

Chiropractic Patient Information

Welcome to Good Health - Naturally

ABOUT YOU

Date ____/____/____

Name _____ What do you prefer to be called: _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Cell Phone _____ Fax _____

Email Address _____ M F Marital Status: M S W D

Age _____ Birth Date _____ SS# _____

EMPLOYER(S)

Occupation _____ Employer _____

Employer's Address _____ Office Phone _____

FAMILY Family Medical Doctor _____ Location _____

Spouse's Name _____ Birth Date _____ Health **Good Fair Poor**

Children's Name(s) _____ Age(s) _____

Name of Nearest Relative _____ Address _____ Phone _____

INSURANCE – Please provide a copy of your driver's license and insurance card(s) so that we may obtain your insurance ID information and the claims address & phone number.

REFERRAL? Who may we thank for referring you to our office? Patient Referral (indicate name) _____

Yellow Pages / Newspaper / Another Physician _____ Other _____

Cancellation Policy: A 24-hour notice is required to avoid being charged for your appointment. The fee amount is determined by the type of appointment.

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.

Patient Health Information Consent: We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used, and I agree to these policies and procedures.

Patient or Guardian (if minor) Signature _____

1. Please Describe Your Major Complaint(s) _____

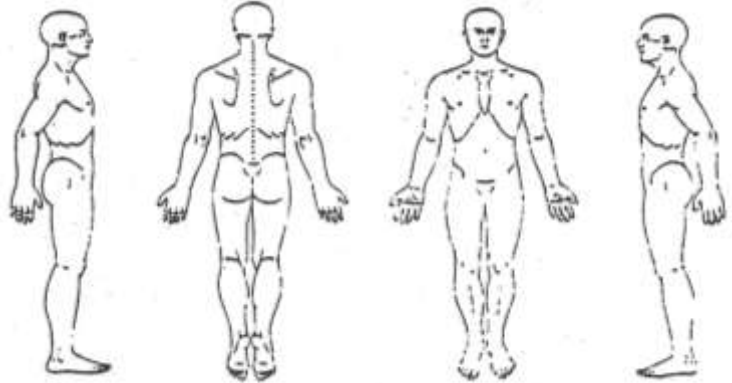
a. Description:

- Sharp Pain
- Dull Pain
- Ache
- Weak
- Throbbing
- Numb
- Shooting
- Gripping
- Burning
- Tingling

b. Frequency:

- Constant (76-100%)
- Frequent (51-75%)
- Occasional (26-50%)
- Intermittent (25% or less)

—————▶
**MARK ON THE PICTURE
 WHERE YOU HAVE PAIN
 OR OTHER SYMPTOMS**



c. Indicate intensity of your pain at its lowest and highest level. No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

d. Your symptoms are decreasing not changing increasing

e. Symptoms are worse in the morning afternoon night increases during the day same all day

2. When did your problem begin: (SPECIFIC DATE IF POSSIBLE) _____ Describe how your problem began: _____

3. Do you have any type of brace / support? Back Arch Heel Lifts Prothesis

4. Have you been treated for this episode? Yes No

If yes, by whom? Chiropractor MD Physical Therapist Other _____

Are you currently being seen? Yes No

When and what treatment? ___ / ___ / ___ _____

Name & City of your Physician _____

5. In the past, have you been treated for the same or a similar problem? Yes No

If yes, by whom? Chiropractor MD Physical Therapist Other _____

When and what treatment did you receive? _____

Last spinal exam and/or x-rays: _____ months / years ago (or date)

6. What makes your problem better? Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity

7. What makes your problem worse? Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity

8. How would you rate your general stress level? Little or no stress Minimal stress Moderate Stress Greatly stressed

Why? _____

9. General Physical Activity: No regular exercise program Light exercise Moderate exercise Strenuous exercise program

Describe: _____

10. Are your complaints affecting your ability to be active?

- No effect
- Need limited assistance with common everyday tasks
- Have a significant inability to function without assistance
- Some physical restrictions (able to perform light duty work and household tasks)
- Need assistance often
- Am totally disabled (impaired) - Cannot care for self

Describe: _____

11. Occupation: _____ FT PT Has your work status changed because of this complaint? Yes No

12. Physical activity at work: Sitting more than 50% of workday Light manual labor Manual labor Heavy manual labor Repeated motion

Describe physical duties: _____

13. What is your current work status?

- Full time, no restrictions
- Full time, with restrictions
- Part time, no restrictions
- Part time, with restrictions
- Off work due to restrictions
- Full time homemaker
- Unemployed
- Retired
- Full time student
- Other: _____

If you have ever had a listed condition in the past, please check it in the Past column. If you are presently troubled by a particular condition, check it in the Present column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain
<input type="checkbox"/>	<input type="checkbox"/>	Swelling/Stiffness of Joint(s)
<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ear Noises)
<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Breast Soreness/Lumps
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control
<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/irregular bowel habits
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/>	Depression

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Angina
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Tumor
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (chronic lung disorders)
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Liver / Gallbladder problems
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders (by condition)
<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

If a family member has had any of the following, please mark the appropriate box: (and indicate relationship)

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Lupus
<input type="checkbox"/> Chronic Back Problems	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> Cancer
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Other Conditions
<input type="checkbox"/> Lung Problems	

Yes **No** Do you have a permanent disability rating?
 Location _____
 Date rating received ____/____/____
 Rating Percentage _____%

Please check any of the following that apply to you

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>	Hormonal/Estrogen Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Medications (also list purpose of each)

<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations / Surgical Procedures (entire life) Describe & provide dates _____

<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones (& how) _____

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco (quantity per day) _____
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol (frequency: _____)
<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Caffeinated Soft drinks: Quantity per day _____

Present: Weight ____ pounds **Height** ____ feet ____ inches

History of Past Injuries:

<input type="checkbox"/> Car Accident(s)	Date(s) _____
<input type="checkbox"/> Work Injuries	Date(s) _____
<input type="checkbox"/> Sports Injuries	Date(s) _____
<input type="checkbox"/> Slips & Falls	Date(s) _____
<input type="checkbox"/> Other	Date(s) & Describe _____

PATIENT SIGNATURE _____ DATE _____

Doctor's Additional Comments/General Health Concerns:

Trauma: _____

Vitamins: _____

Mattress: C/UN Age: _____ Sleeps on: _____ Quality of sleep: _____ # of pillows _____

Additional Info: _____
