PERSONAL INFORMATION

NAME: _____AGE: _____DATE OF BIRTH: ____/____/____

ADDRESS: _____ PHONE: (_____)_____

CITY: _____STATE: _____ZIP: _____SS#:_____-_____-_____

MARRIED:YES____NO_____ NUMBER OF CHILDREN (if applicable): _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____STATE:_____ ZIP:_____

OCCUPATION: _____ OFFICE PHONE: _____

SPOUSE'S NAME: _____ BIRTH DATE:___/___/____SS#: _____

IN CASE OF EMERGENCY, NOTIFY (other than spouse): _____

ADDRESS: _____ STATE:_____ ZIP:_____

PHONE: _____RELATIONSHIP: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE: _____

WHAT BROUGHT YOU TO OUR OFFICE:_____

NAME OF MEDICAL DOCTOR: _____ PHONE: _____

ADDRESS: _____ STATE:_____ ZIP:_____

The following points are important that you read and agree to in order for you to become a patient at our clinic.

- All services rendered will be considered cash until your insurance is verified.
- If you are unable to keep your appointment, we require that you call ahead to cancel so that someone else, if needed, can be put in your appointed time.
- Payment for services rendered that day are due before you leave unless other financial arrangements have been made.

By signing this, I acknowledge that I have read and agree to the above office policies.

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature: _____Date: _____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign the consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at anytime for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosures of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Printed Name Authorized Provider Signature

_____ _____

Signature Date

Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactory, we will not accept your case. Thank you.

Name_____ Date_____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case.

THIS IS A CONFIDENTIAL HEALTH REPORT.

O - Occasional
F - Frequent
C – Constant

O F C

GENERAL

☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Fever
☐ ☐ ☐ Headache
☐ ☐ ☐ Loss of Sleep
☐ ☐ ☐ Loss of Weight
☐ ☐ ☐ Nervousness
☐ ☐ ☐ Sweats
☐ ☐ ☐ Tremors

MUSCLE & JOINT

☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Hernia
☐ ☐ ☐ Low Back Pain
☐ ☐ ☐ Neck Pain/Stiffness
☐ ☐ ☐ Pain between shoulders

Pain or Numbness in:

☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Hands
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet
☐ ☐ ☐ Painful Tail Bone
☐ ☐ ☐ Poor Posture
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Spinal Curvature
☐ ☐ ☐ Swollen Joints

O F C

GASTRO-INTESTINAL

☐ ☐ ☐ Belching/Gas
☐ ☐ ☐ Colitis
☐ ☐ ☐ Colon Trouble
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Difficult Digesting
☐ ☐ ☐ Excessive Hunger
☐ ☐ ☐ Gall Bladder Trouble
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Liver Trouble
☐ ☐ ☐ Nausea
☐ ☐ ☐ Pain over Stomach
☐ ☐ ☐ Poor Appetite
☐ ☐ ☐ Vomiting

EYES, EARS, NOSE, & THROAT

☐ ☐ ☐ Asthma
☐ ☐ ☐ Colds
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear Infections
☐ ☐ ☐ Ringing in ears
☐ ☐ ☐ Enlarged Glands
☐ ☐ ☐ Enlarged Thyroid
☐ ☐ ☐ Eye Pain
☐ ☐ ☐ Failing Vision
☐ ☐ ☐ Gum Trouble
☐ ☐ ☐ Nasal Obstruction
☐ ☐ ☐ Nosebleeds
☐ ☐ ☐ Sinus Infections
☐ ☐ ☐ Sore Throat
☐ ☐ ☐ Tonsillitis

O F C

CARDIOVASCULAR

☐ ☐ ☐ Hardening of arteries
☐ ☐ ☐ High Blood Pressure
☐ ☐ ☐ Low Blood Pressure
☐ ☐ ☐ Pain over heart
☐ ☐ ☐ Poor circulation
☐ ☐ ☐ Rapid Heart Beat
☐ ☐ ☐ Slow Heart Beat
☐ ☐ ☐ Swelling of ankles

RESPIRATORY

☐ ☐ ☐ Chest Pain
☐ ☐ ☐ Chronic cough
☐ ☐ ☐ Difficult breathing
☐ ☐ ☐ Spitting up blood
☐ ☐ ☐ Wheezing

SKIN

☐ ☐ ☐ Boils
☐ ☐ ☐ Bruise easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Hives or allergies
☐ ☐ ☐ Itching

GENITO-URINARY

☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Blood in Urine
☐ ☐ ☐ Frequent Urination
☐ ☐ ☐ Loss of Kidney Control
☐ ☐ ☐ Kidney Stones
☐ ☐ ☐ Painful Urination
☐ ☐ ☐ Prostate trouble

WOMEN ONLY

☐ ☐ ☐ Congested breasts
☐ ☐ ☐ Cramps or backache
☐ ☐ ☐ Excessive Menstrual flow
☐ ☐ ☐ Irregular cycles
☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD

☐ Alcoholism	☐ Cold Sores	☐ Goiter	☐ Miscarriage	☐ Scarlet Fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Multiple Sclerosis	☐ Stroke
☐ Appendicitis	☐ Diphtheria	☐ Heart Disease	☐ Mumps	☐ Tuberculosis
☐ Arteriosclerosis	☐ Eczema	☐ Influenza	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Measles	☐ Rheumatic Fever	☐ Venereal Diseases

PLEASE PRINT

List any medications that you are taking: _____

_____

Age of mattress: _____ yrs. ☐ Firm ☐ Soft ☐ Comfortable ☐ Uncomfortable

Are you wearing: ☐ Heal lifts ☐ Sole lifts ☐ Inner Soles ☐ Arch Supports

Have you ever had any mental or emotional disorders: ☐ No ☐ Yes When_____

HAVE YOU EVER:	**YES**	**NO**	**DESCRIBE:**
Been knocked unconscious?	☐	☐	_____
Used a cane, crutch, or other support?	☐	☐	_____
Been treated for a spine of nerve disorder?	☐	☐	_____
Had a fractured bone?	☐	☐	_____
Been hospitalized for anything?	☐	☐	_____

DO YOU:			
Now take vitamins or minerals?	☐	☐	_____
Think you may need vitamins or minerals?	☐	☐	_____
Have an allergy to any drugs?	☐	☐	_____

DATES OF LAST:	**Within 6 months**	**6-18 months**	**Over 18 months**	**Never**
Spinal Examination	☐	☐	☐	☐
Physical Examination	☐	☐	☐	☐
Blood Test	☐	☐	☐	☐
Chest X-Ray	☐	☐	☐	☐
Spinal X-Ray	☐	☐	☐	☐
Dental X-Ray	☐	☐	☐	☐
Urine Test	☐	☐	☐	☐

HABITS:	**Heavy**	**Moderate**	**Light**	**None**
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Illegal Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

NAME:_____ PHONE:_____

ADDRESS:_____