WELCOME TO OUR OFFICE

First Name: | Last Name: | Date Of Birth:

Home Phone: | Mobile Phone: | Work Phone:

@E-Mail: | Preferred Communication: (Circle) H M W E@

Street Address: | Apt/Suite #:

City: | ZipCode: | State:

HT:_____ WT:_____

Gender: ♀ Female ♂ Male Other

Preferred Language: ❑ English ❑ Other _____

Race & Ethnicity:

❑ American Indian or Alaska Native ❑ Hispanic or Latino
❑ Asian ❑ Native Hawaiian or Other Pacific Islander
❑ Black or African American ❑ White ❑ Other

Marital Status:

❑ Single ❑ Married ❑ Other
❑ Divorced ❑ Widowed ❑ Separated

Emergency Contact Name: | Phone: | Relationship:

Who Do You Know That Would Benefit From Seeing Dr. Tribble? | ▫Phone:

Employer/Company Name: | Phone:

Street Address: | Apt/Suite #:

City: | ZipCode: | State:

Job Title/Position:

Currently Working: ❑ Yes ❑ No ➪ Date Stopped Working:

Insurance Detail

Primary Insurance Coverage

Insurance Company Name:		Policyholder Name:
Insurance ID #:		Group Number:
Plan Name:	Phone Number:	
Street Address:	Suite/Unit #:	
City:	ZipCode:	State:
(Office Use) Policy Effective Date(s):		Payer ID:
Co-Pay $:	Co-Insurance %:	Deductible:

Secondary Insurance Coverage

Insurance Company Name:		Policyholder Name:
Insurance ID #:		Group Number:
Plan Name:	Phone Number:	
Street Address:	Suite/Unit #:	
City:	ZipCode:	State:
(Office Use) Policy Effective Date(s):		Payer ID:
Co-Pay $:	Co-Insurance %:	Deductible:

Financially Responsible Party

❑ Self ❑ Other (If Other Please Complete Section Below)

First Name:	Last Name:	Date Of Birth:
Home Phone:	Mobile Phone:	Work Phone:
@ E-Mail:	Relationship With Patient:	
Street Address:	Apt/Suite #:	
City:	ZipCode:	State:

Medical Detail

Reason For Your Visit

MM DD YYYY

☐ Wellness & Health Maintenance		
☐ Injury, Pain Complaint, or Ailment	Date Of Injury (When Did Your Pain Start?)	
☐ Accident ☐ Automobile Related Accident ☐ Other Type Of Accident	Date Of Accident: MM/DD/YYYY	State: Where Accident Occurred MM/DD/YYYY
Please Provide Brief Details Of Your Injuries & Pain:		

Referring Provider

☐ I Was Referred By My Primary Care Physician (Same Doctor Listed On First Page)

☐ I Was Referred By Another Doctor (Please Fill Out Doctor Info Below)

Referring Provider Name:		Phone:
Street Address:	Apt/Suite #:	@ E-Mail:
City:	ZipCode:	State:

Primary Care Provider Name

Provider Name:		Phone:
Street Address:	Apt/Suite #:	
City:	ZipCode:	State:

Medical History

Lifestyle

Are You A Smoker? ❑ Yes ❑ No	If Yes ➪ How Often? _____ /Day /Week
Do You Drink Alcohol? ❑ Yes ❑ No	If Yes ➪ How Often? _____ /Day /Week
Do You Exercise? ❑ Yes ❑ No	If Yes ➪ How Often? _____ /Day /Week

Have You Ever Been Hospitalized? ❑ Yes ❑ No	Have You Had Any Surgeries? ❑ Yes ❑ No
If Yes, Please List Dates/Details:	

Do You Have Any Allergies? ❑ Yes ❑ No ➪ Do You Require Medical Treatment For Your Allergies? ❑ Yes ❑ No	
If Yes, Please Provide Details:	

Do You Take Any Medications? ❑ Yes ❑ No
Please List All Medications & Dosage (How Much & How Often?)

Please Provide Any Other Medical Information You Feel The Doctor Needs To Know About

_____ Patient Signature

_____ Date

Review of Systems - (Check box if you have had trouble with any of the following)

Cardiovascular			No	Respiratory			No	Allergic/Immunologic			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack Chest				Cold/Flu				Cortisone Use			
Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								Ear, Nose and Throat			No
Jaw Pain				Eyes			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of leg				Glaucoma				Dizziness			
				Double Vision				Hearing: Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				Psychiatric			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				Gastrointestinal			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine				Bowel Problems			
Neurologic			No		Past	Present		Constipation Liver			
	Past	Present		Thyroid				Problems Ulcers			
Stroke				Diabetes				Diarrhea			
Seizures				Hair Loss				Nausea Vomiting			
Head injury				Menopausal				Stools			
Brain Aneurysm				PMS				Poor Appetite			
Numbness											
Severe Headaches				Hematologic			No				
Pinched Nerves					Past	Present		Musculoskeletal			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficult Sleeping								Low Back Pain			
								Upper Back Pain			

Are your symptoms changing? o Getting Better o Not Changing o Getting Worse

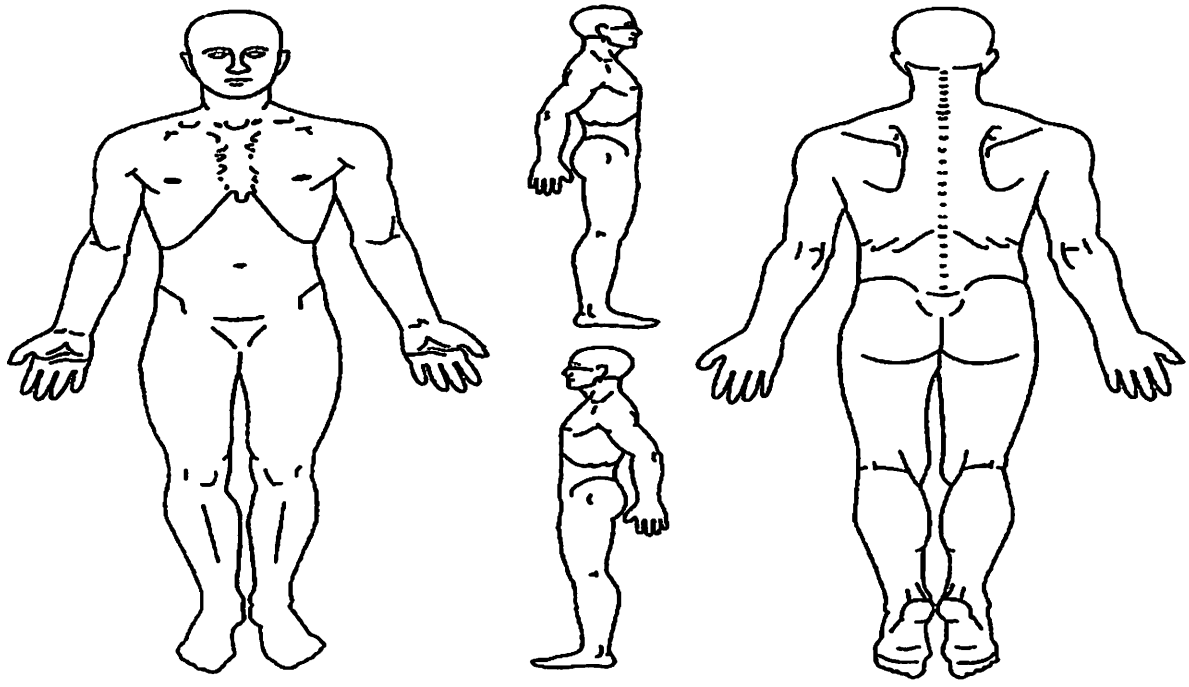
Are you pregnant? o YES o NO

Patient Name_____ Date_____

Pain Chart

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Sharp T=Tingling A=Dull Ache



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain 10
Past week: no pain 0 1 2 3 4 5 6 7 8 9 worst pain

Does anything improve your pain? Yes No If yes, please list:_____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident

Other How did your symptoms begin? _____

How often do you experience your symptoms?

- o **Constantly** (76-100% 0U1e day)
- o **Frequently** (S1-75% ofthe day)
- o **Occasionally** (26-50% of the day)
- o **Intermittently** (0-25% of the day)

What describes the nature of your symptoms?

- o **Sharp**
- o **Ache**
- o **Numb**
- o **Shooting**
- o **Burning**
- o **Tingling**
- o **Throbbing**
- o **Other**___

Patient Name: _____ **Date:**_____

Patrick A. Tribble Chiropractic, Inc.
912 The Alameda
Berkeley, CA 94707

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, Physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy and overcerebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate any risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the Dr. Patrick Tribble and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment

PLEASE SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____

Printed Name of Patient

_____ _____

Signature of Patient Date

_____ _____

Signature of Representative (if patient is minor or handicapped) Date

PATRICK A. TRIBBLE CHIROPRACTIC INC.
912 THE ALAMEDA
BERKELEY, CA 94707

PAYMENT POLICY

Thank you for choosing *Patrick A. Tribble Chiropractic,* Inc. as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have and sign in the space provided below. A copy will be provided to you upon request.

1. CASH: Payment in full is expected at the time of service.
2. INSURANCE: We are a cash office. We will however send a claim to your insurance company including Medicare. Payment is due in full at the time of your visit. Since we are non participating providers we will submit claims on your behalf and request that insurance company send reimbursement directly to you. Knowing your insurance benefits is *YOUR* responsibility, so please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral from your primary physician, it is your responsibility to provide us with a referral prior to your first visit. All patients must complete our patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance.
3. MISSED APPOINTMENT: Please provide our office with 24 hour notice if you need to cancel or reschedule your appointment. This allows us to treat patients in need of immediate care. Failure to do so will result in a *$45.00 missed appointment fee* So please help us to serve you better by keeping your regular scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party Date