



Confidential Patient Information

Your First Name: MI Last Name: Male Female Date of Birth: Age: Social Security Number: last 4 digits:

Your Preferred Name? same Marital Status: Single Married Other Number of Children:

Insured First Name: MI Last Name: Male Female Date of Birth: Age: Social Security Number: last 4 digits:

Your Home Address: City: State: Zip:

Cellular Phone #: Work Home Phone #: E-mail Address: Your email will NOT be shared with any 3rd parties, and is used for general office announcements and promotions.

Employer Name: Your Job title/Occupation: Years employed:

Work Address: City: State: Zip:

If you have ever had a symptom in the past or if you are presently experiencing any of the following please check it in the list below.

- Neck Pain
- Shoulder Pain
- Pain in Upper Arm or Elbow
- Hand Pain
- Wrist Pain
- Upper Back Pain
- Lower Back Pain
- Pain in Upper Leg or Hip
- Pain in Lower Leg or Knee
- Pain in Ankle or Foot
- Jaw Pain
- Headache
- Swelling, Stiffness of Joint(s)
- High Blood Pressure
- Aortic Aneurysm
- Heart Attack (Date: _____)
- Stroke (Date: _____)
- Asthma
- Cancer, Explain _____
- Prostate Disorders, Explain _____
- Blood Disorder
- Emphysema (Chronic Lung Disorders)
- Arthritis
- Rheumatoid Arthritis
- Diabetes, Type: _____
- Fainting, Visual Disturbances, Dizziness
- Tinnitus (Ear Noises)
- Rapid Heart Beat Chest Pains
- Excessive Thirst
- Chronic Cough
- Chronic Sinusitis
- General Fatigue

women only:

S^{***} Abnormal Menstrual Flow: Irregular Profuse

Breast Soreness Lumps

Endometriosis

Pregnancy, # Births: _____

Birth Control Pills, Type: _____

Breast Augmentation

Continues...

Family Physician Name and Phone #?

Emergency Contact Name and Phone #?

Who may we thank for referring you?

- ... Continued
- Constant pain that does not improve by changing position or lying down.
 - Neck pain with difficulty swallowing.
 - Recent or current fever over 102°F.
 - Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
 - Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions.
 - Leg pain that worsens with exercise but is relieved by resting.
 - Recent major accident such as a fall from height, whiplash or blow to the head.
 - Back pain with urinary problems.
 - Severe pain that interrupts sleep.
 - Memory loss after injury.
 - History of compression fracture.

Family history

If a family member has had any of the following please mark the appropriate box and indicate which family member.

<input type="checkbox"/>	Arthritis	_____
<input type="checkbox"/>	Cancer	_____
<input type="checkbox"/>	Chronic headaches	_____
<input type="checkbox"/>	Chronic back pain	_____
<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	Epilepsy	_____
<input type="checkbox"/>	Heart disease	_____
<input type="checkbox"/>	High blood pressure	_____
<input type="checkbox"/>	Kidney disease	_____
<input type="checkbox"/>	Lupus	_____
<input type="checkbox"/>	Lung problems	_____
<input type="checkbox"/>	Osteoporosis	_____
<input type="checkbox"/>	Rheumatoid arthritis	_____
<input type="checkbox"/>	Other?	_____

Patient name: _____

How is your **overall health** right now? Excellent Very Good Good Fair Poor

How tall are you? _____' _____" What is your present weight? _____ lbs.

Do you sleep well? Yes No What are your normal **sleeping hours**? _____ to _____

Do you wear orthotics (shoe inserts)? Yes No If Yes, What kind and for what reason? _____

Are you currently under the care of a medical doctor or other type of health care provider for any condition?

No Yes → For what condition? _____

Name of doctor/specialist: _____ Phone number: _____

Who have you seen for current symptoms? No one Medical Doctor Other
 Chiropractor Physical Therapist

What treatment did you receive and when? _____

What tests have you had for your symptoms and when were they performed?

X-rays, date: _____ MRI, date: _____

CT scan, date: _____ Other, date: _____

Have you ever had an **overnight stay in a hospital** or a **surgical procedure** of any kind?

No Yes → If yes, please describe the event below:

Event _____ Year _____

Event _____ Year _____

Are you currently taking any **prescription medication**?

No Yes → 1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please check any of the following that apply to you: Past Present

Alcohol – Drinks per week: _____
Tobacco – Packs per Day _____ Years _____
Coffee/Tea/Caffeinated Soft drinks:
cups/cans per day: _____

Please list your reason(s) for this visit in the order of importance below.

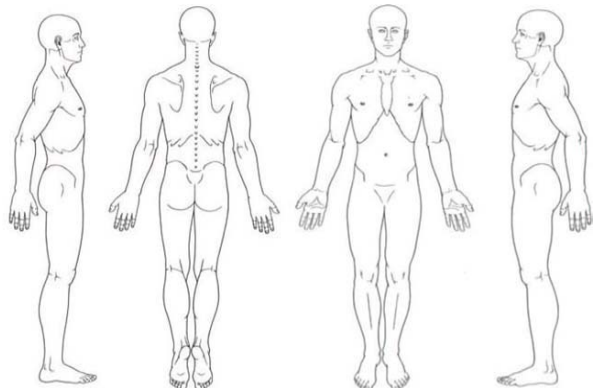
#1 _____ Date you first noticed: _____

#2 _____ Date you first noticed: _____

#3 _____ Date you first noticed: _____

Please **mark on the picture** where your current symptoms are located.

Note anything you would like to add regarding your symptoms here:



Problem #1:

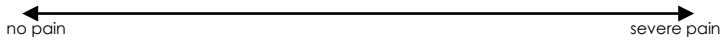
Location of pain: Right side Left side Both sides

During what **time of the day** does this feel **worse**? _____

Does the **pain radiate** to different areas? Yes No

If yes, where to: _____

How severe is the pain? (Please mark on the line below)



During a normal day **how frequently** do you experience the pain/problem?

0 – 25 % of the time 25 – 50 % of the time

50 – 75 % of the time 75 – 100 % of the time

What makes the pain **worse**? _____

What **relieves** the pain? _____

Please explain **how** this problem happened:

- Developed over time
- Illness
- Injury
- Auto Accident
- Other
- I don't know

Explain:

Problem #2:

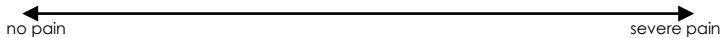
Location of pain: Right side Left side Both sides

During what **time of the day** does this feel **worse**? _____

Does the pain **radiate** to different areas? Yes No

If yes, where to: _____

How severe is the pain? (Please mark on the line below)



During a normal day **how frequently** do you experience the pain/problem?

0 – 25 % of the time 25 – 50 % of the time

50 – 75 % of the time 75 – 100 % of the time

What makes the pain **worse**? _____

What **relieves** the pain? _____

Please explain **how** this problem happened:

- Developed over time
- Illness
- Injury
- Auto Accident
- Other
- I don't know

Explain:

Problem #3:

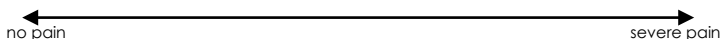
Location of pain: Right side Left side Both sides

During what **time of the day** does this feel **worse**? _____

Does the pain **radiate** to different areas? Yes No

If yes, where to: _____

How severe is the pain? (Please mark on the line below)



During a normal day **how frequently** do you experience the pain/problem?

0 – 25 % of the time 25 – 50 % of the time

50 – 75 % of the time 75 – 100 % of the time

What makes the pain **worse**? SSS _____

What **relieves** the pain? _____

Please explain **how** this problem happened:

- Developed over time
- Illness
- Injury
- Auto Accident
- Other
- I don't know

Explain:

Patient name: _____

Patient Authorization ~ Signature Page

Release of information & Payment Guarantee

I certify that the above information is true and correct to the best of my knowledge. I agree to notify the Doctor immediately whenever I have a change in my health condition.

I consent to the release of my confidential medical and patient information in the possession of my treating Doctor to other health care professionals to whom I am referred and to the insurance company or other entity responsible for payment for all or portion of my care.

I authorize the Doctor and his/her staff to perform any services needed during diagnosis and treatment and I authorize payment of insurance benefits to the Doctor for services rendered.

Our policy requires payment for services rendered at the time of visit unless other arrangements have been made with the office manager.

I agree to pay 1½ % interest per month on any overdue balances. I understand that I am ultimately liable for all charges for services rendered.

Please note that we reserve the right to charge for appointments missed or cancelled without 24 hours advance notice.

The signature below certifies that I have read and understand the above information.

Initial: _____

Informed Consent

You have a right as a patient to be informed about your condition and the recommended chiropractic and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I have read this document in its entirety and understand the potential benefits and risks of the care which you are recommended. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

Chiropractic manipulation. As with any healthcare procedure, I understand that there are certain complications, although rare, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare".

Patient's Consent. I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy, on me by the treating Doctor.

The signature below certifies that I have read and understand the above information.

Initial: _____

HIPAA Patient's Statement of Privacy Rights - Acknowledgement of Receipt

I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with the law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this office.

The signature below certifies that I have read and understand the above information.

Initial: _____

Patient or Guardian Signature:

Date: