Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION Today's Date: _________

Last Name: ________________________ First Name: __________________ Sex: ❑ Male ❑ Female

Date of Birth: ___________________ Age: _______ Social Security #:____________

Marital Status: ❑Married ❑Single ❑Divorced ❑Separated ❑Other __________

Address: _____________________________ City: _______________ State: ____ Zip: _________

Home Phone: _____________ Work Phone: ______________ Cell Phone: ______________

Email: ______________________ Occupation: ____________________ Employer: _______________

Name of Spouse or Nearest Relative: __________________________ Phone: _________________

Referred to this Office by: ❑Friend/Family Member - Name? ___________________________

❑Yellow Pages ❑ Mail ❑Clinic Location Other__________

Payment for Services will be by: ❑Self-Pay ❑Automobile Insurance ❑Worker's Compensation

❑Health Insurance (fill out information below)

Insurance Co.:__________________________ Policy ID #:__________________ Group#: __________

Insured's Name: ______________________ Insured's Date of Birth: ______________

Are you covered by more than one insurance company? ❑Yes ❑No Insurance: ________________

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	venereal disease

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition________________________________ Date of Last Physical Exam__________

SURGICAL HISTORY:

1.____ Date: _________________

2.____ Date: _________________

3.____ Date: _________________

Have you ever had a metal implant? ❑Yes ❑No Ever been gunshot? ❑Yes ❑No

ACCIDENT HISTORY:

❑Job ❑Auto ❑Other 1. ___________________________ Date: _________________

❑Job ❑Auto ❑Other 2.____________________________ Date: _________________

❑Job ❑Auto ❑Other 3.____________________________ Date: _________________

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Check the box and rate your symptoms on a scale of 1-10, with 10 being most painful.

❑ Headache ________	❑ Lt Shoulder Pain ________	❑ Rt Shoulder Pain ________
❑ Neck Pain ________	❑ Left Leg Pain ________	❑ Right Leg Pain ________
❑ Stiff Neck ________	❑ Left Hip Pain ________	❑ Right Hip Pain ________
❑ Low Back Pain________	❑ Left Knee Pain ________	❑ Right Knee Pain ________
❑ Mid Back Pain ________	❑ Left Arm Pain ________	❑ Right Arm Pain ________

❑ Other ____ ________

SYMPTOMS DEVELOPED FROM: ❑UNKNOWN CAUSE ❑GRADUAL ONSET ❑JOB RELATED INJURY
❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT ❑ILLNESS
DATE OCCURRED: ___________________ HOW OCCURRED? ____
____
SYMPTOMS HAVE PERSISTED FOR: ____HOUR(S) ____DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)
SYMPTOMS ARE WORSE IN: ❑MORNING ❑AFTERNOON ❑NIGHT
SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT
IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?
____ ____________________________
NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):
____
____
ARE YOU ALLERGIC TO ANY MEDICATIONS ❑NO ❑YES WHAT KIND?____________________________
ARE YOU TAKING ANY MEDICATIONS ❑NO ❑YES WHAT KIND?____________________________
ARE YOU PREGNANT ❑NO ❑YES DATE OF LAST MENSTRUAL PERIOD__________________

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:
❑BENDING ❑COUGHING ❑LIFTING ❑LYING DOWN ❑REACHING ❑SNEEZING ❑SITTING
❑STRAINING AT STOOL ❑STANDING ❑ TURNING HEAD ❑TWISTING ❑WALKING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:
❑BENDING ❑HEAT ❑ICE ❑LIFTING ❑LYING DOWN ❑MEDICATION ❑REACHING ❑RESTING
❑SITTING ❑STANDING ❑TURNING HEAD ❑WALKING

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:
❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss /confusion
❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever
❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of smell
❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 18%.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office. **"My signature below acknowledges that I have had an opportunity to view and/or receive a copy of the Provider's Notice of Privacy Practice"**

Patient's Signature: ___________________________________ Date: ______________________