

**PERSONAL INFORMATION**

Date of First Visit \_\_\_\_\_

Name \_\_\_\_\_ Nickname \_\_\_\_\_  
FIRST MIDDLE INITIAL LAST

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Home Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Cell Phone \_\_\_\_\_

Describe job duties \_\_\_\_\_ Work Phone \_\_\_\_\_

Single  Married Spouse \_\_\_\_\_ Employer \_\_\_\_\_ # Children \_\_\_\_\_

In case of emergency contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Referred by:  Insurance  Employer  Web Site  Yellow Pages  \_\_\_\_\_

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

↓ Continue on other side ↓

# 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:

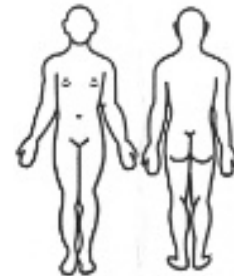
- Sleeping
- Lifting
- Recreation
- Walking
- Sitting
- Standing
- Concentration
- Working

Other doctors you have seen for this condition:

Names/Dates: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Treatment: \_\_\_\_\_

Mark your area of pain



Are there 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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Financial and Insurance Agreement

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 is 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 each visit will be due.
- AUTO ACCIDENT No matter who was at fault, your auto insurance med-pay generally covers all medical 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 after each visit as services are rendered.

Payment or co-pay today will be:  Cash  Check  Visa  MasterCard **Thank-you.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date