



6925 East 96th Street Suite 125
Indianapolis, IN 46250

Patient Information

Name: _____
First Initial Last

Address: _____

City _____ State _____ Zip _____

Home Ph: _____ Cell: _____

Date Of Birth : _____

Sex: ☐ Male ☐ Female

Email: _____

Marital Status: ☐ Single ☐ Divorced
☐ Married ☐ Separated ☐ Widowed

Employment Status: ☐ Full Time ☐ Student
☐ Part Time

Employer _____

Spouse: _____
First Initial Last

How did you hear about our clinic?: _____

Insurance

Insurance Name: _____

ID # _____

Group # _____

Policy Holder's Name _____

Date Of Birth _____

Relationship to patient _____

Policy Holder's Employer _____

Accident Information

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

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

Have you reported the accident to one of the following?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable): _____

Emergency Contact

Emergency Contact: _____

Emergency Phone: _____

Relationship: _____

Patient Condition

Reason for visit: _____

When did symptoms first appear? _____

Is the condition getting progressively worse?

☐ Yes ☐ No

How would you describe your pain?

☐ Sharp ☐ Dull ☐ Throbbing

☐ Aching ☐ Shooting ☐ Burning

☐ Stiffness ☐ Cramping ☐ Other

Is the pain: ☐ Constant ☐ Comes and Goes

Have you had similar pain in the past? ☐ Yes ☐ No

If so, when?: _____

Using the appropriate symbol, mark on the picture where you continue to have: Pain (X), Numbness (/), or Tingling (#)



Signature _____

Date _____

Health History

Check treatments received for this condition? Chiropractic Medication None Physical Therapy Surgery

Name and location of other Doctor(s) treating you for this condition: _____

Date of last: X-ray: _____ MRI: _____ CT-Scan: _____ Bone Scan: _____

Indicate if you currently have or have had any of the following:

Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anorexia / Bulimia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety Attacks	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Auto Immune Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast Lumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prostate Problems (Men)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Crohn's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Digestion Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumor/Growth (non-cancer)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Herniated Disc	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No

EXERCISE

WORK ACTIVITY

HABITS

☐ None

☐ Moderate

☐ Mostly Sitting

☐ Moderate Labor

☐ Smoking: Packs/Day ()

☐ Daily

☐ Heavy

☐ Light Labor

☐ High Labor

☐ Alcohol: Drinks/Week ()

Are you PREGNANT? ☐ Yes (Due Date:) ☐ No ☐ Maybe ☐ Coffee/Pop # per day ()

Please describe any of your **SURGERIES** or **BROKEN BONES**? Give dates.

Surgeries: _____

Broken Bones: _____

Any other conditions not covered on this form? _____

MEDICATIONS

ALLERGIES

VITAMINS/HERBS

Assignment & Release

I, the undersigned, certify that I (or my dependent) have Insurance coverage and assign directly to Symmergy Clinic, P.C. all Insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all Insurance submissions.

Signature: _____ Date: _____



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QUADRUPLE VISUAL ANALOGUE SCALE

Circle the number that best describes the pain you are experiencing. If you have more than one chief complaint, feel free to circle a number for each complaint and note which score is for which complaint.

1. What is your pain right now?

0 1 2 3 4 5 6 7 8 9 10

2. What is your pain level on an average day?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level on your best days?

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain at its worst?

0 1 2 3 4 5 6 7 8 9 10

Name: _____ Date: _____



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Your signature is required for us to process insurance claims and receive payment for services rendered in this facility.

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I acknowledge that I have received a copy of the *Notice of Privacy Practices* from the staff at Symmetry Clinic.

I authorize the release of all medical information necessary to process claims pertinent to my medical care, and I request that my insurance company honor my assignment of insurance benefits applicable to the services and pay all insurance benefits directly to my physician, on my behalf.

I acknowledge and understand that all accounts are the full responsibility of the patient. I understand that deductibles, co-pays, co-insurance and non-covered services are my responsibility. Symmetry Clinic will prepare and file your insurance claims directly with your primary and secondary insurance carriers. It is your responsibility to ensure that insurance payments are processed and paid in a timely fashion. In case of default of payment, I agree to pay legal fees on the balance due, collection costs, and reasonable attorney fees incurred to recover such payments.

Returned checks will be charged \$20 (non-sufficient funds) fee.

24-Hour notice for all cancellations or a \$25.00 fee applied.

Name: _____ Date: _____

Signature: _____



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CHIROPRACTIC INSURANCE COVERAGE

While our office staff is eager to help you with insurance questions, it is ultimately your responsibility to know your insurance coverage prior to receiving chiropractic care.

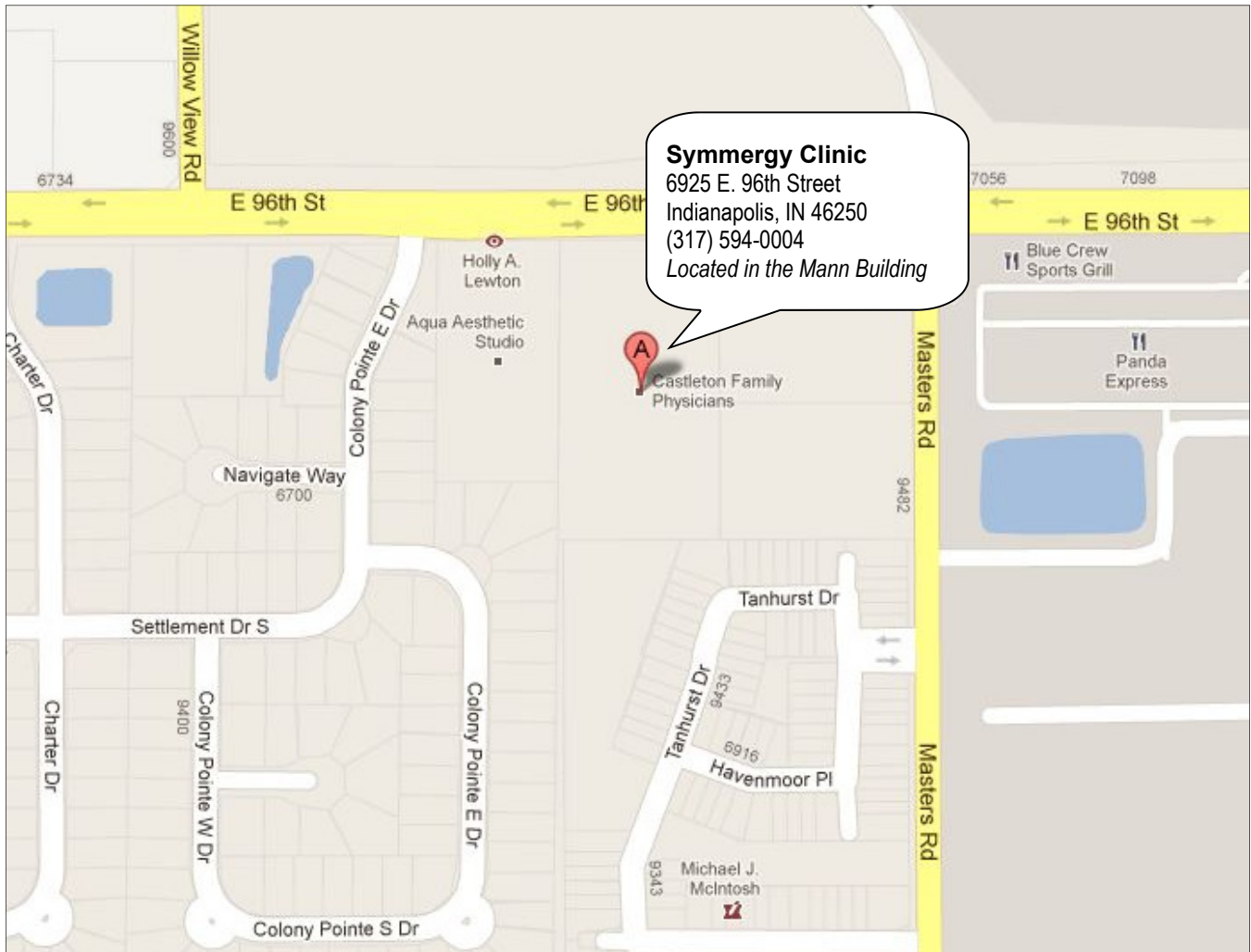
If you do not have chiropractic benefits, our clinic has very reasonable cash prices.

Please call the customer service phone number on the back of your insurance card.

Questions To Ask You Ins Co Representative		Answers
1.	Name of the representative you spoke with	
2.	Do I have chiropractic coverage ?	
3.	What is my co-pay for chiropractic care?	
4.	Do I have a deductible?	
5.	How much of my deductible has been met?	
6.	How many chiropractic visits am I allowed?	
7.	Do I have Coverage for the following Codes: 99203 or 99213 Exam / Re-exam 97530 or 97110 Physical Therapy 98941 Adjustment 97813 Acupuncture 97124 Massage	



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From I-465

Take I-465 to the I-69 North / Fort Wayne exit
Take I-69 North to the 96th Street exit and turn WEST (left)
Turn SOUTH (left) on Masters Road located before Gordon Food Service
Turn WEST (right) at your first street immediately after Gordon Food Service
Symmetry Clinic is located in the MANN building on the south side of the building

North of Fishers

Take I-69 South to the 96th Street exit and turn WEST (right)
Turn SOUTH (left) on Masters Road located before Gordon Food Service
Turn WEST (right) at your first street immediately after Gordon Food Service
Symmetry Clinic is located in the MANN building on the south side of the building

If you need more in-depth directions, please contact our clinic at 317.594.0004