CONFIDENTIAL PATIENT INFORMATION

Name:_____ SSN:_____-_____-_____ Date:_____

Address:_____ City:_____ State: _____ Zip:_____

Home Phone:_____ Cell Phone: _____ Birth Date:_____ Age:____ Marital S M W D

Employer:_____ Occupation:_____

Address:_____ Phone:_____

Spouse's Name:_____Birth Date:_____SSN:_____-_____-_____

Employer:_____ Phone:_____

Email: _____ May we send you our newsletter? ☐ Yes ☐ No

How did you hear about our office:_____

HEALTH HISTORY

Purpose of Appointment (Major Complaint):_____

Explain what happened:_____

Date symptoms appeared:_____ Have you ever had the same or similar symptoms? ☐ Yes ☐ No

If yes, when and describe: _____

Is current condition: ☐ Job related ☐ Auto accident ☐ Other:_____

Other doctors seen for this condition: _____

Do you have any other health conditions at this time? ☐ Yes ☐ No If yes, describe: _____

Females only: When was your last period? _____ Are you pregnant now? ☐ Yes ☐ No ☐ Not Sure

Check all of the following which apply to you:

☐ Headache	☐ Shoulder Pain	☐R ☐L	☐ Dizziness	☐ Chest Pain	☐ Cold Sweats
☐ Neck Pain	☐ Arm/hand Pain	☐R ☐L	☐ Sleeping Problems	☐ Loss of Smell	☐ Cold Hands
☐ Mid-back Pain	☐ Hip/leg Pain	☐R ☐L	☐ Nervousness	☐ Loss of Taste	☐ Cold Feet
☐ Low-back Pain	☐ Arm Numbness	☐R ☐L	☐ Ringing in ears	☐ Diarrhea	☐ Face Flushed
☐ Jaw Pain	☐ Leg Numbness	☐R ☐L	☐ Memory Loss	☐ Constipation	☐Fainting Spells

Symptoms other than above: _____

Check all of the following items that apply to your condition:

☐ Dull Pain ☐ Sharp Pain ☐ Constant Pain ☐ Pain off & on ☐ Worse in Morning ☐ Worse in Evening

Worse with: ☐ Sitting ☐ Laying ☐ Standing ☐ Driving ☐ Lifting Heavy Objects ☐ Other: _____

PAST HEALTH HISTORY

Surgeries: _____Broken Bones: _____

Serious Illness/conditions: (heart disease/attack, stroke, cancer, diabetes, high blood pressure, lung disease, epilepsy)

Other:_____ Serious Illness/Disease in Family? _____

Prior Accidents or Injuries: (Date and type of injury) 1. _____ 2. _____

Previous Chiropractic Care: ☐ Yes ☐ No Doctor's name and last visit date: _____

Allergies:_____ Do You Exercise? Y/N Times Per Week_____

Do You: Smoke? Y/N How Much?_____ How long?____ Alcohol? Y/N How Much?_____

List your medications: _____

INSURANCE INFORMATION (please allow us to photocopy your card)

Who is responsible for your bill? Myself and ☐ Spouse ☐ Auto Insurance ☐ Personal Insurance ☐ Medicare

Health Ins. Co. Name: _____ Phone: _____ Group #:_____

Insured Name:_____ Insured ID#:_____Date of Birth _____

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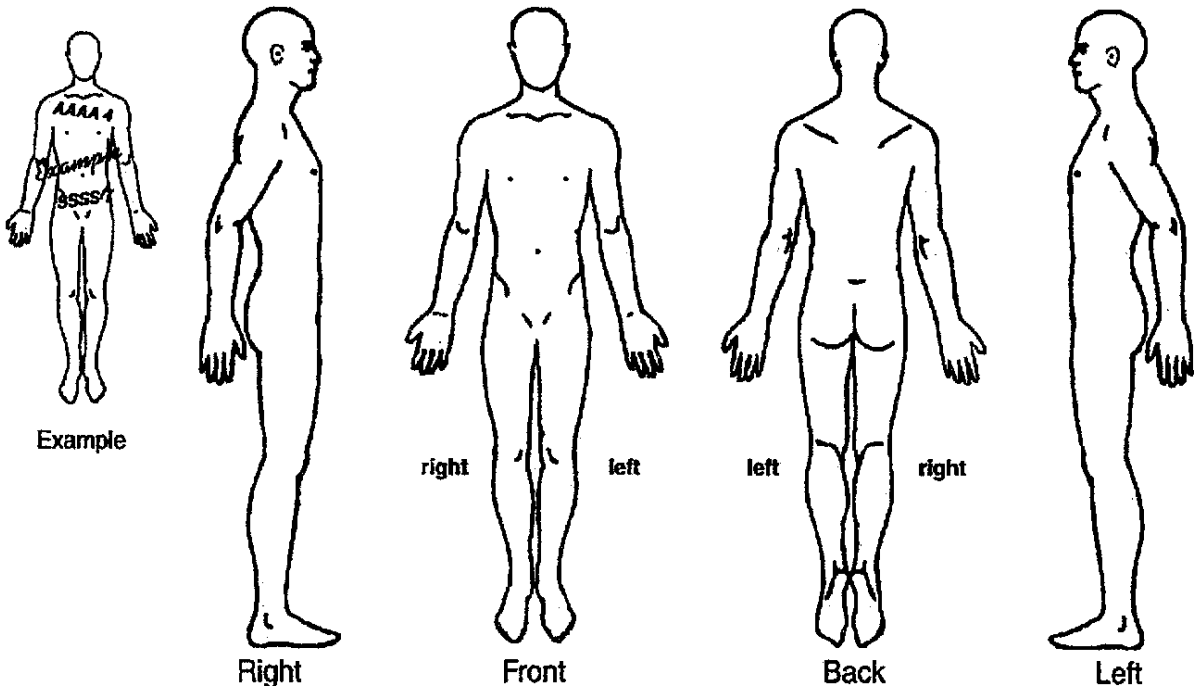
Pain Chart

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

○ Circle any area of pain not represented by a symbol.



Financial Policy

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. I also authorize my insurance company to make payment directly to this office. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. If this account is assigned for collection and/or suit, collection costs and/or interest, and/or attorney fees, and/or court costs will be added to the total amount due.

I have read the office financial policy, and agree to abide by its terms.

Patient/Guardian Signature: _____Date:_____

AUTHORIZATION FOR TREATMENT, MEDICAL RELEASE, AND INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various physical therapy modalities and x-rays on me by the doctor of chiropractic and/or other licenced doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic and/or other office personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature: _____Date:_____