

PERSONAL INFORMATION

Date of First Visit _____

Name _____ Nickname _____
FIRST MIDDLE INITIAL LAST

Address _____ City _____ ST _____ Zip _____ Email _____

Age _____ Birthdate _____ - _____ - _____ Home Phone _____ Cell Phone _____

Occupation _____ Employer _____ Work Phone _____

Describe job duties _____

Single Married Spouse _____ Employer _____ # Children _____

In case of emergency contact _____ Relation _____ Phone _____

Referred by: Insurance Employer Web Site Yellow Pages Other _____

Attorney Doctor Patient Their Name _____

HEALTH HISTORY

Check any problems you have had:

- | | | | | |
|------------------------------------|-----------------------------------|-------------------------------------|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Ear Noises | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Kidney | <input type="checkbox"/> Bladder | <input type="checkbox"/> Colon | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Sinus | <input type="checkbox"/> Prostate | <input type="checkbox"/> Low Back | <input type="checkbox"/> Mid Back | <input type="checkbox"/> Upper Back |
| <input type="checkbox"/> Leg | <input type="checkbox"/> Neck | <input type="checkbox"/> Hip | <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> _____ |

Explain _____

Current medications and dosage: None 1. _____ 2. _____

3. _____ 4. _____ 5. _____

Surgical Operations and dates _____

Have you ever had any car accidents, falls, or serious injuries? No Yes Date _____

Describe _____

Any family history of back or neck problems? _____

Do you exercise regularly? No Yes Describe _____

Family Medical Doctor _____ Last physical exam _____ - _____ - _____ Results _____

Previous chiropractic care? No Yes Dr. _____ Last visit _____ - _____ - _____ X-rays? _____ Date _____

Minors: _____ **Females:** Are you pregnant or could you be? _____ Date Last cycle _____

PARENT/GUARDIAN SIGNATURE AUTHORIZING CARE

MAJOR COMPLAINT

Describe your main problem _____

What caused this _____ When did this episode start _____

Have you ever had any previous episodes of this problem? _____ When _____

Describe the pain: Sharp Dull Ache Numbness Cramp-like Localized
 Stabbing Deep Ache Tingling Throbbing Radiating to _____

Pain Level: 0 1 2 3 4 5 6 7 8 9 10 [0=none 10=severe] Level you *have* experienced with this _____ [0-10]

Percentage of the time you have pain: < 25% 25%-50% 50%-75% > 75% 100%

Has your problem been: Improving The Same Getting Worse **Work Days Missed:** _____

Is your pain worse: Morning Day Night **What makes the pain worse:** _____

What have you done to relieve this: Heat Ice Rest Medication Other _____

Circle any areas that are affected in your normal daily living:

Sleeping Lifting Recreation Walking Sitting Standing Concentration Working

Other doctors you have seen for this condition:

Name: _____ Date: _____ Diagnosis: _____ Treatment: _____

Name: _____ Date: _____ Diagnosis: _____ Treatment: _____

Do you have any comments or concerns of which we should be aware? _____

CONSENT FORMS

Privacy Notice Agreement

The Health Insurance Portability and Accountability Act (HIPAA) requires us to let you know how your Patient Health Information (PHI) is going to be used and your rights concerning those records. I agree to allow this office to use my PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. I have the right to examine and obtain a copy of my health records and request corrections. I can request to know what disclosures have been made and submit any future restrictions. All staff will take precautions to assure my records are not available to those who do not need them and I have a right to file a complaint with the office manager regarding any violations. I also understand there are some semi-private areas here where I may receive treatment.

X _____

Signature

Date

Financial and Insurance Agreement (check one box)

As a courtesy to our patients, we will verify benefits and process your claims and do whatever we can to see your carrier meets their obligation for payment. Your signature below authorizes us to release information necessary and assigns benefits to our office. In the unlikely event that your insurance carrier refuses to pay for treatment, you agree to be financially responsible for charges incurred.

- INSURANCE** For our insurance patients, only your co-pay and any deductible are due today.
 MEDICARE Medicare and any supplemental insurance will reimburse you, so today's visit will be due.
 MEDICAID Only your initial exam and a small co-pay will be due today.
 AUTO ACCIDENT No matter who was at fault, your auto insurance med-pay generally covers all health related services.
 WORK ACCIDENT Your employer's worker's compensation carrier will usually cover all claims.
 TIME OF SERVICE If you have no third-party payer, payment is due today, after services are rendered.

Payment or co-pay today will be: (check one box) Cash Check Visa MasterCard **Thank-you.**

X _____

Signature

Date

Date _____ Name _____

Mark the areas of the body where you feel pain or discomfort. Include all areas.

