
Dr. Nikoleta Alexander

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www.alexander-chiro.com

The purpose of our office is to restore and maintain the health of our patients through natural, chiropractic methods.

Please complete this confidential health questionnaire fully and accurately in **Blue or Black Ink Only**. The more we know about the overall picture of your health, the better we will be able to help you.

Doctors of Chiropractic are trained to detect and correct vertebral subluxations. Please respond to this questionnaire thoroughly, to help us determine potential causes and effects of subluxations in your case.

If you have any questions, please don't hesitate to ask for guidance.

## Patient Information

Name: _____

Street Address: _____

_____

City: _____ State: _____

Zip: _____ Email: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Ext.: _____

Insurance Provider: _____

Subscribers name: _____

Contract Number: _____

Group #: _____ PH #: _____

Birthdate: ___ - ___ - ___ Age: ___

Height: _____ Weight: _____

Gender: ☐ Male ☐ Female # of Children: ___

Marital Status: ☐ Single ☐ Married ☐ Separated

☐ Divorced ☐ Widowed ☐ Common Law

Name of Spouse/Significant Other: _____

My Occupation: _____

Employer: _____

## Experience with Chiropractic Care

Who referred you to this office? _____

Have you ever been adjusted by another Chiropractor?
☐ Yes ☐ No

Reason for those visits? _____

_____

Were X-rays taken? ☐ Yes ☐ No

Did your family receive chiropractic care? ☐ Yes ☐ No ☐ N/A

Chiropractor's Name: _____

Approximate date of last visit: _____

## Goals For My Care

People see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, and others for the correction of whatever is malfunctioning in their bodies. We will weight your needs and desires when making recommendations for care. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **Relief Care** – symptomatic relief of pain or discomfort.

☐ **Corrective Care** – correcting and relieving the cause of the problem as well as the symptoms.

☐ **Comprehensive Care** – bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic adjustments.

☐ I want the Doctor to select the type of care appropriate to my health status.

_____ ___ / ___ / ___
(signature) (date)

Patient's Name: _____

# Alexander Chiropractic
# Health History Information

## HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*:**

**Primary** or chief complaint is: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**Second** complaints is: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**Third** complaint: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**Fourth** complaint: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

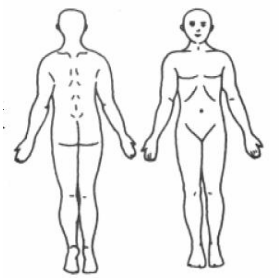
How did the injury happen? _____

**How does this problem relate to your daily life?** (For example: exercise, sleep, work)

| | **PREVIOUS ACTIVITY LEVEL** | **CURRENT ACTIVITY LEVEL** |
|---|---|---|
| **EXAMPLE: RUNNING** | 6 MONTHS AGO, I RAN 5 MILES WITHOUT PAIN | CAN'T RUN 1 MILE WITHOUT PAIN |
| **DRIVING** | | |
| **SLEEPING** | | |
| **WORKING** | | |
| **EXERCISING** | | |
| **OTHER** | | |

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

**R** = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching **N** = **N**umbness **S** = **S**harp/ **S**tabbing **T**= **T**ingling



What relieves your symptoms? _____

What makes them feel worse? _____

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

Identify any other injury(s), minor or major, that the doctor should know about: (ex: car accident, falls, concussions, sports injuries)

_____

_____



Dr.'s Signature: _____

Date: _____

Patient's Name: _____

## PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes **If yes** how many times? ____

When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried? ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____

And who provided it: _____ **How long ago?** _____ What were the results? ☐ Favorable ☐ Unfavorable

Please explain. _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

**PLEASE identify ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem:

| | HOW LONG AGO | TYPE OF CARE RECEIVED | BY WHOM |
|---|---|---|---|
| **INJURIES** → | | | |
| **SURGERIES** → | | | |
| **CHILDHOOD DISEASES** → | | | |
| **ADULT DISEASES** → | | | |

## SOCIAL HISTORY

**1. Smoking:** ☐ cigars ☐ pipe ☐ cigarettes → How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

**2. Alcoholic Beverage:** consumption occurs → ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

**3. Recreational Drug use:** consumption occurs → ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Explain: _____

## FAMILY HISTORY

**1.** Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes

**If yes whom:** ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister's ☐ brother's ☐ son(s) ☐ daughter(s)

Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

**2. Any** other hereditary conditions the doctor should be aware of: ☐ No ☐ Yes Explain: _____



Dr.'s Signature: _____

Date: _____

Alexander Chiropractic

Patient's Name: _____

**Please mark P** for in the **Past, C** for **Currently** have and **N** for **Never**

| | | | | |
|---|---|---|---|---|
| ___Broken Bone | ___Dislocations | ___Fracture | ___Rheumatoid Arthritis | ___Osteo Arthritis |
| ___Tumors | ___Cancer | ___Heart Attack | ___Diabetes | ___Disability |
| ___Cerebral Vascular | ___ Pregnant (Now) | ___ ADD/ADHD | ___ Eating Disorder | ___ Depression |
| ___ Headache | ___ Frequent Colds/Flu | ___ Dizziness | ___ Prostate Problem | ___ Ulcers |
| ___ Neck Pain | ___ Convulsions/Epilepsy | ___ Loss of Balance | ___ Impotence/Sexual Dysfun. | ___ Heartburn |
| ___ Jaw Pain, TMJ | ___ Tremors | ___ Fainting | ___ Digestive Problem | ___ Heart Problem |
| ___ Shoulder Pain | ___ Chest Pain | ___ Double Vision | ___ Colon Trouble | ___ High Blood Pressure |
| ___ Upper Back Pain | ___ Pain w/Cough/Sneeze | ___ Blurred Vision | ___ Diarrhea/Constipation | ___ Low Blood Pressure |
| ___ Mid Back Pain | ___ Foot or Knee Problem | ___ Ringing in Ears | ___ Menopausal Problem | ___ Asthma |
| ___ Low Back Pain | ___ Sinus/Drainage Problem | ___ Hearing Loss | ___ Menstrual Problem | ___ Difficulty Breathing |
| ___ Hip Pain | ___ Swollen/Painful Joints | ___ PMS | ___ Learning Disability | ___ Lung Problem |
| ___ Back Curvature | ___ Skin Problem | ___ Irritable | ___ Bed Wetting | ___ Kidney Trouble |
| ___ Scoliosis | ___ Allergies | ___ Mood Changes | ___ Trouble Sleeping | ___ Gall Bladder Trouble |
| ___ Numb/Tingling arms, hands, fingers | | | ___ Hepatitis (A,B,C) | ___ Liver Trouble |
| ___ Numb/Tingling legs, feet, toes | | | | |

**List Prescription & Non-Prescription drugs you take:** _____

_____

_____

Office Use Only:_____

_____

_____

_____

_____

_____



Dr.'s Signature: _____

Date: _____

Patient's Name: _____

**Quadruple Visual Analogue Scale**

**Patient Name:** _____ Date___ / ___ / ___

My ***primary*** complaint is:_____

On a scale of 0 to 10, 0 being no pain and 10 being the worst pain,

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| What is your pain **right now**? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 |
| What is your **typical or average pain**? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 |
| What is your pain level at its **best**? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 |
| What is your pain at its **worst**? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 |

My ***secondary*** complaint is: _____

On a scale of 0 to 10, 0 being no pain and 10 being the worst pain,

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| What is your pain **right now**? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 |
| What is your **typical or average pain**? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 |
| What is your pain level at its **best**? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 |
| What is your pain at its **worst**? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 |

Other Comments:_____

_____

_____

_____



Dr.'s Signature: _____

Date: _____

Patient's Name: _____

# Alexander Chiropractic
# Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental, and social well-being, not merely the absence of infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.
(please print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis. _____ ___ / ___ / ___
(signature) (date)

**Consent to evaluate and adjust a minor child**

I, _____, being the parent or legal guardian of _____

have fully read and understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ ___ / ___ / ___
(signature of Insured / Guardian) (date)



Dr.'s Signature: _____

Date: _____

Patient's Name: _____

# Alexander Chiropractic
# Financial Policies

## *Insurance Assignment Program*

It is our desire to assist our patients whenever possible. The following insurance assignment program allows you, our patient, to receive the care you need without undue financial strain.

1. We will bill your insurance company as a convenience for you. Waiting for insurance payment is a courtesy provided by this clinic. We reserve the right to withdraw this courtesy at any time.
2. All deductible amounts must be paid by you in the advance of the first billing. Also, you must stay current with your percentage of responsibility. This must be paid at least weekly. Prepayments may also be made.
3. Insurance carriers are billed on weekly cycles. It is your responsibility to supply this office with necessary forms to complete billing if needed.
4. If you discontinue your care for any reason other than discharge by the doctor, you will be responsible for any unpaid balance regardless of any claims submitted to your insurance company, at the time you discontinue care.
5. This clinic does not promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, it will be the patient's responsibility to pay all the charges and pursue reimbursement from the insurance company on his or her own. The insurance company has 30 days from the billing date to make this decision. Patient payment is expected on fees over 30 days.

## *Release Of Information And Assignment Of Benefits*

The undersigned hereby authorizes this chiropractic provider to release any and all personal information to his/her health insurance company(s), or other physicians or hospitals involved in the treatment of said patient(s), or to any other individuals relative to the health care providers operations. The undersigned does specifically authorize release of said information in accordance with the HIPAA Privacy Act. I also authorize payment directly to the chiropractic provider for all the chiropractic benefits, if any, otherwise payable to me for the services rendered by said chiropractic provider.

**ALL PATIENTS ARE RESPONSIBLE FOR FULL PAYMENT OF ACCOUNTS AT THE TIME SERVICES ARE RENDERED, UNLESS PRIOR ARRANGEMENTS ARE APPROVED.**

The undersigned understands that they are fully responsible for all charges associated with their treatment, including my insurance deductible, copayment, and any other services rejected by my insurance company. The undersigned further agrees that in the event that this account is placed for collection, that he/she will be responsible for all collection charges, including a reasonable attorney fee and interest. Outstanding balances will accrue interest at the rate of 1.5% per month.

Patient Name _____

Patient Signature _____ Date / /

Patient Rep. _____

Patient Rep. Signature _____ Date / /

_____

Description of Patient Rep.'s Authority to Act for the Patient (i.e., parent, guardian, etc)

Staff Member Signature _____



Dr.'s Signature: _____

Date: _____

# Alexander Chiropractic
# Privacy Notice Acknowledgement

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use of dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Alexander's Chiropractic's Notice of Privacy Practices for Protected Health Information

Patient Name _____ Date___ / ___ / ___

Patient Signature_____ Staff Member_____

Patient Rep. _____ Patient Rep. Signature_____

_____

Description of Patient Rep.'s Authority to Act for the Patient (i.e., parent, guardian, etc)

# Alexander Chiropractic
# Authorization Form

I authorize Alexander Chiropractic, LLC to use my name for the following:

| | | |
|---|---|---|
| Yes | No | Using my name to thank the person who referred me |
| Yes | No | Using my name on the "welcome as a new patient" board |

This notice is effective as of the date below and expires seven years from the date I last received service in this office.

Patient Name _____ Date___ / ___ / ___

Patient Signature_____ Staff Member_____

Patient Rep. _____ Patient Rep. Signature_____

_____

Description of Patient Rep.'s Authority to Act for the Patient (i.e., parent, guardian, etc)



Dr.'s Signature: _____

Date: _____

# Text Messaging Consent

Patient's Name: _____

Date of Birth: _____ (Must be aged 17 or over)

Mobile Tel. #: _____

I would like to receive text messages to the above mobile telephone from Alexander Chiropractic and understand that the content may include confirmation of an appointment or a reminder alert.

Should I wish to withdraw consent I accept that I must give at least 2 days' notice in writing or by phone quoting the above mobile number. I will advise Alexander Chiropractic if I change my mobile number and understand that a new consent form is required.
Text message appointment reminders will only be sent to the patient attending an appointment, not to the person making the appointment if different.

**I confirm that I understand the above statement and that I am the patient listed above. I understand that it is my responsibility to advise the Alexander Chiropractic to stop sending texts to the telephone number listed.**

Full Name: _____

Signature: _____

Date____ / ____ / ____

* I am aware that my cell service provider may charge additional fees if I do not have a text messaging feature on my phone plan. Text messages will be sent from (251) 210-7024. You may also text appointment requests and/or appointment changes to this number.

** Please **do not** call this number. It is to be used for text messages only.



Dr.'s Signature: _____

Date: _____

Patient's Name: _____

# Medicare Patients Only: Complete Pages 10 & 11

## Activities of Daily Living/Symptoms/Medications

### Daily Activities: Effects of Current Conditions on Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

| | | | | |
|---|---|---|---|---|
| **Bending** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Concentrating** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Doing Computer Work** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Gardening** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Playing Sports** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Recreation Activities** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Shoveling** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Sleeping** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Watching TV** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Carrying** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Dancing** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Dressing** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Lifting** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Pushing** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Rolling Over** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Sitting** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Standing** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Working** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Climbing** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Doing Chores** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Driving** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Performing Sexual Activity** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Reading** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Running** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Sitting to Standing** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| **Walking** | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |



Dr.'s Signature: _____

Date: _____

**Notifier: Alexander Chiropractic** **50 S. Greeno Rd. Suite 1A, Fairhope, AL 36532** **251.929.2095**

**Patient Name:** **Identification Number:**

# Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn't pay for the services listed below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the services listed below.

| Service | Reason Medicare May Not Pay: | Estimated Cost |
|---|---|---|
| Initial or Routine Exam | Medicare does not pay for this test for your condition. | $45.00 to $55.00 |
| One set of X-Rays | Medicare does not pay for this test for your condition. | $80.00 to $160.00 |

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the services listed above.
  **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**OPTIONS: Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

**Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

| **Signature:** | **Date_____ / _____ / _____** |
|---|---|