• Chiropractic Care Centers, s.c. •

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PATIENT INFORMATION

(Please Print)

DATE_____

FIRST NAME_____LAST NAME_____

ADDRESS_____

CITY/STATE_____ZIP_____HOME PHONE#_(_____)_____

CELL PHONE#_(_____)_____ E-MAIL(FOR NEWSLETTERS AND HEALTH INFO)_____

SOCIAL SECURITY #__ __ __-__ __-__ __ __ __BIRTH DATE_____AGE_____SEX ☐ M ☐ F

EMPLOYED BY_____OCCUPATION_____

WORK ADDRESS_____WORK PHONE#_(_____)_____

CITY/STATE/ZIP_____ YEARS AT THIS JOB_____

OF CHILDREN_____ MARITAL STATUS ☐S ☐M ☐D ☐W

SPOUSES NAME_____PERSON RESPONSIBLE FOR PAYMENT_____

HOW WERE YOU REFERRED TO OUR OFFICE?_____

ARE YOU COVERED UNDER ANY HEALTH INSURANCE POLICIES THROUGH YOURSELF/SPOUSE/PARENT? ☐YES ☐NO
IF YES, PRESENT YOUR CARD AT THE FRONT DESK.

WE WILL VERIFY YOUR COVERAGE FOR YOU, HOWEVER NEITHER YOUR INSURANCE NOR OUR OFFICE CAN GUARANTEE PAYMENT. YOU ARE RESPONSIBLE FOR YOUR CO-PAYMENT, DEDUCTIBLE, AND ANY OTHER AMOUNTS NOT COVERED BY YOUR INSURANCE.

HAVE YOU EVER HAD CHIROPRACTIC CARE BEFORE?_____IF YES, WHEN?_____

HEIGHT_____' _____" **WEIGHT**_____lbs

IS THIS CONDITION DUE TO: ☐ AUTO ACCIDENT ☐ WORK INJURY ☐ ILLNESS ☐ OTHER

PLEASE EXPLAIN WHAT HAPPENED:_____

HAS THE CONDITION ALTERED YOUR ABILITY TO WORK, ALTERED ANY RECEATIONAL ACTIVITIES, OR ANY OF YOUR NORMAL DAILY LIFE ACTIVITIES? ☐YES ☐NO IF YES, PLEASE EXPLAIN:_____

_____

WHEN DID THE CONDITION BEGIN?_____/_____/_____ OR _____ WEEKS / MONTHS AGO

ARE THE SYMPTOMS:

☐ IMPROVING ☐ GETTING WORSE ☐ ABOUT THE SAME ☐ INTERMITTENT (COMES AND GOES)

CHECK ANY ACTIVITIES WHICH AGGRAVATE YOUR CONDITION:

☐ STANDING
☐ WALKING
☐ SITTING
☐ LYING
☐ BENDING
☐ LIFTING
☐ TWISTING
☐ COUGHING
☐ OTHER_____

HAVE YOU SEEN ANOTHER DOCTOR FOR THIS CONDITION?

☐ M.D.
☐ CHIROPRACTOR
☐ OSTEOPATH
☐ ACUPUNCTURIST
☐ DENTIST
☐ PODIATRIST
☐ OTHER_____

DRS. NAME(S)_____DATE CONSULTED_____

PAIN LEVEL:

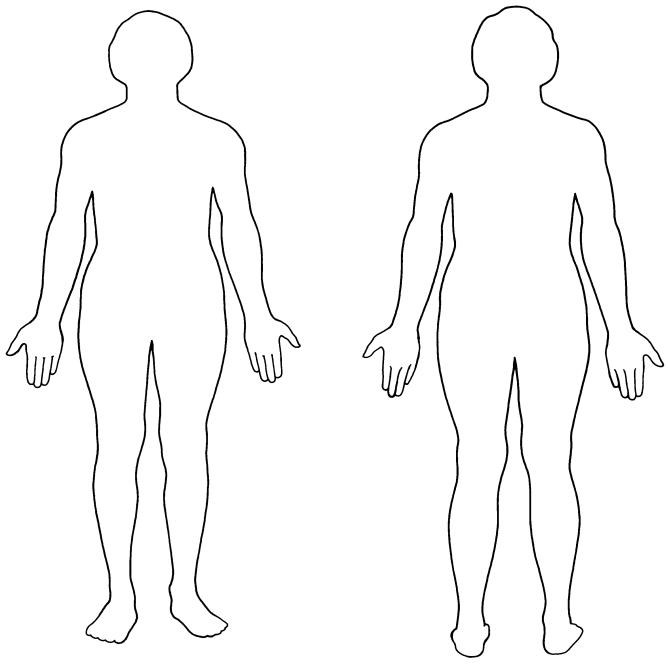
On a scale of 0-10, with 0 being you're pain free and can function quite well, and 10 being you're in severe pain and cannot function at all, where would you rate yourself now? (Place an X on the line)

0 ——————————————— 10

NO PAIN VERY SEVERE PAIN

Please mark the exact location of your pain on this diagram.

FRONT VIEW **BACK VIEW**



Please describe your major complaint with regards to the type and frequency of your pain. For example: dull, sharp, constant, off, on, etc.

PATIENT HEALTH HISTORY/FAMILY HISTORY

WHICH OF THE FOLLOWING HAVE YOU, OR ANY OF YOUR BLOOD RELATIVES HAD? (Please Check ALL That Apply)

	I HAVE HAD:	MY BLOOD RELATIVES HAVE HAD:
CHICKEN POX	☐	☐
MEASLES	☐	☐
MUMPS	☐	☐
RUBELLA (GERMAN MEASLES)	☐	☐
RHEUMATIC FEVER	☐	☐
TUBERCULOSIS	☐	☐
THYROID DISEASE	☐	☐
ASTHMA	☐	☐
DIABETES	☐	☐
EPILEPSY OR CONVULSIONS	☐	☐
RHEUMATISM OR ARTHRITIS	☐	☐
HEART DISEASE	☐	☐
LUNG DISEASE	☐	☐
HEPATITIS OR JAUNDICE	☐	☐
KIDNEY OR BLADDER INFECTION OR STONE	☐	☐
MENTAL OR NERVOUS BREAKDOWN	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
TUMOR OR CANCER	☐	☐
PEPTIC ULCER DISEASE	☐	☐
ANEMIA	☐	☐
GLAUCOMA OR CATARACTS	☐	☐
ALCOHOLISM	☐	☐
STROKE	☐	☐
PNEUMONIA	☐	☐
GALL BLADDER DISEASE	☐	☐
DEPRESSION	☐	☐
HYPERTENSION/HIGH BLOOD PRESSURE	☐	☐
HIV VIRUS/AIDS	☐	☐
SKIN DISEASE	☐	☐
SICKLE CELL ANEMIA	☐	☐
BRONCHITIS	☐	☐
ALLERGIES, HAYFEVER, ECZEMA	☐	☐
EMPHYSEMA	☐	☐

PLEASE LIST ALLERGIES:_____

PATIENT HISTORY

WHICH OF THESE SYMPTOMS DO YOU EXPERIENCE ON A REGULAR BASIS? (Please Check ALL That Apply)

HEARTBURN	☐
BREATHING AND SWALLOWING PROBLEMS	☐
"BACK-WASH" OF STOMACH CONTENTS INTO THE MOUTH AT NIGHT	☐
MORNING HOARSENESS	☐
UPSET STOMACH	☐
ABDOMINAL PAIN	☐
NAUSEA OR VOMITING	☐
GAS, BLOATING, OR BELCHING	☐

PLEASE INDICATE ANY HOSPITALIZATION AND/OR SURGERIES YOU HAVE HAD:

YEAR	OPERATION/ILLNESS	HOSPITAL/LOCATION

LIFESTYLE HISTORY

CHECK ANY MEDICATIONS YOU NOW TAKE (EITHER PRESCRIPTION OR OVER THE COUNTER):

☐ ASPIRIN
☐ PAIN KILLERS
☐ TRANQUILIZERS
☐ INSULIN
☐ BIRTH CONTROL PILLS
☐ OTHER_____

_____

	YES	NO	N/A
ARE YOU PREGNANT NOW?	☐	☐	☐
HAVE YOU EVER BEEN PREGNANT?	☐	☐	☐

OF PREGNANCIES_____ # OF MISCARRIGES_____ CONTRACEPTIVE METHOD_____

	YES	NO	
DO YOU TAKE ANTACIDS MORE THAN THREE TIMES A WEEK?	☐	☐	
DO YOU HAVE A REGULAR EXERCISE PROGRAM?	☐	☐	MINUTES PER WEEK
DO YOU SMOKE?	☐	☐	PACKS PER DAY
DO YOU DRINK ALCOHOLIC BEVERAGES?	☐	☐	AMOUNT/FREQUENCY
HAVE YOU BEEN OUTSIDE OF THE U.S. WITHIN THE LAST 12 MONTHS?	☐	☐	

IN THE EVENT OF AN EMERGENCY, PLEASE CONTACT:_____ RELATION:_____

HOME PHONE:_____ CELL PHONE_____ WORK PHONE:_____

INFORMED CONSENT FOR TREATMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Chiro-Health Care Center and/or other licensed clinic doctors who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor, including those working at the clinic.

I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of examinations, chiropractic adjustments and other procedures.

I understand and am informed that there are some risks to treatment including, but not limited to, fractures, disk 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 doctors 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 the 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.

I authorize any insurance policy I am covered under during my treatment to be billed and assign all insurance benefits to Chiro-Health Care Center. I understand that I am financially responsible for all charges incurred. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I also understand that if collection actions need to be taken on my account, a 33% collection fee will be added.

Patient's Name_____Signature of Patient_____
(PLEASE PRINT)

Date Signed_____Witness of Patient's Signature_____

Parent or Guardian Signature: _____
(MUST BE SIGNED BY PARENT OR LEGAL GUARDIAN FOR ANY PATIENT UNDER 18 YEARS OF AGE)