chiropractic Clinic

Cody Hopson, D.C.
2901 Judson Road
Longview, TX 75605

Terms of Acceptance

Financial Policy

1) We accept cash, check, and credit cards/debit cards (Visa, Mastercard, American Express) payments at this time.
2) All payments are due at this time of service unless special arrangements have been agreed upon prior to your visit.
3) If you have Medicare, after your deductible is met, your co-pay and any non-covered services will due at the time of service.
4) As a courtesy to our patients, we offer electronic claims submission. Please notify the staff if you wish to utilize this service.

Workers Compensation

5) All workers compensation cases are treated same as cash.

Personal Injury /Motor Vehicle Accidents

6) Personal injury and auto accidents cases are treated same as cash. We will provide you with the necessary documentation to file with your insurance company to facilitate your reimbursement.

We invite you to discuss with us any questions regarding our services. The best health services are based upon a friendly, mutual understanding between provider and patient. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process this insurance claim. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

I have read, understand, and agree with the above financial policy.

_____ _____

Signature of Insured/Guardian Date

_____

Printed Patient Name

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Legal Assignment of Benefits; Release of Medical & Plan Documents & Verification of Insurance

In considering the amount of medical expense to be incurred, I, the undersigned, have insurance and/or employee health benefits coverage with the above captioned, and hereby assign and convey directly to Cody Raymond Hopson, D.C., all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and client. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies, and/or employee health care plan, and claim, chose in action, or other right I may have to such insurance and/or employee health care benefit coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim chose in action or right against my insurers and/or employee health care plan, including if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured/Guardian Date

_____

Printed Patient Name