Dr. Shawn A DeVary, DC
1121 North Saginaw St. Ste 2 Holly, MI 48442
Ph: (248) 328-9291

PATIENT INFORMATION

Patient Name: _____ **Today's Date:** _____

Email address: _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____

Address: _____

City/State/Zip: _____

Birth Date: _____ **Sex:** MALE FEMALE

Occupation: _____ **Employer:** _____

Can we send text messages to your Cell Phone for appointment reminders? Yes____ No____

How did you hear about us? (Check all that apply)

- ☐ Search Engine (Google, Bing, etc.)
- ☐ Customer Review Site
- ☐ Customer Testimonial
- ☐ Social Media
  - ☐ Facebook
  - ☐ Instagram
  - ☐ Tik Tok
  - ☐ YouTube
  - ☐ Twitter/X
- ☐ Internet Ad
- ☐ Website
- ☐ Email
- ☐ Newspaper/Online Newspaper
- ☐ Mail
- ☐ Brochure
- ☐ Word of Mouth
- ☐ Referral _____
- ☐ Other _____

I have received, read, and understand this information. I certify that the information I have provided to Well Adjusted Chiropractic is correct to the best of my knowledge. I will not hold my doctor or any staff member of Well-Adjusted Chiropractic responsible for any errors or omissions that I may have made in completion of these forms. I understand that it is my responsibility to notify the office if any of the provided information changes. Any charges incurred for text messages from Well Adjusted Chiropractic will be my responsibility. By signing below, I authorize consent to Well Adjusted Chiropractic to provide medical treatment.

Patient Printed Name: _____

Signature: _____ **Date:** _____

If Patient is Under 18 years of age

Parent/Guardian Signature: _____ **Date:** _____

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PATIENT ACKNOWLEDGMENT OF INSURANCE RESPONSIBILITY

This letter is intended to help you understand insurance costs. There are thousands of different insurance plans and contracts. **It is your responsibility to know the particulars of your insurance plan and coverage information.** You can find the following in your insurance handbook: what procedures your policy will or will not cover, what your deductible is and if you have met it, and what co-pays or co-insurances will be your responsibility after your deductible has been met. In preparation for your appointment, we do our best to verify your insurance eligibility and benefits and what costs may pertain to your visits. Every effort will be made by this office to have all services and procedures pre-authorized by your health insurance company, when applicable. Please note that a quote of benefits and/or authorization does not guarantee insurance payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of your contract with your insurance company at the time of service. **Please keep in mind that your insurance policy is a contract between you and your insurance company and not with our practice.** Health insurance companies will only pay for services that they determine to be "reasonable and necessary." If your health insurance company determines that a particular service is not "reasonable and necessary" or that a particular service is not covered under your plan, your insurer will deny payment for that service. If your insurance company does not pay for our services, you will be responsible for payment of the services provided to you by our clinic. **Any copays, deductibles, coinsurances, and non-covered services are your responsibility and must be paid in full at time of service.** We are happy to answer any questions you may have. For HMO Patients, it is your responsibility to be sure the required referrals from your primary care physician instructing your insurance carrier to pay for your medical claims is received by us prior to your appointment. As a courtesy to our patients, we will try to assist in all areas to obtain these pre-certifications and/or referrals.

INSURANCE INFORMATION/GUARANTOR

Primary Insurance: _____ **Policy#:**_____

Subscriber Name: _____ **Subscriber Birthdate:** _____

Relationship to Subscriber: SELF CHILD SPOUSE

Secondary Insurance: _____ **Policy#:**_____

Subscriber Name: _____ **Subscriber Birthdate:**_____

Relationship to Subscriber: SELF CHILD SPOUSE

Beneficiary Agreement: I understand that my health insurance company may deny payment for chiropractic services if they are not deemed reasonable and necessary. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make a payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies as well as any non-covered services and that all payments are due at time of service.

Patient Printed Name: _____

Signature: _____ **Date:** _____

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Parent/Guardian Signature: _____ **Date:** _____

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Email: devarychiropractic@yahoo.com

Website: www.DeVaryChiro.com

OFFICE POLICIES

MISSED APPOINTMENTS

There is no charge to any patient who calls to cancel an appointment with 24 hours notice. However, to have a scheduled appointment with time allotted for your care and not keep that scheduled appointment results in physician time that could be used to treat other patients. Therefore, canceling your appointment with less than 24-hour notice will result in a charge of $25.00. If you do not give any notification that you are not able to keep your scheduled appointment time, you will be charged a $50.00 no show fee.

I GIVE PERMISSION TO DISCUSS MY MEDICAL CARE AND/OR APPOINTMENTS WITH THE FOLLOWING:

Name: _____ **Phone:** _____

Name: _____ **Phone:** _____

Name: _____ **Phone:** _____

EMERGENCY CONTACT

Emergency Contact Name: _____

Phone Number: _____ **Relationship:** _____

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

I, the undersigned, acknowledge the receipt of the Notice of Privacy Practices. I understand that a copy of this office's Notice of Privacy Practices is available to take upon request.

Patient Printed Name: _____

Signature: _____ **Date:** _____

If Patient is Under 18 years of age

Parent/Guardian Signature: _____ **Date:** _____

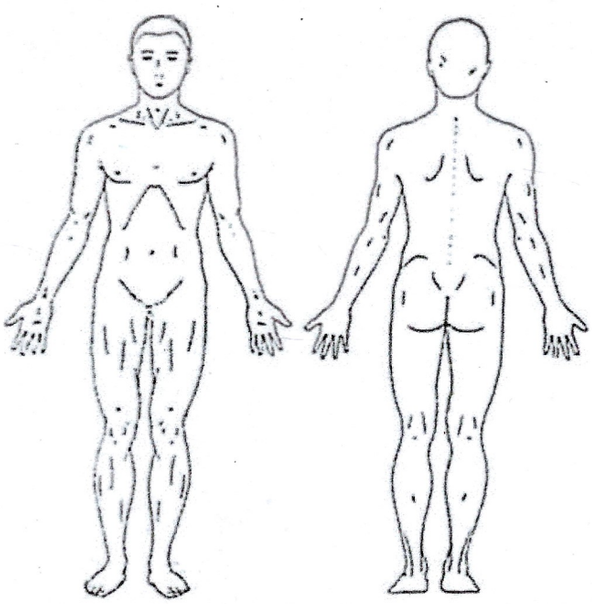
Patient Name: _____ **Today's Date:** _____

Patient Birth Date: _____

What is the cause of your current symptoms? _____

Date of Injury or Onset of Current Symptoms: _____

Mark an "X" on the body diagram where you have pain or other symptoms:



Use the scale below to rate your pain levels:

Primary Complaint: _____

Pain: 0 1 2 3 4 5 6 7 8 9 10

Is the pain/symptoms getting worse (circle all that apply)

YES NO COMES & GOES CONSTANT

Secondary Complaint: _____

Pain: 0 1 2 3 4 5 6 7 8 9 10

Is the pain/symptoms getting worse (circle all that apply)

YES NO COMES & GOES CONSTANT

Are your symptoms worse (check all that apply):

_____ Morning
_____ Mid-Day/Noon
_____ Evening
_____ All Day
_____ Other: _____

_____ While Sleeping
_____ After Activities
_____ During Activities

For Office Use Only	Temperature	Weight	Height	Pulse	Blood Pressure

Have you had this Primary or Secondary Complaint or Similar Complaint in the past? (circle one) Yes No

If "Yes," When: _____ **How often does this occur:** _____

What do your symptoms feel like (circle all that apply)?

Numb	Shooting	Tingling	Pounding	Sharp	Tightness	Prickling	Pins/Needles	Excruciating	Sore
Dull	Stabbing	Throbbing	Pulsating	Dead	Stiffness	Burning	Electric Shock	Crawling	Achy

Does your pain radiate/shoot and/or travel? (circle one) Yes No If "Yes," Where? _____

What aggravates this complaint (circle all that apply)?

Coughing	Sneezing	Bending	Carrying	Walking Uphill	Turning Head Left/Right	Looking Up/Down
Reclining	Driving	Stress	Sitting	Shoveling Snow	Emotional Upset	Climbing Stairs/ Ladder
Exercising	Lifting	Pulling	Pushing	Raking Leaves	Getting Out Of Bed	Straining At BM
Standing	Sleeping	Walking	Stooping	Snowmobiling	Getting In/Out of Vehicle	Repetitive Movements

Patient Name: _____ **Date:** _____

This questionnaire will give your provider information about your neck and back conditions that affect your everyday life.

OSWESTRY BACK INDEX		NECK INDEX	
Using the scales below, Mark your pain level from 0-10 (0 = no pain)		Using the scales below, Mark your pain level from 0-10 (0 = no pain)	
Pain Intensity:	0 2 4 6 8 10	Pain Intensity:	0 2 4 6 8 10
Standing:	0 2 4 6 8 10	Concentration:	0 2 4 6 8 10
Personal Care:	0 2 4 6 8 10	Personal Care:	0 2 4 6 8 10
Sleeping:	0 2 4 6 8 10	Work:	0 2 4 6 8 10
Lifting:	0 2 4 6 8 10	Driving:	0 2 4 6 8 10
Traveling:	0 2 4 6 8 10	Reading:	0 2 4 6 8 10
Walking:	0 2 4 6 8 10	Sleeping:	0 2 4 6 8 10
Social Life:	0 2 4 6 8 10	Headache:	0 2 4 6 8 10
Sitting:	0 2 4 6 8 10	Recreation:	0 2 4 6 8 10
Change Degree of Pain	0 2 4 6 8 10	Change Degree of Pain	0 2 4 6 8 10

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CPT CODES				DIAGNOSIS					
99202		72040		1					
99203		72070		2					
99212		72100		3					
99213		72082		4					
98940		72083		5					
98941		72084		NOTES					
98942									
97012		97112							
97110		97124							

Personal Health History

Patient Name: _____ **Today's Date:** _____

Are you currently under the care of a family doctor or any other doctor? **YES** **NO**

If yes, Doctor's Name? _____ Phone Number _____
What condition(s) are you being treated for: _____

Please Indicate all past and present medical health conditions for Self (S) and/or Family (F)

Aneurysm	S	F	Fibromyalgia	S	F	Sciatica	S	F
Arthritis	S	F	Heart Problems	S	F	Scoliosis	S	F
Asthma	S	F	Intestinal Problems	S	F	Shoulder Pain	S	F
Blood Clots	S	F	Low Back Pain	S	F	Tennis Elbow	S	F
Cancer	S	F	Migraines	S	F	TMJ	S	F
Disc Herniation	S	F	Neck Pain	S	F	Vertigo	S	F
Disc Pain	S	F	Pacemaker	S	F	Other _____		

Please list any/all past surgeries and injuries and provide dates.

Surgery/Injury	**Date**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any medications/supplements you currently take below OR CHECK I'll provide a list ____

Medication	**Dosage**	**Times Per Day**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History (circle answers)

Highest Level of Education	Not Completed High School Associate's Degree	GED or Equivalent Bachelor's Degree	HS Graduate Master's Degree Trade School Doctorate
Do You Eat a Well-Balanced Diet?	Never Rarely	Occasionally	Usually Regularly
Do You Exercise?	**NO**	**YES** Type of Exercise?_____ How Often?_____times per week for _____minutes	
Do You Drink Alcohol?	**NO**	**YES** _____# Drinks per **day/week/month** for _____#years	**Formerly** Quit Date_____
Do You Use Tobacco Products?	**NO**	**YES** _____# Packs per **day/week/month** for _____#years	**Formerly** Quit Date_____
Do You Vape (E-Cigarettes)?	**NO**	**YES** _____# Puffs per **day/week/month** for _____#years	**Formerly** Quit Date_____
Do You Use Recreational Drugs?	**NO**	**YES** _____# Times per **day/week/month** for _____#years **Circle all that apply:** Marijuana Cocaine Opioids Other	**Formerly** Quit Date_____