

**Ravenswood Chiropractic and Wellness Center**

DR TODD C RENN, P.C.

Patient Initials: \_\_\_\_\_

#: \_\_\_\_\_

**WHAT TO EXPECT.....**

**Paperwork & Consultation**...to help us get to know you, your lifestyle and health history to customize a care plan that is a solution to fit your life, health, financial, personal needs and wants.

**Examination**...is focused on identifying the CAUSE of the problem & how they influence your function, adaptability, health and lifestyle.

**Solutions**...We'll review your findings and present options for your care.

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**CONFIDENTIAL PATIENT INFORMATION**

Full Name \_\_\_\_\_ Social Security#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Sex: M F

Address \_\_\_\_\_ Apt.# \_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ @ \_\_\_\_\_ . \_\_\_\_\_

Cell # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Occupation \_\_\_\_\_

Single Divorced Widowed Employer \_\_\_\_\_

Married → Name of Spouse / Partner: \_\_\_\_\_ Employer: \_\_\_\_\_

In Case of Emergency, please contact: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

How did you hear about us?  Walk by  Did you view our Website? Y N  Physician \_\_\_\_\_

Internet Search → Google Bing Yahoo MSN Other search \_\_\_\_\_

AD in \_\_\_\_\_  Coupon for \_\_\_\_\_  Other \_\_\_\_\_

Friend  Family Member  Coworker → Who may we thank for referring you? \_\_\_\_\_

May the doctor speak orally or in writing to your health care provider or person who referred you regarding your case?  Yes  No Reason for Today's Visit \_\_\_\_\_

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**\*\*Please submit a copy of your: drivers license (or ID), insurance card(s), additional documents or any medical reports or imaging films that you may have.**

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**Paperwork**...Insurance claims are gladly filed by our office.

**We**...accept Cash, Check & Credit Card as forms of payment for any balances that may exist.

**Solutions**... We have numerous policies so that we can work with everyone's finances to accommodate your health care needs.

**Please indicate below which category your financial situation applies.**

**Health Insurance**

Policy Holder (if other than self): Spouse / Partner / Parent Name: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Medicare** OR  **Medicare with Supplemental Insurance**

**Self Pay**

Pay at the time of service (TOS) and receive a 35% discount off our services.

Take advantage of one of our pre-payment all inclusive visit package programs.

**Accident Information** Is condition due to an accident?  No  Yes, Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Auto Accident/Private Insurance** (Additional Information is needed)

**Worker's Compensation** (Additional Information is needed)

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**PURPOSE FOR YOUR VISIT...**

**PRIMARY COMPLAINT** (List only one): \_\_\_\_\_

How & When did you first experience this problem? \_\_\_\_\_

Please describe the location of the pain: \_\_\_\_\_

Does this problem cause the pain to travel to any other area?  No  Yes, where? \_\_\_\_\_

How often do you experience this problem?  daily/constant  \_\_\_\_\_ times per week

Is this problem getting:  worse?  better?  staying the same?

Does it interfere with your:  Work  Sleep  Daily Routine  Recreation  Other \_\_\_\_\_

Activities, movements that is painful to perform:  Sitting  Standing  Walking  Bending

Lying Down  Other \_\_\_\_\_

Have you seen any other doctors for this problem? No Yes, who? \_\_\_\_\_

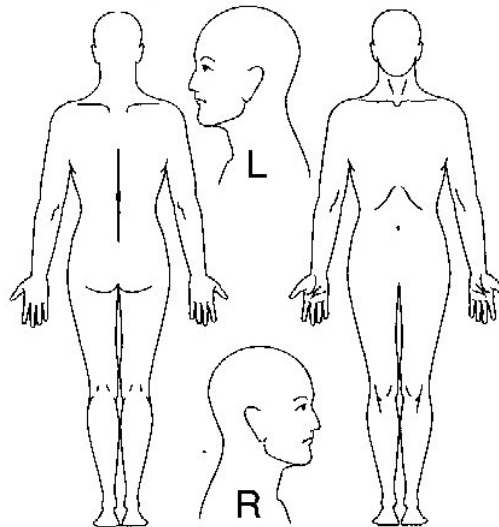
What treatment was given? \_\_\_\_\_ How effective was the care? \_\_\_\_\_

What else have you tried to relieve this problem ( treatments, aspirin, medications, surgery)?

Type of pain:  Sharp  Shooting  Burning  Throbbing  Dull  Aching  Cramps  Stiffness

Swelling  Numbness  Tingling  Other \_\_\_\_\_

Please indicate where the pain is occurring by drawing on the pictures to the right. →



Please circle the number which best describes your pain for each question below. ↓

Pain right <b>Now</b>	0	1	2	3	4	5	6	7	8	9	10
Pain at <b>Best</b>	0	1	2	3	4	5	6	7	8	9	10
Pain at <b>Worst</b>	0	1	2	3	4	5	6	7	8	9	10
<b>Average</b> Pain	0	1	2	3	4	5	6	7	8	9	10

*No Pain*

*Unbearable Pain*

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**SECONDARY COMPLAINT** (List only one): \_\_\_\_\_

How & When did you first experience this problem? \_\_\_\_\_

Please describe the location of the pain: \_\_\_\_\_

Does this problem cause the pain to travel to any other area?  No  Yes, where? \_\_\_\_\_

How often do you experience this problem?  daily/constant  \_\_\_\_\_ times per week

Is this problem getting:  worse?  better?  staying the same?

Does it interfere with your:  Work  Sleep  Daily Routine  Recreation  Other \_\_\_\_\_

Activities, movements that is painful to perform:  Sitting  Standing  Walking  Bending

Lying Down  Other \_\_\_\_\_

Have you seen any other doctors for this problem? No Yes, who? \_\_\_\_\_

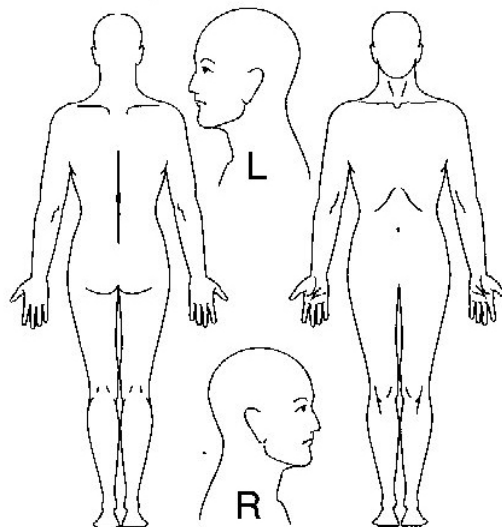
What treatment was given? \_\_\_\_\_ How effective was the care? \_\_\_\_\_

What else have you tried to relieve this problem ( treatments, aspirin, medications, surgery)? \_\_\_\_\_

Type of pain:  Sharp  Shooting  Burning  Throbbing  Dull  Aching  Cramps  Stiffness

Swelling  Numbness  Tingling  Other \_\_\_\_\_

Please indicate where the pain is occurring by drawing on the pictures to the right. →



Please circle the number which best describes your pain for each question below. ↓

Pain right <b><u>Now</u></b>	0	1	2	3	4	5	6	7	8	9	10
Pain at <b><u>Best</u></b>	0	1	2	3	4	5	6	7	8	9	10
Pain at <b><u>Worst</u></b>	0	1	2	3	4	5	6	7	8	9	10
<b><u>Average</u></b> Pain	0	1	2	3	4	5	6	7	8	9	10

*No Pain*

*Unbearable Pain*

**HEALTH HISTORY**

**Place an (X) in any box to indicate if you currently or have had in the past year any of the following:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Pneumonia            |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Polio                |
| <input type="checkbox"/> Allergy Shots       | <input type="checkbox"/> Gout                | <input type="checkbox"/> Pregnancy            |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Prostate Problem     |
| <input type="checkbox"/> Anorexia            | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Prosthesis           |
| <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Psychiatric Care     |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Herniated Disk      | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Bleeding Disorders  | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Scarlet Fever        |
| <input type="checkbox"/> Breast Lump         | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Suicide Attempt      |
| <input type="checkbox"/> Bulimia             | <input type="checkbox"/> Measles             | <input type="checkbox"/> Thyroid Problem      |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Migraine Headaches  | <input type="checkbox"/> Tonsillitis          |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Miscarriage         | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Tumors, Growths      |
| <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Typhoid Fever        |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Vaginal Infections   |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Whooping Cough       |
| <input type="checkbox"/> Fractures           | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Pinched Nerve       |   |

**INJURIES/SURGERIES you have had:**

Head Injuries \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_      Surgery \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  
 Broken Bones \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_      Surgery \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  
 Dislocations \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_      Falls \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_

**CURRENT LIFESTYLE HABITS:**

**Exercise:** Frequency: None \_\_\_\_\_ days/wk      Duration: \_\_\_\_\_ min per day  
 Type: Walking Running/Jogging Weight Lifting Swimming Biking Yoga/Pilates Other \_\_\_\_\_  
**Work:** Usual Activity: Sitting Standing Walking \_\_\_\_\_  
 Type: Light Labor Medium Heavy Labor \_\_\_\_\_  
**Habits:** Smoking: Packs/Day \_\_\_\_\_ Years \_\_\_\_\_      Alcohol: Drinks/Week \_\_\_\_\_  
Coffee/Caffeine Drinks: Cups/Day \_\_\_\_\_      High Stress Level: Reason: \_\_\_\_\_

<b>Medications</b>	<b>Reason For Taking</b>	<b>Allergies</b>	<b>Vitamins/Herbs/Minerals</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**FAMILY HEALTH HISTORY: Significant Illnesses**

Condition	Father	Mother	Sister	Brother		
Age:						
1						
2						
3						
4						
5						

**About Your Health**

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system and spine that can result in poor health. Following your exam, your chiropractor will outline a course care to begin to correct these layers of damage and to help you recover your inborn/innate health potential.

**About Your Care**

There are three phases of care that Chiropractic patients often go through. **The first...** is Initial Intensive Care which corrects the most recent layer of Spinal and Neurological damage (VSC Vertebral Subluxation Complex). This care often reduces or eliminates the symptoms. **Then...** begins Reconstructive Care which corrects the years of damage that occurred when there were few symptoms. And **Finally...** Chiropractic offers a genuine approach to Wellness Care. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your goals.

**Acknowledgements, Policies & Agreements**

**HIPAA Acknowledgement** \_\_\_\_\_ *initials*

I acknowledge that I have received a copy of Ravenswood Chiropractic & Wellness Center's (DR TODD C RENN, P.C.) Practice's Privacy Notice that has an effective date of March 1, 2006.

**Payment Expectation Policy** \_\_\_\_\_ *initials*

For insurance patients it is your responsibility to pay for any co-payments, deductibles, and co-insurance required by your insurance plan, as well as all services provided and not covered by your insurance plan (patient insurance portions). We are happy to provide any service(s) you need, however, if your insurance plan does not cover certain services, you will be responsible for payment. If we have not received payment from your insurance plan within 60 days after the date of service, or if the insurance plan has denied payment in part or in full, we reserve the right to defer the outstanding balance to you.

The above mentioned patient insurance portions and any self pay payments are expected at the time of service, as well as any prior balance you might owe. If balance cannot be paid in full,

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#: \_\_\_\_\_

other arrangements need to be made prior to service. We accept Cash, Check, Credit Card (Visa, MasterCard & Discover) in satisfaction of your obligation. We will bill outstanding balances to you monthly and payment is due upon receipt. Unpaid balances that are owed for more than 30 days will accrue at an interest rate of one and a half (1.5) percent per month.

I understand this policy has no expiration date. I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits that is applicable and otherwise payable to me. I authorize DR. TODD C. RENN, P.C. and its agents to submit all health insurance claims, for services rendered, to my insurance company. If for any reason my insurance company denies/rejects my claim I am fully responsible for the balance on the account. I authorize DR. TODD C. RENN, P.C. and its agents to release information from my medical chart that pertains to filing and providing adequate documentation for any insurance claim or collection of a debt. I agree to pay any and all collection costs (35%), attorney fees, and/or court costs, should they arise from an attempt to collect a debt. I hereby authorize DR. TODD C. RENN, P.C. (or a contracted 3rd party agent) to submit any and all credit discrepancies to any credit-reporting bureau and/or run a credit inquiry now or at any time I may owe money.

**MISSED/CANCELLED APPOINTMENTS** \_\_\_\_\_ *initials*

Every appointment is important. The practitioner has set aside that time to meet with you. If you cannot make a scheduled appointment, kindly call the office and give 24 hours notice - you may leave a message on our voice mail if you are calling after hours. If you do not give 24 hours notice, we reserve the right to apply a \$35 administrative cancellation fee for MASSAGE or ACUPUNCTURE appointments to your account. There is no charge for chiropractic appointments. I understand that I am responsible for payment of this fee and it is not covered by insurance

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PRINTED Name of Patient: \_\_\_\_\_

X \_\_\_\_\_ & Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Signature of Patient (or Guardian/Guarantor; or if Patient is a Minor)*

PRINTED Name of Guardian/Guarantor: \_\_\_\_\_

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**Consent For “Evaluation of Minor”**

I, \_\_\_\_\_ being the parent or legal guardian, hereby authorize DR TODD C. RENN, P.C. to examine \_\_\_\_\_.  
(Name of Minor)

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