Patient Information Form

PATIENT INFORMATION

Date _____

Patients Name _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Seperated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone _____

Spouse's Name _____

Birthdate _____

Would you like text message reminders of your appointments?

☐ Yes ☐ No

AUTHORIZATION & 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 payers 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. NSF Fee of $50.00 for any returned check. A no-show will be charged a fee for that days service.

The patient understands and agrees to allow this chiropractic office to use their Patient Health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information will 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 Patient Health Information we encourage you to read the HIPAA notice that is available at the front desk before signing this consent form. If there is anyone that you do not want to receive your medical records, please inform the office.

Patients Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

PHONE NUMBERS

Home Phone (___) _____ Cell Phone (___) _____

IN CASE OF EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone (___) _____ Work Phone (___) _____

WORK ACTIVITY

☐ Sitting

☐ Standing

☐ Light Labor

☐ Heavy Labor

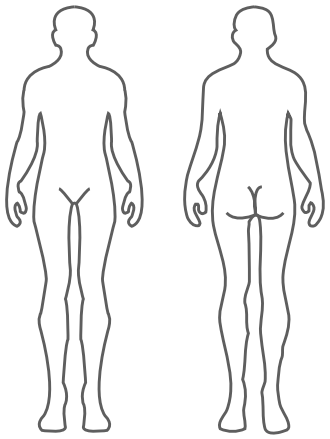
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progessively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the image where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ Other ☐ None

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Pacemaker
☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Polio
☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Hardening of the Arteries	☐ Yes ☐ No	Pinched Nerve
☐ Yes ☐ No	Auto Accident	☐ Yes ☐ No	Heart Condition	☐ Yes ☐ No	Parkinson's Disease
☐ Yes ☐ No	Bleeding Disorders	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pneumonia
☐ Yes ☐ No	Blood Clots	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Prostate Problem
☐ Yes ☐ No	Breast Lump	☐ Yes ☐ No	Herniated Disc	☐ Yes ☐ No	Prosthesis
☐ Yes ☐ No	Breast Removal	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Psychiatric Care
☐ Yes ☐ No	Bronchitis	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Rheumatoid Arthritis
☐ Yes ☐ No	Cancer	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Sinus Issues
☐ Yes ☐ No	Cataracts	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Stroke
☐ Yes ☐ No	Carotid Artery Surgery	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Suicide Attempt
☐ Yes ☐ No	Concussion	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Thyroid Problems
☐ Yes ☐ No	Detached Retina	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	TMJ
☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Tumors, Growths
☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Ulcers
☐ Yes ☐ No	Fibromyalgia	☐ Yes ☐ No	Neuropathy	☐ Yes ☐ No	Vaginal Infections
☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Osteoporosis		

Are you Pregnant? ☐ Yes ☐ No If yes, How far along? _____ Due Date: _____

Injuries

Joint Replacements _____ _____

Broken/Fractured/Dislocated _____ _____

Surgeries

	R/L	R/L	R/L	R/L	R/L
☐ Spinal	☐ Gallbladder	☐ Shoulder	☐ Knee	☐ Elbow	☐ Wrist	☐ Ankle

MEDICATIONS

ALLERGIES

VITAMINS/MINERALS