Case # _____

PATIENT INFORMATION

Please allow our staff to photocopy your driver's license and all available insurance cards.

WELCOME! PLEASE PRINT.

Full Name _____ Gender: M F Home Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth Date _____ Marital Status (Circle One): S M W D Sep No. Children _____

SS# _____ Driver's License # _____

Your Employer _____ Your Occupation _____ Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

Work Phone _____ Cell Phone _____

Do you have health insurance where you work? ☐ Yes ☐ No Plan/Group # _____

Insurance Company _____

Name of Spouse, Parent or Guardian _____ Age ____ Birth Date _____ SS# _____

Spouse's Employer _____ Spouse's Occupation _____ Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

Work Phone _____

Does your spouse have health insurance at work? ☐ Yes ☐ No Plan/Group # _____

Insurance Company _____

How did you find out about our office? _____

Describe the major complaints that bring you to our office: _____

_____

Is your condition due to an accident? ☐ Yes ☐ No Date of your accident: _____

_____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all copayments and non-covered services. I also understand and agree to pay all copays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of all consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

Patient's Signature _____ Date _____

Spouse's or Guardian's Signature _____ Date _____

We file your primary insurance at no charge to you. Filings for policies in addition to your primary coverage are completed *for a fee and as time permits.*

Payment Options (Please Indicate): ☐ Cash ☐ Check ☐ MasterCard ☐ Visa ☐ Discover

rev. 08/04

Case # _____

CASE HISTORY

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past or present.

An understanding of your health history will help us to determine appropriate care.

FULL NAME _____ DATE _____

AGE _____ RACE _____ GENDER _____ HEIGHT _____ WEIGHT _____

Review of Systems

1. Do you have skin, hair or nail problems: ☐ Yes ☐ No _____
2. Do you have mouth and/or throat problems? ☐ Yes ☐ No _____
3. Do you have nose and/or sinus problems? ☐ Yes ☐ No _____
4. Do you have ear problems? ☐ Yes ☐ No _____
5. Do you have eye problems? ☐ Yes ☐ No _____
6. Do you have chest or lung (breathing) problems? ☐ Yes ☐ No _____
7. Do you smoke? ☐ Yes ☐ No Amount per day _____ How Long? _____
8. Do you have heart and/or blood vessel problems? ☐ Yes ☐ No _____
9. Do you have blood or lymph node problems? ☐ Yes ☐ No _____
10. Do you have digestive problems? ☐ Yes ☐ No _____
11. Do you have genital problems (e.g. prostate, testicular, vaginal)? ☐ Yes ☐ No _____
12. Do you have urinary (including kidney or bladder) problems? ☐ Yes ☐ No _____
13. Females, have you had menstrual problems? ☐ Yes ☐ No _____
    Have you ever taken birth control pills? ☐ Yes ☐ No For how long? _____
    Is there any chance that you are currently pregnant? ☐ Yes ☐ No
    Do you have any breast problems? ☐ Yes ☐ No _____
14. Do you have any nervous system diseases and/or mental health problems? ☐ Yes ☐ No
    _____
15. Do you have any gland and/or hormone problems? ☐ Yes ☐ No _____
16. Do you have allergy or immuity problems? ☐ Yes ☐ No _____
17. Do you have any muscle, tendon or ligament problems? ☐ Yes ☐ No _____
18. Do you have any bone or joint diseases (examples: bone = osteoporosis, joint = arthritis)? ☐ Yes ☐ No _____
    _____

Past History

19. List any diseases which you have had in the past, including childhood diseases: _____
    _____
20. Tell us if you have ever been diagnosed as having a particular condition such as diabetes, cancer, AIDS, etc.: _____
    _____
21. Have you suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones? ☐ Yes ☐ No
    _____
    _____
22. List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):
    _____ Date _____
    _____ Date _____
    _____ Date _____
    _____ Date _____

(OVER PLEASE)

Case # _____

CASE HISTORY
(CONTINUED)

FULL NAME _____ DATE _____

23. Have you ever been hospitalized for any reason other than surgery? ☐ Yes ☐ No _____
24. Medications: Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis: _____

_____

25. Your diet is: ☐ Balanced ☐ Fair ☐ Poor ☐ Excessive ☐ Restricted

Family History

26. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)? ☐ Yes ☐ No _____

Social History

27. In what position do you usually sleep, and how well? _____

_____

28. Do you exercise on a regular basis? ☐ Yes ☐ No How? _____
29. How do you spend your spare time (hobbies, etc)? _____
30. Do you use: ☐ Caffiene? ☐ Tobacco? ☐ Nicotine? ☐ Recreational Drugs? ☐ Alcohol?
31. Please describe your work.

    Type: ☐ Professional ☐ Physical Labor ☐ Driver ☐ Clerical ☐ Factory ☐ Homemaker

    Physical Demands: ☐ Heavy ☐ Moderate ☐ Mild ☐ Sedentary

    Stress Level: ☐ High ☐ Medium ☐ Low

Additional Questions

32. Do you have problems with recurring headaches? ☐ Yes ☐ No _____
33. Are you losing weight without trying? ☐ Yes ☐ No
34. Does your pain wake you up at night? ☐ Yes ☐ No
35. Have you had a change in bowel or bladder habits? ☐ Yes ☐ No _____
36. Have you had a sore that doesn't heal? ☐ Yes ☐ No _____
37. Have you recently had any unusual bleeding or discharge? ☐ Yes ☐ No _____
38. Do you have a thickening/lump in the breast or elsewhere? ☐ Yes ☐ No _____
39. Do you have indigestion or difficulty swallowing? ☐ Yes ☐ No _____
40. Have you had an obvious change in a wart or mole? ☐ Yes ☐ No _____
41. Do you have a nagging cough or hoarseness? ☐ Yes ☐ No _____
42. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history which was not requested, please fill it in below.

_____

_____

43. Please describe your current complaint. In other words, what brought you here? _____

_____

_____

44. Who is your:

    Medical Doctor? _____

    OB/GYN? _____

    Dentist? _____

Case # _____

PATIENT HEALTH SURVEY

FULL NAME _____ AGE _____ DATE _____

Have you ever (at any time) experienced any of the following?

Difficulty urinating	Y	N	Claustrophobia (fear of small spaces)	Y	N
Loss of bladder control	Y	N	Spinal surgery	Y	N
Loss of bowel control	Y	N	Common cold/flu	Y	N
Temporary loss of vision, one eye	Y	N	Carotid artery surgery	Y	N
Blood in urine	Y	N	Breast removal	Y	N

Have you ever been diagnosed with or told you have one of the following?

Detached retina	Y	N	Rheumatoid Arthritis	Y	N
Stroke	Y	N	Fractured/broken vertebra	Y	N
Slipped disc	Y	N	Bleeding disorders	Y	N
Herniated disc	Y	N	High blood pressure	Y	N
Osteoporosis	Y	N	Blood in stool	Y	N
TIA's (pin or mini strokes)	Y	N	Cancer	Y	N
Drop attacks (collapsing, but not fainting)	Y	N	AIDS	Y	N
Hardening of the arteries	Y	N	Kidney disease	Y	N
Partial or complete paralysis	Y	N	Prostate disease	Y	N

Do you currently have, or could you be, any of the following?

Pregnant	Y	N
Taking birth control pills	Y	N
Receiving hormone therapy	Y	N
☐ Male ☐ Female		
Receiving chemotherapy	Y	N
Receiving radiation therapy	Y	N
Taking blood thinners	Y	N
A heavy smoker (1 or more packs/day)	Y	N
Surgical/medical implanted devices:		
Aortic clips	Y	N
Brain clips	Y	N
Artificial heart valves	Y	N
Rods, pins, screws	Y	N
IUD	Y	N
Surgical clips/wires	Y	N
Shunt	Y	N
Neurostimulator	Y	N
Dentures	Y	N
Pacemaker	Y	N
Hearing aid	Y	N
Insulin pump	Y	N
Joint replacement	Y	N
Cochlear implants (ear)	Y	N
Other implanted devices:		
Metal fragments (head, eye, skin)	Y	N
Bullets/shrapnel	Y	N
Body piercing	Y	N
Tattoos	Y	N

In the past 14 days (2 weeks), have you experienced any of the following?

Nausea	Y	N
Vomiting	Y	N
Vertigo (spinning)	Y	N
Difficulty walking	Y	N
Incoordination	Y	N
Numbness or other sensory complaints	Y	N
Loss of consciousness	Y	N
Double vision	Y	N
Blurred vision	Y	N
Tinnitus (ringing in ears)	Y	N
Speech problems	Y	N
Clumsiness	Y	N
Memory loss	Y	N
Travel by car/truck	Y	N
Personality changes	Y	N
Fever	Y	N
Recurrent headaches	Y	N
Diarrhea	Y	N
Used a tanning bed/booth	Y	N
Skin rash/infection	Y	N
A major fall	Y	N
A minor fall	Y	N
An auto accident	Y	N
A work injury	Y	N
Loss of strength	Y	N
Pain moving bowels	Y	N
Head trauma	Y	N
Abnormal period	Y	N

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC
INFORMED CONSENT

CHIROPRACTIC
It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

ANALYSIS
A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS
Although Doctors of Chiropractic are experts in Chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a Chiropractic adjustment, or health care, if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS
The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond to Chiropractic care may come under the control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

TO THE PATIENT
Please discuss any questions or problems with the Doctor **before** signing this statement of policy.

I have read, and understand the foregoing.

DATE _____ SIGNATURE _____

Daniel S. Behe, Jr., D.C.
GRASTON CERTIFIED

CALVERT MEDICAL PROFESSIONAL CENTER
2429 SOLOMONS ISLAND ROAD
HUNTINGTOWN, MD 20639
TELEPHONE (410) 535-5559
FAX (410) 535-4919

Patient Name: _____ Date:_____

CANCELLATION/MISSED APPOINTMENT POLICY

Your appointment time has been set aside for you. This time is unavailable to other patients. Therefore, we require minimum of 24 hour notice if you need to cancel your appointment. For all missed or cancelled appointments with less than 24 hours' notice, you will be charged a $50.00 cancellation fee.

Appointment reminders are a courtesy. Should you not receive a reminder telephone call, it is still your responsibility to remember your appointment.

I have read and understand the cancellation appointment policy:

Patient Signature: _____

If patient is a minor, please provide parent and/or guardian's information:

Name: _____ _____ Relationship: _____

Parent/guardian signature: _____ Date:_____

Daniel S. Behe, Jr., D.C.
GRASTON CERTIFIED

CALVERT MEDICAL PROFESSIONAL CENTER
2429 SOLOMONS ISLAND ROAD
HUNTINGTOWN, MD 20639
TELEPHONE (410) 535-5559
FAX (410) 535-4919

CONSENT TO TREATMENT OF A MINOR CHILD

I HEREBY AUTHORIZE CARVER CHIROPRACTIC CENTER AND/OR DR.BEHE AND WHOMEVER HE MAY DESIGNATE AS ASSISTANTS, TO ADMINISTER CHIROPRACTIC CARE/PHYSICAL THERAPY AS DEEMED NECESSARY TO MY CHILD/DEPENDANT _____(NAME OF CHILD),

DATED AT _____ (CITY) _____(STATE)
THIS _____ DAY OF _____, 20____

NAME OF PARENT/GUARDIAN: _____

SIGNATURE: _____ _____

WITNESSED: _____

Effective Date

This notice is in effect as of ___/___/___

Patient Acknowledgment

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICE

Carver Chiropractic Center

2429 Solomons Island Road

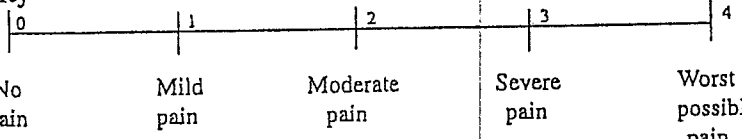
Huntingtown, Maryland 20639

Functional Rating Index

For use with Neck and/or Back Problems only.

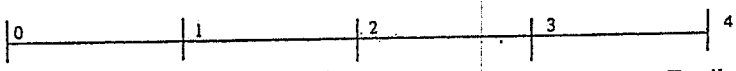
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity



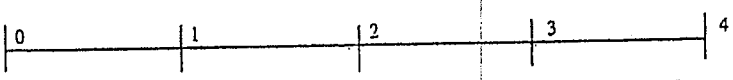
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



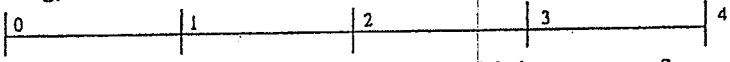
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)



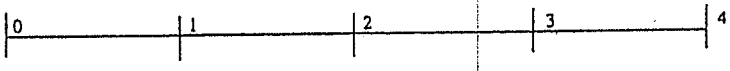
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



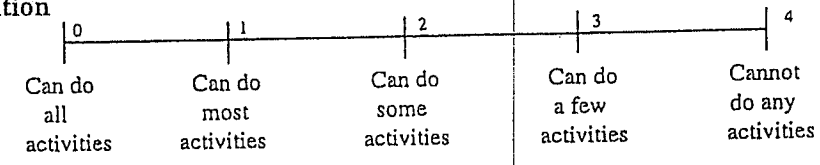
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

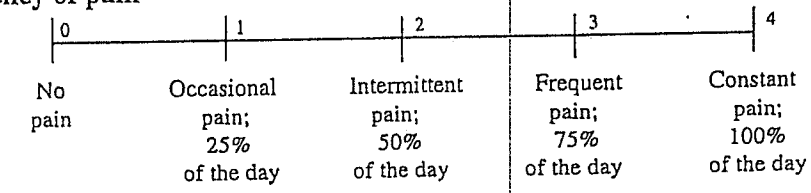


0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

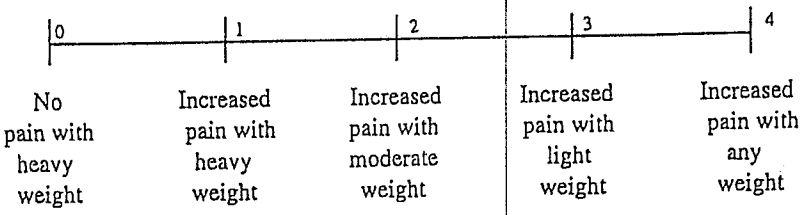
6. Recreation



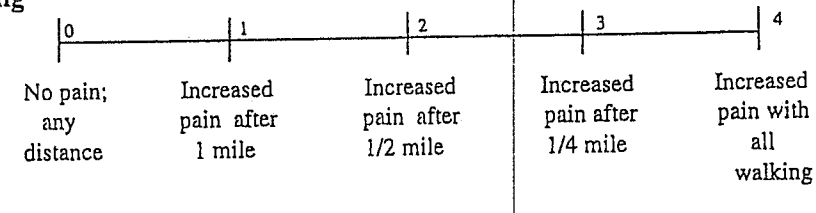
7. Frequency of pain



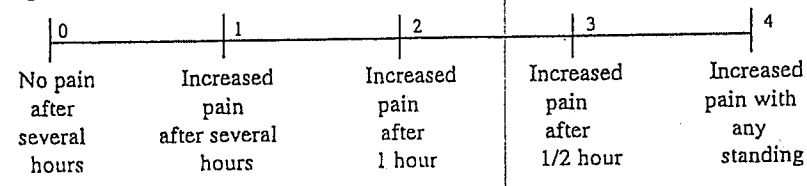
8. Lifting



9. Walking



10. Standing



Patient's Signature

Date