Welcome

OPTIMAL HEALTH THROUGH CHIROPRACTIC CARE

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns do not hesitate to ask for assistance. We are happy to help. (Please Print)

Name_____ D.O.B___/___/___ Date: ___/___/___
First Middle Last

Address: _____ City _____ Zip_____
Sex: □Male □ Female Marital Status / or Minor _____ # of children _____
Home Phone # _____ Work # _____ Cell # _____
We do text message appointment reminders and need the name of your carrier: _____
Do you require interpretive services? □ Yes □ No What is your primary language? _____
E-mail_____ May we contact you via email? □ Yes □ No
Occupation _____ Employer _____
Business Address (City) _____
Spouse or Parent's _____ Primary Care Doctor's Name _____
Whom may we thank for referring you to our office _____
Person to contact in case of emergency _____Phone # _____

Responsible Party or (Primary Name on the Insurance Card)

Name of person who is responsible for this account? _____
Relationship to patient _____
D.O.B ____/____/____ Group ID # _____Insurance Company_____
Member ID # _____

Primary Complaint - How did this complaint start? _____

Where specifically is the problem located? _____
When did you first notice the symptoms? _____Is it progressively getting worse? _____
What makes it better? _____ worse? _____
Does the pain radiate or travel to another area? YES / NO if yes, where: _____
Type of Pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Stiffness □Swelling □ Other
Rate the severity of your pain. (1 is mild pain to 10 severe pain): 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go? _____
Have you been seen by anyone else for this condition? _____
If so, what was the Doctor's name and City of practice? _____

Secondary Complaint - How did this complaint start? _____

Where specifically is the problem located? _____
When did you first notice the symptoms? _____Is it progressively getting worse? _____
What makes it better? _____ worse? _____
Does the pain radiate or travel to another area? YES / NO if yes, where: _____
Type of Pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Stiffness □Swelling □ Other
Rate the severity of your pain. (1 is mild pain to 10 severe pain): 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go? _____
Have you been seen by anyone else for this condition? _____
If so, what was the Doctor's name and City of practice? _____

Health History

Only check those that are applicable:

_____AIDS/HIV	_____Cataracts	____Hepatitis	_____Osteoporosis
_____Anemia	_____Diabetes	____Hernia	_____Pacemaker
_____Appendicitis	_____Emphysema	____Herniated Disc	_____Parkinson's Disease
_____Arthritis	_____Epilepsy	____High Cholesterol	_____Pneumonia
_____Asthma	_____Fractures	____Kidney Disease	_____ Rheumatoid Arthritis
_____Cancer	_____Glaucoma	____Liver Disease	_____ Stroke
_____Gout	_____Heart Disease	_____Tumors	_____Migraine Headaches
_____Any type of Headache		_____Ulcers	_____ Multiple Sclerosis

_____Other _____

Date of Last Exams _____

List any type of surgeries had and the dates, which they occurred:

_____

Known Allergies: _____

Auto Accidents (please list from most recent dates): _____

_____

Daily Habits

What type of exercise do you perform on a daily basis? □ None □ Moderate □Heavy

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

How many glasses of water do you drink a day? _____

Do you smoke? □ Yes □ No

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing the most accurate information is important to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or to my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group benefits otherwise payable to me. I understand that my chiropractic insurance may cover less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

SIGNATURE OF PATIENT (OR PARENT IF MINOR) DATE

CONFIDENTIAL

The patient allows this chiropractic office to use their patient's health information for the purposes of payment, health care 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 a more detailed account of our policies and procedures concerning the privacy of your health information, we encourage you to read the HIPPA 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.