NAME _____ DATE_____

WEIGHT _____ HEIGHT _____ AGE_____

PRESENT COMPLAINT _____

WHEN DID THIS PROBLEM START? _____

DID YOU DO ANYTHING THAT BROUGHT THIS PROBLEM ON? _____

_____

HOW DOES THE PROBLEM FOR WHICH YOU ARE SEEING THE DOCTOR TODAY AFFECT YOUR WORK OR DAILY ACTIVITIES? _____

_____

HAVE YOU EVER HAD THIS PROBLEM BEFORE?_____WHEN? _____

HAVE YOU BEEN TO A CHIROPRACTOR BEFORE? _____ WHO? _____

ARE YOU TAKING ANY MEDICATIONS? _____ FOR WHAT CONDITION?

_____

DO YOU SUFFER FROM ANY SERIOUS SYSTEMIC DISEASES? _____

WHAT OPERATIONS HAVE YOU HAD? _____

HAVE YOU HAD ANY BROKEN BONES? ___ NAME THEM _____

HAVE YOU HAD ANY BAD FALLS OR ACCIDENTS? _____

WHEN AND DESCRIBE _____

****

WOMEN ONLY:

I AM NOT KNOWINGLY PREGNANT AT THIS TIME. _____

SIGNED

****

DO NOT WRITE BELOW *DOCTOR' S USE ONLY*

CONFIDENTIAL CASE HISTORY

DATE _____

FULL NAME _____
(first) (middle) (last)

ADDRESS _____
(street) (city/state) (zip)

PHONE NO _____ AGE _____ BIRTHDATE _____

SEX _____ MARITAL STATUS M S W D NUMBER OF CHILDREN _____

SOCIAL SECURITY NO _____ LICENSE NO _____

OCCUPATION EMPLOYER _____

WORK ADDRESS _____ WORK PHONE _____

SPOUSE'S NAME _____ SPOUSE'S BIRTHDATE _____

SPOUSE'S OCCUPATION _____ EMPLOYER _____

WORK ADDRESS _____ WORK PHONE _____

NEAREST RELATIVE NOT LIVING WITH YOU _____ PHONE _____

HOW DID YOU BEAR ABOUT OUR OFFICE? _____YELLOW PAGES _____ NEWSPAPER

_____RADIO _____SPINAL SCREENING _____REFERRAL WHO? _____

****

INSURANCE INFORMATION :

PRIMARY INSURANCE CO _____

INSURED'S NAME _____ SOCIAL SECURITY NO _____

INSURED'S PLACE OF EMPLOYMENT _____

SECONDARY INSURANCE COMPANY _____

INSURED'S NAME _____ SOCIAL SECURITY NO _____

INSURED'S PLACE OF EMPLOYMENT _____

_____

IF RELATED TO AN ACCIDENT, PLEASE ANSWER THE QUESTIONS BELOW:

WERE YOU INJURED ON THE JOB? _____

WERE YOU INVOLVED IN AN AUTOMOBILE ACCIDENT? _____

OTHER _____

_____

SIGNED

I understand and agree that health and accident insurance policies are an arrangement between an Insurance carrier and myself. Furthermore, I understand that TINIUS CHIROPRACTIC CENTER will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to TINIUS CHIROPRACTIC CENTER will be credited to my account on receipt. However, I clearly understand and agree that any services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

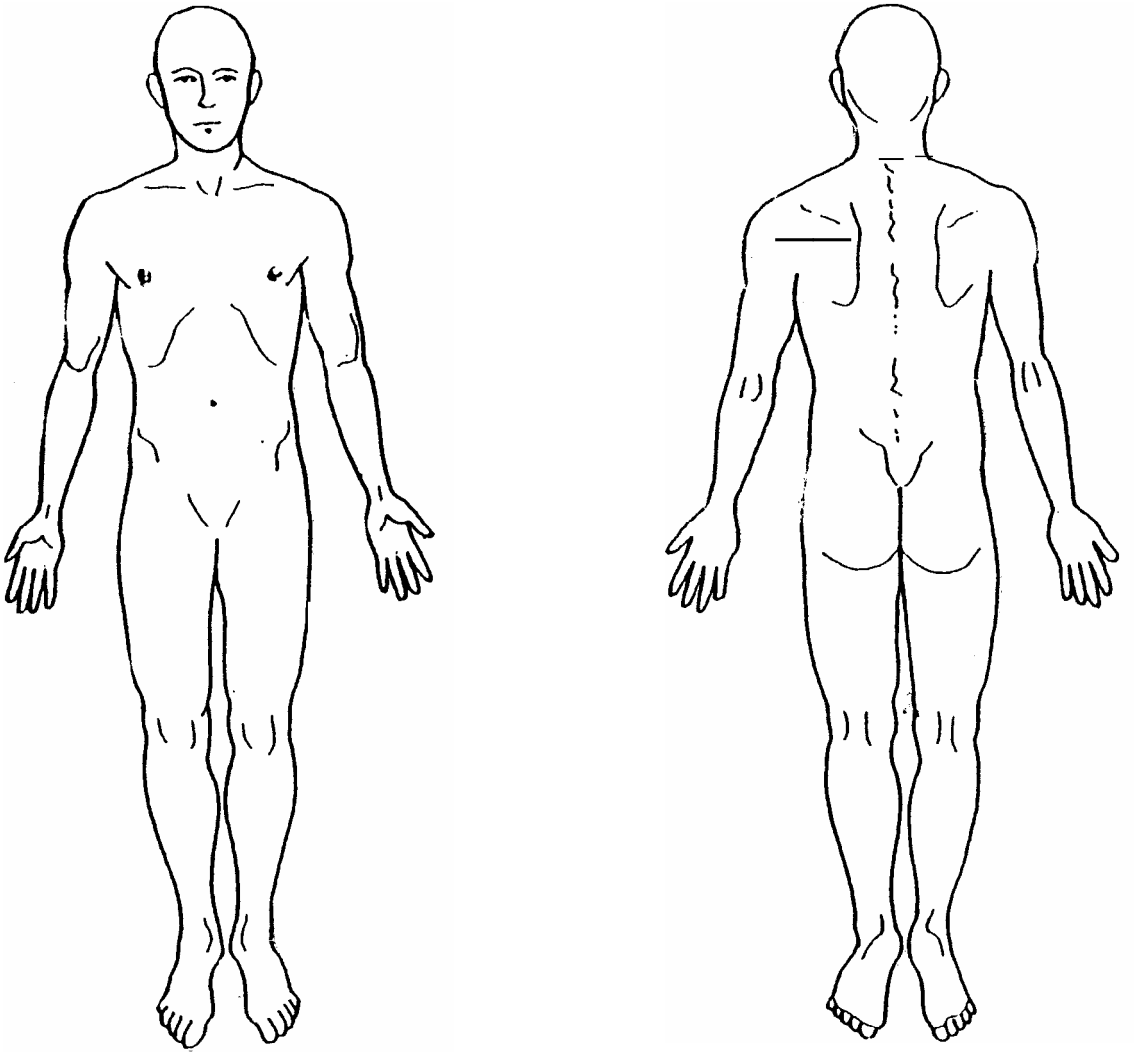
TELL US WHERE YOU HURT

Name _____ Date_____

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbols listed below.

Ache AAAA AAAA	Numbness NNNN NNNN	Pins and Needles PPPP PPPP
Burning BBBB BBBB	Stabbing SSSS SSSS	Throbbing TTTT TTTT



Please mark on the line to indicate how severe your pain has been.

NO PAIN _____ SEVERE PAIN

HIPAA Consent Form

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Tinius Chiropractic Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Tinius Chiropractic Center. I understand that diagnosis or treatment of me by Tinius Chiropractic Center may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Tinius Chiropractic Center is not required to agree to the restrictions that I may request. However, if Tinius Chiropractic Center agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Tinius Chiropractic Center has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Tinius Chiropractic Center's Notice of Privacy Practices prior to signing this document. The Tinius Chiropractic Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Tinius Chiropractic Center. The Notice of Privacy Practices for Tinius Chiropractic Center is also provided in the HIPPA handbook in the reception area and on the Tinius Chiropractic Center website at www.tiniuschiropractic.com This Notice of Privacy Practices also describes my rights and the Tinius Chiropractic Center's duties with respect to my protected health information.

Tinius Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Tinius Chiropractic Center's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

X_____
Signature of Patient or Personal Representative

X_____
Name of Patient or Personal Representative

HIPAA Authorization Form "A"

THIS NOTICE DESCRIBES HOW MEDICAL INFORINIATION ABOUT YOU MAY BE USED ANTI) DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY.

I, _____, hereby authorize Tinius Chiropractic Center to use the following protected health information, and/or disclose the following protected health information to:

_____

This protected health information is being used or disclosed to inform another physician, insurance company or its representatives, attorney, or other sources necessary for referral, treatment, reimbursement or other legal reasons.

This authorization shall be in force and effect until six (6) years from the date of this authorization at, which time this authorization to use or disclose this protected health information, expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Larry H. Tinius D.C. at Tinius Chiropractic Center. I understand that a revocation is not effective to the extent that Tinius Chiropractic Center has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may

be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Tinius Chiropractic Center will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.) I further understand that I may refuse to sign this authorization.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to the Tinius Chiropractic Center from a third party.

X_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Patient Acknowledgment of Privacy Notice

To Be Maintained with Patient's Chart

This is to acknowledge that I (print name) _____
have been given the opportunity to review Tinius Chiropractic Center's, **Notice of Privacy Practices.** I understand that I have the right to request a personal copy of this office's **Notice of Privacy Practices.**

_____ _____
Sianature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

INSURANCE QUESTIONNAIRE

NAME: _____ AGE :_____ SEX: _____

ADDRESS:_____

DATE OF ACCIDENT:_____

TYPE OF ACCIDENT: ( ) AUTOMOBILE ( ) INDUSTRIAL ( ) FALL ( ) OTHER

WHERE AND WHEN DID THE ACCIDENT TAKE PLACE? _____

AREA OF BODY INJURED? ( ) NECK ( ) UPPER BACK ( ) MID-BACK ( ) LOW BACK

HAVE YOU EVER INJURED THIS AREA BEFORE? ( ) YES ( ) NO

STATE IN YOUR OWN WORDS HOW ACCIDENT HAPPENED AND DESCRIBE INJURIES RECEIVED:

_____

_____

_____

OCCUPATION: _____

EMPLOYED BY: _____

DID YOU NOTIFY YOUR EMPLOYER: _____

DOES YOUR PRESENT JOB AGGRAVATE YOUR CONDITION? ( ) YES ( ) NO

HAVE YOU MISSED WORK SINCE THE ACCIDENT? _____ DAYS ____ WEEKS _____ MONTHS

DATES OF TOTAL DISABILITY FROM _____ TO _____

DATES OF PARTIAL DISABILITY FROM _____ TO _____

HAVE YOU BEEN SEEN BY ANY OTHER DOCTOR FOR THIS INJURY? ( )YES( )NO

NAME OF DOCTOR: _____

WHAT WAS HIS DIAGNOSIS? _____

WERE YOU HOSPITALIZED? ( )YES ( )NO

IF S0, NAME HOSPITAL _____ DATE OF : _____

SINCE THE ACCIDENT HAS YOUR CONDITION:( )IMPROVED ( )STAYED SAME ( )WORSENED

DATE _____ SIGNATURE _____

Name _____ Date _____

CURRENT MEDICAL COMPLAINTS

NECK PAIN

My pain began: ( ) gradually ( )suddenly

I have pain: ( ) sometimes ( ) all of the time

My pain goes into my: ( ) right arm ( ) left arm ( ) both ( ) none

I have tingling and/
Or numbness in my; ( ) right arm ( ) left arm ( ) both ( ) none

My pain is worse when I:

cough or sneeze	( ) yes	( ) no
bend forward	( ) yes	( ) no
lift	( ) yes	( ) no
push	( ) yes	( ) no
pull	( ) yes	( ) no
turn my head	( ) yes	( ) no

My pain wakes me up in the middle of the night: ( ) yes ( ) no

Changes in the weather affect my pain: ( ) yes ( ) no

The pain is: ( ) sharp pain ( ) stinging/burning ( ) throbbing
( ) stiffness ( ) aching ( ) catching

I have headaches: ( ) yes ( ) no

If I do get headaches, they occur: ( ) sometime ( ) all of the time

UPPER BACK PAIN

My pain began: ( ) gradually ( ) suddenly

The pain is: ( ) sharp ( ) dull ( ) stinging/burning ( ) throbbing

I have pain: ( ) sometimes ( ) all of the time

The pain goes into my: ( )ribs ( ) shoulders ( ) chest

The pain is aggravated
by movement: ( ) yes ( ) no

Does rest lesson pain: ( ) yes ( ) no

UPPER BACK PAIN cont.

My pain is worse when I:

cough or sneeze	( ) yes	( ) NO
sit	( ) yes	( ) NO
bend	( ) yes	( ) NO
walk	( ) yes	( ) NO
lift	( ) yes	( ) NO
push	( ) yes	( ) NO
pull	( ) yes	( ) NO

The pain wakes me up in the middle of the night: ( ) yes ( ) no
Changes in the weather affect my pain: ( ) yes ( ) no

LOW BACK PAIN

My pain began: ( ) gradually ( ) suddenly

The pain is: ( ) sharp ( ) dull ( ) stinging/burning ( ) throbbing

I have pain: ( ) sometimes ( ) all of the time

Does the pain go into
your legs: ( ) right leg ( ) left leg ( ) both ( ) none

I have tingling and/
or numbness in my: ( ) right leg ( ) left leg ( ) both ( ) none

Is the pain aggravated
by movement: ( ) yes ( ) no

Does rest lesson pain:( ) yes ( ) no

My pain is worse when I:

cough or sneeze	( ) yes	( ) no
sit	( ) yes	( ) no
bend	( ) yes	( ) no
walk	( ) yes	( ) no
lift	( ) yes	( ) no
push	( ) yes	( ) no
pull	( ) yes	( ) no

The pain wakes me up in the middle of the night: ( ) yes ( ) no

Changes in the weather affect my pain: ( ) yes ( ) no

Signature _____