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# N E R E M

FAMILY CHIROPRACTIC INC.  
925 S.E. Gateway Dr., Grimes, Iowa 50111, 515-986-1400

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Personal Information: Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Last First Middle

\_\_\_\_\_  
Address Apt.

\_\_\_\_\_  
City State Zip

( ) ( ) ( )  
Cell Number Home Number Work Number E-mail Address

\_\_\_\_\_  
Employer Name Occupation Title

( ) ( ) ( )  
Emergency Contact Name/Relationship Cell Number Home Number Work Number

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Current Health Condition: What brought you to our office today?

Unwanted Condition: \_\_\_\_\_

Please indicate the location of the sensations you are experiencing.

When did this condition/pain BEGIN?: \_\_\_\_/\_\_\_\_/\_\_\_\_

Has it ever occurred

before?   Y  N    When: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this condition:    Auto related    Job Related

   Home Injury    Slip / Fall    Lifting    Slept Wrong

   Unknown    Other – Please explain \_\_\_\_\_

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Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_

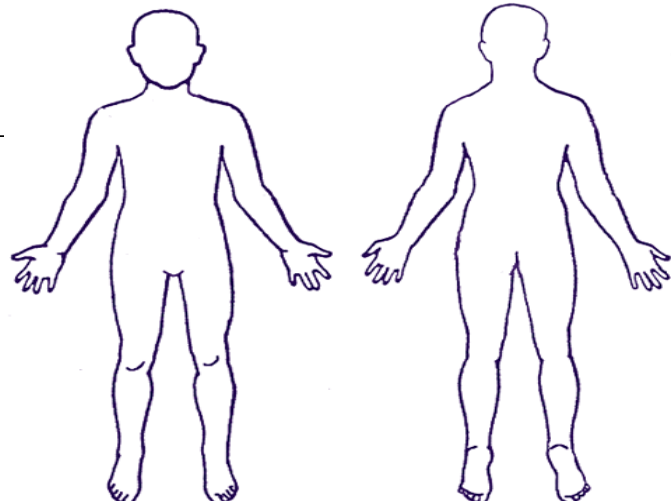
Time of Accident \_\_\_\_ a.m./p.m.

Do you suffer from ANY OTHER CONDITION than which you are now consulting us? Please explain \_\_\_\_\_

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FRONT

BACK



Previous care for this same condition:

No, I have not previously seen a doctor for this condition, OR

Yes, I have previously seen a doctor for this condition and his/her information is below:

Other doctors seen for this condition:  Chiropractor  Medical  Other \_\_\_\_\_

Type of Treatment: \_\_\_\_\_

Were you satisfied with the results of the treatment?  Yes  No

Please explain: \_\_\_\_\_

Review of Systems: Please check all CURRENT and PAST conditions. List any health conditions that are not shown below. Even if a condition seems unrelated to care, please check. These may affect your overall health.

ADD	Cystic kidney disease	High / low blood pressure	Psychiatric problems
Alzheimers	Depression	Influenza pneumonia	Scoliosis
Anemia	Diabetes (insulin dep)	Liver disease	Seizures
Arthritis	Diabetes (non-insulin)	Lung disease	Shingles
Asthma	Eczema	Lupus erythema (discoid)	Past history of similar symptoms
Cancer	Emphysema	Lupus erythema (systemic)	STD'S (unspecified)
Cerebral palsy	Eye problems	Multiple sclerosis	Suicide attempt(s)
Chicken pox	Fibromyalgia	Parkinson's disease	Thyroid problems
Crohn's / colitis	Heart disease	Unspecified pleural effusion	Dizziness
CRPS (RSD)	Hepatitis	Pneumonia	Diarrhea/constipation
CVA (stroke)	HIV	Psoriasis	High cholesterol
Anxiety / stress	Heartburn	Difficulty sleeping	Frequent colds
Jaw pain	Numbness	Fatigue	Other:
Sinus problems	Headaches	Currently pregnant	Other:
Ear infections	Traumatic birth (your own)		

Surgery (ies): List ALL surgical procedures. Write the DATE of the procedure immediately afterward.

Angioplasty	Cosmetic	Hysterectomy	Pacemaker insertion
Appendectomy	D & C	Joint reconstruction	Rotator cuff
Caesarian section	Dental surgery	Joint replacement	Spinal fusion
Cardiac catheterization	Gall bladder	Knee repair	Tonsillectomy
Carpal tunnel repair	Hemorrhoidectomy	Laminectomy	Other:
Coronary artery bypass	Hernia repair	Mastectomy	Other:

Injury(ies): Mark or list ALL injuries: Write the DATE of the injury immediately afterward.

Back injury	Head injury (loss of consciousness)	Motor vehicle accident
Broken bones	Head injury (no loss of consciousness)	Soft tissue injury (mild)
Disability (ies)	Industrial accident	Soft tissue injury (severe)
Fall (severe)	Joint injury	Other:
Fracture	Laceration (severe)	Other:

Family History:

We know that many health problems can be genetic and run in families. Does anyone in your immediate family have/had health problems that concern them?

Social History: Mark all that apply below:

Alcohol:  None  Social consumption only  Drink regularly, quantity of \_\_\_ glasses per \_\_\_

My dietary intake consists mainly of the following: (mark all that apply)

High Fat	High Salt	Low Fiber	Low Sugar
Low Salt	High Fiber	Low Carbohydrate	

Tobacco: \_\_\_ None \_\_\_ Live with a smoker \_\_\_ Quit Smoking \_\_\_ Smoke/Chew

Goals for my care: (Please read the following thoroughly so you know why these forms are important.)

At Nerem Family Chiropractic we focus on your ability to be healthy. Our goals are to first address the *issues* that brought you to this office, and second, to offer you the opportunity to improved health, wellness and quality of life in the future.

On a daily basis we all experience physical, biochemical and psychological / emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the questions on these forms gives us a profile of your specific stresses, past and present, that you face and allow us to better assess the challenges to your health potential.

In addition, we would like to know what your goals here are. Please check one or more of the following:

\_\_\_ **Relief Care** -- Treatment designed to address an obvious symptom, disease, or condition.

\_\_\_ **Stabilization Care** -- Continue with the care necessary to fully heal soft tissues and muscles.

\_\_\_ **Wellness Care** -- Non-symptomatic or maintenance care, designed to maximize optimum spinal and nervous system function and help prevent disease.

*Are we coordinating care with your physician?*

I would like a copy of my records sent to my physician \_\_\_ Yes \_\_\_ No

(Please indicate) Primary Care Physician, Ob/Gyn, Asthmatic Specialist, Orthopedic Surgeon, Internist,

Other Doctor: \_\_\_\_\_

Clinic's Name and Address:

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*Informed Consent:*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Nerem, Dr. Lahr and /or other licensed doctors of chiropractic who now or in the future work at Nerem Family Chiropractic, Inc.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment while the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that results are not guaranteed.

I have read the above consent. I understand I have the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information. I assume and agree to be held responsible for reasonable collection agency fees, "administration fees," filing fees, court costs and other costs incurred if my account enters default status.

Patient Print Name: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Consent to Treat a Minor / Guardian or Spouse's Signature of Authorizing Care:

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**N E R E M**  
**FAMILY CHIROPRACTIC INC.**  
925 S.E. Gateway Dr., Grimes, Iowa 50111  
Phone: 515-986-1400 Fax: 515-986-7111

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ASSIGNMENT OF INSURANCE BENEFITS FORM

Assignment of Benefits:

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE OR MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO NEREM FAMILY CHIROPRACTIC, INC., FOR ANY SERVICES FURNISHED ME BY THE PROVIDER/CLINIC. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY OR TO CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. *In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services.*

Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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