



Today's Date _____

Name _____ Birth Date ___/___/___ Age _____

Address _____ Apt. _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____

Preferred Method of Contact Home Cell (For Appt. Reminder Do You Prefer: Text Or Voice Mail- Please Circle One)

Email _____ Male Female Married Single Divorced Widow Separated

No. of Children _____ (Ages) _____ Health Issues _____

Soc Sec _____/_____/_____ Occupation _____ Employer _____

Emergency Contact Name _____ Phone _____

Primary Care Physician _____ Phone _____

Referred From: Family Family Doctor Internet Lecture Website

PAST HISTORY

Alcohol Never Occ (3x/Week) Daily Former Smoke Never Occ (3x/Week) Daily Former

Race: Black/African White Hispanic Or Latino Asian American Indian Pacific Islander

Ethnicity: Hispanic Non-Hispanic

Have You Ever Had- check off IF NONE

TB Cancer Epilepsy Diabetes Arthritis Asthma Heart Disease Sinus Kidney Hepatitis

HIV-Aids Polio Thyroid Disease Alcohol/Drug Dependency Other _____

Previous Chiropractic Care (Where And When) _____

Surgery _____

Previous Spine Injuries _____

Are You Pregnant? Yes No Last Menstrual Period _____

List Vitamins/Medications _____

INSURANCE

The Clinic Policy Requires Payment Arrangements Be Made on The First Visit.

If you were involved in an Auto Accident or Work Comp Case, please inform The Eisman Clinic Team Member at the Front Desk.

INSURANCE INFORMATION-Please check below

NO INSURANCE/CASH PERSONAL MEDICAL INSURANCE AUTO INSURANCE WORK COMP

IF PERSONAL MEDICAL INSURANCE:

Insurance Company _____

Policy Number _____

Secondary Ins _____

Policy Number _____

Relationship Self Spouse Mother Father

Spouse's Birth Date ___/___/___

Spouse's Soc Sec _____

IF AUTO ACCIDENT:

Insurance Company _____

Date of Injury _____

Claim Number _____

Policy Holder _____

Adjuster _____

Adjuster's Phone No. _____

Attorney _____

Attorney's Phone No. _____

IF WORK COMP:

Employer/Company Name _____

Date of Injury _____

Company Address _____

Work Comp Ins Co. _____

Claim Number _____

Adjuster _____

Adjuster's Phone No. _____

Attorney _____

Attorney's Phone No. _____

FINANCIAL POLICY

I understand and agree that my insurance policies are an arrangement between the insurance company and myself. The clinic, as a courtesy to you, will bill your insurance company. I authorize my insurance company to pay the **Eisman Clinic, P.C.** directly. All monies paid will be applied to my account. However, I clearly understand and agree that all services rendered to 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, any fees for professional services rendered to me will be immediately due and payable. Some plans may not cover the entire bill or may refuse to pay. You will be responsible to pay any unpaid balance. If you do not have insurance, then all services are paid per visit or in advance. Please speak to the doctor about payment/family plans. I authorize the **Eisman Clinic, P.C.** to release all records as needed for collecting bills for services that I may or will incur. Records may be sent via mail or electronically (fax or email) as deemed by the **Eisman Clinic**. I understand and agree to the financial policies of the **Eisman Clinic, P.C.**

Signature

Date

MEDICAL RECORD RELEASE

The undersigned does hereby authorize you to allow my Physician/Insurance Company/Attorney to examine and copy any and all records and reports that the **Eisman Clinic PC** may presently or hereafter acquire concerning my examination and or treatments, past, present, and future. This includes x-rays, diagnostic testing and treatment reports, prognosis, and financial records. This pertains to any and all accidents or illnesses of mine which the **Eisman Clinic** has examined or treated me and to discuss the same. I understand and agree to the medical release policies of the **Eisman Clinic, P.C.**

Signature

Date

Name _____

Date _____

NECK PAIN

How often

- Constant
- Frequent
- Intermittent
- Occasional

Severity

- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Movement

- Inflexibility
- Restricted Movement
- Stiffness

Sensation

- Crawling
- Dead
- Numb
- Pins and Needles
- Prickly
- Tingling

Pain Types

- Achy
- Burning
- Dull
- Excruciating
- Numb ache type
- Pounding
- Pulsating
- Sharp
- Shooting
- Stabbing
- Stinging
- Throbbing

Area

- Generalized In
- Localized In
- Migrating To
- Radiating To
- Shooting Into

Region

- Shoulder Rt Lt
- Arm Rt Lt
- Forearm Rt Lt
- Wrist Rt Lt
- Hand Rt Lt
- Fingers Rt Lt

Aggravate

- Coughing
- Sneezing
- Straining at BM's
- Looking down
- Looking up
- Reclining
- Repetitious Movement
- Sleeping
- Turning the head left
- Turning the head right
- Emotional Upset
- Stress
- Flashing Lights
- Other _____

RELIEVE

- Having Adjustments
- Taking Advil
- Taking Aspirin
- Taking Pain Pills
- Taking Tylenol
- Exercising
- Reclining
- Resting
- Sitting
- Sleeping
- Cold
- Heat
- Throbbing Heat Liniment
- Nothing
- Hot Showers
- Rubbing Mineral Ice
- Other _____

MID BACK PAIN

How often

- Constant
- Frequent
- Intermittent
- Occasional

Severity

- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

MOVEMENT

- Inflexibility
- Restricted Movement
- Stiffness
- Spasm
- Cramps

Sensation

- Crawling
- Dead
- Numb
- Pins and Needles
- Prickly
- Tingling

PAIN TYPES

- Achy
- Burning
- Dull
- Excruciating
- Numb Ache Type
- Pounding
- Pulsating
- Sharp
- Shooting
- Stabbing
- Stinging
- Throbbing
- Electric Shock
- Hurting
- Exquisite
- Scalded
- Sore

MID BACK PAIN

continued

Area

- Generalized In
 Localized In
 Migrating To
 Radiating To
 Shooting Into

AGGRAVATE

- Coughing
 Sneezing
 Straining at BMs
 Reclining
 Repetitious Movements
 Sleeping
 Emotional Upset
 Stress
 Flashing Lights
 Walking
 Getting Out of Bed
 Exercising
 Driving
 Carrying
 Breathing

Other _____

RELIEVE

- Having Adjustments
 Taking Advil
 Taking Aspirin
 Taking Pain Pills
 Taking Tylenol
 Exercising
 Reclining
 Resting
 Sitting
 Cold
 Heat
 Throbbing Heat Liniment
 Nothing
 Hot Showers
 Rubbing Mineral Ice

Other _____

LOWER BACK PAIN**How often**

- Constant
 Frequent
 Intermittent
 Occasional

Severity

- Mild
 Mild to Moderate
 Moderate
 Moderate to Severe
 Severe

Movement

- Inflexibility
 Restricted Movement
 Stiffness

Sensation

- Crawling
 Dead
 Numb
 Pins and Needles
 Prickly
 Tingling

Pain Types

- Achy
 Burning
 Dull
 Excruciating
 Numb ache type
 Pounding
 Pulsating
 Sharp
 Shooting
 Stabbing
 Stinging
 Throbbing

Area

- Generalized In
 Localized In
 Migrating To
 Radiating To
 Shooting Into

REGION

- Hip Rt Lt
 Buttock Rt Lt

- Thigh Rt Lt
 Knee Rt Lt
 Leg Rt Lt
 Foot Rt Lt
 Toes Rt Lt

AGGRAVATE

- Bowel Movements
 Coughing
 Sneezing
 Straining at BMs
 Arising From A Chair
 Bending
 Carrying
 Climbing A Ladder
 Climbing Stairs
 Driving
 Exercising
 Getting In and Out Of A Car
 Getting Out Of Bed
 Lifting
 Pulling
 Pushing
 Reclining
 Sitting
 Standing
 Stooping
 Walking Uphill
 Walking
 Emotional Upset
 Stress
 Other _____

RELIEVE

- Having Adjustments
 Taking Advil
 Taking Aspirin
 Taking Pain Pills
 Taking Tylenol
 Exercising
 Reclining
 Resting
 Sitting
 Sleeping
 Cold
 Heat
 Nothing
 Massaging by hand
 Massaging with a vibrator
 Tub soaking
 Stretching
 Other _____



CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I acknowledge that Eisman Clinic's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Eisman Clinic's Notice of Privacy Practices prior to signing this document. 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 Eisman Clinic.

The Notice of Privacy Practices for Eisman Clinic is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Eisman Clinic's duties with respect to my protected health information.

Eisman Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, ask for one at the time of my next appointment or accessing Eisman Clinic.

I have the right to revoke this consent, in writing, except to the extent that Eisman Clinic has taken action in reliance on this consent.

PATIENT ACKNOWLEDGEMENT

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

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

17401 Greenfield
Detroit, MI 48235

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🌐 www.eismanchiro.com

Pain Management • Health and Wellness