

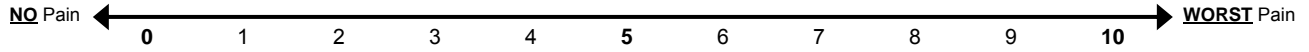


Name: \_\_\_\_\_

Date: \_\_\_\_\_

• REASON FOR YOUR VISIT •

In the spaces below, please indicate the symptom(s) you experience(d) that either prompted today's visit or are generally of concern to you (one per line). Indicate those symptoms that are more troublesome **first**. At the end of each line, please rate the severity of each of these symptoms according to the condition indicated at the top of each column. Please use the following scale to rate your symptoms (if you need additional space, please use the reverse side of this page):



1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

<i>AT BEST</i>	<i>ON AVERAGE</i>	<i>AT WORST</i>

Is your **MAIN condition** due to a(n):  Automobile Accident  Work Injury  Other Accident  Illness  Other / Unknown Cause

Date Symptoms Appeared (approximate if date unknown): \_\_\_\_\_ Did your symptoms appear:  Suddenly  Gradually

Are your symptoms:  Improving  Getting Worse  About the Same  Intermittent ("Come and Go")

**How often** do you experience your symptom(s)?  Constantly (100%)  Frequently (75%)  Intermittently (50%)  Occasionally (25%)  Rarely (≤10%)

Do Your Symptoms Radiate or Travel anywhere?: \_\_\_\_\_

What seems to **AGGRAVATE** your condition?: \_\_\_\_\_

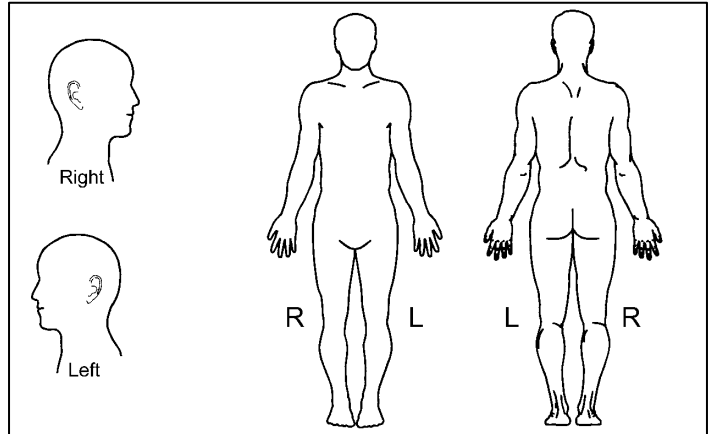
Is there anything that **EASES** your symptoms?  No  Yes (describe) \_\_\_\_\_

Do your symptoms **wake you up at night**?  No  Yes (describe) \_\_\_\_\_

Are your symptoms **worse during any particular time of day**?  No  Yes (describe) \_\_\_\_\_

On the diagram at the right, please outline the areas of your pain and/or discomfort. Use the following symbols, as applicable, to diagram areas of discomfort (you may also write in any other description that applies):

- A = Aching
- B = Burning
- C = Cold
- H = Hypersensitivity
- N = Numbness
- R = Throbbing
- S = Stabbing
- T = Tingling



Have you had **these or similar symptoms before**?  No  Yes → If "Yes," when? \_\_\_\_\_

Have you seen **another doctor for this condition**?  No  Yes, a medical physician  Yes, another chiropractor

Other doctor's name: \_\_\_\_\_ Date Consulted: \_\_\_\_\_ Were X-Rays Taken?  No  Yes

**Please List Anything Else That is of a Health Concern:**

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• All information is kept **STRICTLY CONFIDENTIAL**. Please complete as accurately as possible. •

Patient Name (Printed): \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Please check mark each of the conditions below that you are currently experiencing:

**MUSULOSKELETAL SYSTEM**

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

**GENITO-URINARY SYSTEM**

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

**FEMALE**

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps in the breast

**ARE YOU PREGNANT?**

- Yes
- No

**GASTRO-INTESTINAL SYSTEM**

- Poor appetite
- Excessive hunger
- Difficulty chewing
- Difficulty swallowing
- Excessive thirst
- Nausea
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

**NERVOUS SYSTEM**

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

**HABITS**

- Cigarettes
- Alcohol abuse
- Coffee or tea
- Exercise
- Drug abuse
- \_\_\_\_\_

**CARDIO VASCULAR RESPIRATORY**

- Chest pain
- Pain over heart
- Difficulty breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung Problems
- Varicose veins

**EYE, EAR, NOSE AND THROAT**

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficulty breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw pain

**Patient Accepted?**

- Yes
- No

**Doctors Signature:**

\_\_\_\_\_

**ALL STAR CHIROPRACTIC, PLLC  
AUTHORIZATION OF TREATMENT  
ASSIGNMENT OF INSURANCE BENEFITS  
FINANCIAL AGREEMENT**

Authorization must be signed by patient if age 18 or over or by a minor (under 18) emancipated or otherwise eligible pursuant to KRS 214.185 (See Consent Procedure); or by the parent or legal guardian for any other minor or by the patient's guardian if the patient is disabled.

PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_

1. I hereby consent to treatment by Robert A. Coppola, D.C, and/or Matt Kelly, D.C. believing that I am suffering from a condition requiring chiropractic treatment, and authorize such care and diagnostic procedures. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment of any condition.
2. I understand that no assurances or guarantees have been given by anyone concerning this treatment or the results that may be obtained.
3. I acknowledge that it has been explained to me the diagnostic and treatment procedures to be provided are limited to chiropractic treatment.
4. I hereby authorize treatments and/or procedures and the use of same or further medical study. I further authorize Robert A. Coppola, D.C., and/or Matt Kelly, D.C., to use his discretion in allowing persons to observe such treatment, testing or treatments in the furtherance of diagnostic research.
5. I hereby authorize ALL STAR CHIROPRACTIC, PLLC to release medical and any psychological information to third party payers.
6. I understand that charges will be made for treatment and the use of laboratory and diagnostic testing and any other services performed in accordance with the prescribed treatment plan all of which I agree to pay. I hereby assign all hospital insurance benefits, workers compensation benefits, personal injury protection benefits and any other insurance benefits that may arise to ALL STAR CHIROPRACTIC, PLLC. A photocopy of this authorization shall be considered as effective and valid as the original.
7. I understand that should the status of my account become delinquent, any charges resulting from the collection of said account are incurred by myself. I also understand and acknowledge that should my account become delinquent and sent to collections, a 30% fee will be assessed to your account to cover our collections fees.

\_\_\_\_\_  
PATIENT'S SIGNATURE (If minor, parent or guardian)

\_\_\_\_\_  
Witness



To all All-Star Chiropractic Patients:

All-Star Chiropractic is dedicated to providing you with the highest quality of healthcare services. To keep the registration process as smooth as possible, please be aware of the following guidelines:

- ❖ Please bring your medical insurance card with you if and when there has been any change or update to your health insurance policy. We will make a photocopy for our records and update your file.
- ❖ If your health insurance requires a co-payment to see a physician, it **MUST** be paid at the time of your appointment. If you cannot make the co-payment at the time of your appointment, we may ask that you please make arrangements with us ahead of time. Ask your doctor about long-term payment plans that are available for corrective Chiropractic care.
- ❖ If you are unable to keep a scheduled appointment in the future, please call at least 24 hours in advance to cancel the appointment so that someone else who needs to be seen can be scheduled in your place.
- ❖ For regular Chiropractic visits, we require a 24-hour notice to cancel an appointment. If a 24-hour notice is not received, the appointment must be made up during the current week, or a \$25.00 charge will be assessed to your account. For a visit that includes massage therapy, if a 24-hour notice to cancel an appointment is not received, your account will be charged \$50.00 for a 1-hour massage, and \$25.00 for a ½ hour massage. These charges for missed appointments are not covered by your insurance and must be paid at the time of your next visit. Massage therapy will **NOT** be prescribed if you are missing your appointments, and you will be financially responsible for massage charges. Your health insurance will only cover massage therapy if it is prescribed by the doctor.

Signing below acknowledges that you understand these guidelines and were given a copy of the NOTICE OF PRIVACY PRACTICES in accordance with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

Please ask to speak with the office administrator if you have any questions or concerns. Thank you very much for your cooperation.

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Patient Name (Print)

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Patient Signature (Parent or Legal Guardian, if patient is a minor)

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Date



Chiropractic & Rehabilitation  
X-Ray Release

I \_\_\_\_\_, do hereby give my consent to allow All Star Chiropractic and Rehabilitation and its representatives to take X-Rays as deemed appropriate by the examining doctor of chiropractic.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**FEMALES ONLY**

I hereby declare that to my knowledge, I am not pregnant.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date