

Patient Information Form

Patient Information

Patient Last Name: _____ First: _____ MI: _____
Address: _____ City: _____ State/Zip: _____
Home Phone: _____ Cell Phone: _____ # of Children: _____
SSN: _____ Patient DOB: _____ Age: _____ Marital Status: _____
Email Address: _____
Would you like text message and/or email reminders of your appointments? _____
If you would like text message reminders, please write your mobile carrier _____
Patient Occupation: _____ Employer: _____
Employer Address: _____ Work Phone: _____

Emergency Contact Information

Contact Name: _____ Relationship: _____
Address: _____ City: _____ State/Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance Information

Do you have insurance? _____
Would you like us to bill your insurance for you? _____
If yes to both questions, please provide us your card to take a copy of.

Referral/Purpose

How were you referred? _____
Purpose of this appointment _____
Have you ever had same/similar condition? Describe: _____

Days lost from work? _____

AUTHORIZATION AND 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 and 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.

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 is going to be used in this office and your rights concerning those records. If you would like to have 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 to you at the front desk before signing this consent. If there is anyone that you do not want to receive your medical records, please inform the office.

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Case History

Review or Systems

Do you have skin, hair, or nail problems? _____

Do you have mouth and/or throat problems? _____

Do you have nose and/or sinus problems? _____

Do you have ear problems? _____

Do you have eye problems? _____

Do you have chest or lung (breathing) problems? _____

Do you Smoke? _____ Cigarettes per day? _____ How long have you smoked? _____

Do you have heart and/or blood vessel problems? _____

Do you have blood or lymph node problems? _____

Do you have digestive problems? _____

Do you have genital problems? (Ex. Prostate, testicular, vaginal)? _____

Do you have urinary (including kidney or bladder) problems? _____

Do you have any gland and/or hormone problems? _____

Do you have allergy or immunity problems? _____

Do you have any muscle, tendon, or ligament problems? _____

Do you have any bone or joint diseases (Ex. osteoporosis, arthritis)? _____

Do you have any nervous system, disease and/or mental health problems? _____

Females Only

Have you had menstrual problems? _____

Have you ever taken birth control? _____

Is there any chance you could be currently pregnant? _____

Do you have any breast problems? _____

Past History

List any diseases that you have had in the past, including childhood disease: _____

Tell us if you have ever been diagnosed as having a particular condition such as diabetes, AIDS, ect.: _____

Have you suffered any physical injuries, such as falls or blows, auto accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken, or cracked bones? _____

List any surgeries you have had. (Including appendix, tonsils, ear tubes, and wisdom teeth): _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Have you ever been hospitalized for any reason other than surgery? _____

Medications: Please list all prescriptions/non-prescriptions medication you are taking on a regular and/or occasional basis _____

Patient Name: _____ DOB: _____

Social History

In what position do you usually sleep and how well? _____
Do you exercise on a regular basis? _____
How do you spend your spare time? _____
Do you use: Caffeine? _____ Tobacco? _____ Nicotine? _____ Recreation drugs? _____ Alcohol? _____
Please describe your work type: Physical labor? _____ Driver? _____
Clerical? _____ Factory? _____ Homemaker? _____
Describe your physical demands: Heavy? _____ Moderate? _____ Mild? _____ Sedentary? _____
Please describe your work stress level: High? _____ Medium? _____ Low? _____
Your diet is: Balanced: _____ Fair: _____ Poor: _____ Excessive: _____ Rstrctd: _____

Family History

Are there any diseases or conditions that are common among your family members? _____

Additional Questions

Do you have a problem with recurring headaches? _____
Are you losing weight without trying? _____
Does your pain wake you up at night? _____
Have you had a sore throat that doesn't heal? _____
Do you have indigestion or difficulty swallowing? _____
Have you had an obvious change in a wart or mole? _____
Do you have a nagging cough or hoarseness? _____
In the space below, please explain or give additional details regarding the information you have given above.
Also, if there is any information about your health history that was not requested, please fill it in below: _____

Patient Health History

Have you ever (at any time) experienced any of the following?

Difficulty urinating			Claustrophobia (fear of small spaces)	Y	N
Loss of bladder control			Spinal surgery	Y	N
Loss of bowel control			Common cold/flu	Y	N
Temporary loss of vision (one eye)			Carotid artery surgery	Y	N
Blood in urine			Breast removal	Y	N

Have you ever been diagnosed with or told you have one of the following?

Detached retina	Y	N	Hardening of the arteries	Y	N
Stroke	Y	N	Rheumatoid arthritis	Y	N
Slipped disc	Y	N	Fractured/broken vertebra	Y	N
Herniated disc	Y	N	Bleeding disorders	Y	N
Osteoporosis	Y	N	High blood pressure	Y	N
Drop attacks	Y	N	Blood in stool	Y	N
TIAs (pin or mini strokes)	Y	N	Cancer	Y	N
Kidney disease	Y	N	Prostate Disease	Y	N
AIDS	Y	N	Partial or complete paralysis	Y	N

Patient Name: _____ DOB: _____

Patient Health History Continued

Do you currently have or could be, any of the following?

In the past 14 days, have you experienced any of the following?

Pregnant	Y	N	Nausea	Y	N
Taking birth control pills	Y	N	Vomiting	Y	N
Receiving hormone therapy (male)(female)	Y	N	Vertigo (spinning)	Y	N
Receiving chemotherapy	Y	N	Difficulty walking	Y	N
Receiving radiation therapy	Y	N	Uncoordinated	Y	N
Taking blood thinners	Y	N	Numbness or other sensory complaints	Y	N
Head Trauma	Y	N	Abnormal period	Y	N
A heavy smoker (1 or more packs a day)	Y	N	Loss of consciousness	Y	N
Surgical/medical implanted devices:	Y	N	Double vision	Y	N
Aortic clips	Y	N	Blurred vision	Y	N
Brain clips	Y	N	Tinnitus (ringing in ears)	Y	N
Artificial heart valves	Y	N	Speech problems	Y	N
Rods, pins, screws	Y	N	Clumsiness	Y	N
IUD	Y	N	Memory loss	Y	N
Surgical clips/wires	Y	N	Travel by car/truck	Y	N
Shunt	Y	N	Personality changes	Y	N
Neurostimulator	Y	N	Fever	Y	N
Dentures	Y	N	Recurrent headaches	Y	N
Pacemaker	Y	N	Diarrhea	Y	N
Hearing aid	Y	N	Use a tanning booth/bed	Y	N
Insulin pump	Y	N	Skin rash/infection	Y	N
Joint replacement	Y	N	A major fall	Y	N
Cochlear implants (ear)	Y	N	A minor fall	Y	N
Other implanted devices:	Y	N	An auto accident	Y	N
Metal fragments	Y	N	A work injury	Y	N
Bullets/shrapnel	Y	N	Loss of strength	Y	N
Body piercing	Y	N	Pain during bowel movements	Y	N

Do you currently have any of the following?

Integument System

Endocrine System

Skin rash	Y	N	Hormone problems	Y	N
Skin lesion	Y	N	Hot flashes	Y	N
Changes in skin color	Y	N	Thyroid problems	Y	N
Itching (pruritus)	Y	N	Hormone therapy	Y	N
Hair changes	Y	N	Growth abnormalities	Y	N
Nail changes	Y	N	Metabolism changes	Y	N

Digestive System

Abdominal pain	Y	N	Hormone problems	Y	N
Nausea	Y	N	Jaundice	Y	N
Vomiting	Y	N	Abdominal distention	Y	N
Constipation	Y	N	Cramping	Y	N
Diarrhea	Y	N	Lump/mass	Y	N

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Cardiovascular System

Chest pain	Y	N	Changes in skin color	Y	N
Irregular heartbeat	Y	N	Stroke (full of pain)	Y	N
Shortness of breath	Y	N	Dizziness	Y	N
Fainting	Y	N	Cool hands or feet	Y	N
Fatigue	Y	N	Varicose veins	Y	N
Swelling of legs	Y	N	Mitral valve problems	Y	N

Pulmonary System

Musculoskeletal System

Coughing	Y	N	Stiffness	Y	N
Phlegm/expectorant	Y	N	Popping noises	Y	N
Coughing up blood	Y	N	Joint pain	Y	N
Shortness of breath	Y	N	Weakness	Y	N
Wheezing	Y	N	Limitation of movement	Y	N
Blue skin (cyanosis)	Y	N	Extremity deformities	Y	N
Chest pain	Y	N	Difficulty walking	Y	N

Nervous System

Partial paralysis	Y	N	Lack of coordination	Y	N
Complete paralysis	Y	N	Psychiatric disorders	Y	N
Headache	Y	N	Speech abnormalities	Y	N
Are you right-handed?	Y	N	Visual disturbances	Y	N
Loss of consciousness	Y	N	Are you left-handed?	Y	N
Dizziness	Y	N	Gait disorders	Y	N
Memory loss	Y	N	Tremors	Y	N
Numbness	Y	N	Tics (spasms)	Y	N
Weakness	Y	N	Sensory changes	Y	N
Depression	Y	N	Mood changes	Y	N

Genital/Urinary System

Special Senses

Pain during urination	Y	N	Visual problems	Y	N
Changes in urine flow	Y	N	Hearing loss	Y	N
Lump or mass in groin	Y	N	Loss of balance	Y	N
Kidney stones	Y	N	Loss of taste	Y	N
Chronic bladder infections	Y	N	Loss of smell	Y	N
Genital itching	Y	N	Loss of touch sensation	Y	N
Changes in urination frequency	Y	N	Temporary vision loss in one eye	Y	N
Changes in urine color	Y	N			

Male Reproductive System

Female Reproductive System

Testicular pain	Y	N	Abnormal vaginal bleeding	Y	N
Prostate pain	Y	N	Painful menstruation	Y	N
Infertility	Y	N	Breast lump/mass	Y	N
Impotence	Y	N	Vaginal discharge/itching	Y	N
Discharge	Y	N	Nipple Discharge	Y	N
Lump or mass	Y	N	Infertility	Y	N
			Abnormal periods	Y	N
			Male pattern baldness	Y	N

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Head/Neck Region

Headaches	Y	N	Ring in ears	Y	N
Neck stiffness	Y	N	Ear pain	Y	N
Neck lump/pain	Y	N	Ear discharge	Y	N
Eye pain	Y	N	Ear itching	Y	N
Eye redness	Y	N	Nasal discharge	Y	N
Eye discharge	Y	N	Sinus trouble	Y	N
Double vision	Y	N	Bad breath	Y	N
Dry eyes	Y	N	Nasal obstruction	Y	N
Excessive tearing	Y	N	Snoring	Y	N
Spinning sensation	Y	N			

Blood, Lymphatic, Immunology, Allergy

Anemia	Y	N	Frequent illness	Y	N
Iron deficiency	Y	N	Immunity problems	Y	N
Clotting problems	Y	N	Allergies	Y	N
Bruise easily	Y	N	Take allergy shot	Y	N
Swollen lymph	Y	N			

Current Treating Physicians

Primary Care Physicians: _____ Phone #: _____
OB/GYN: _____ Phone #: _____
Dentist: _____ Phone #: _____

Any Additional Information

Credit Guarantee Insurance Assignment & Personal Balance

Insurance Assignment: Our Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your insurance carrier on your behalf and wait up to 90 days for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you leave a credit card to guarantee payment.

Filing Procedure: Claims for initial services are submitted within 48 hours after your visit. On day 90, if your insurance company had not paid the bill, we will change your designated credit card below for the amount of the claim. You will be sent a payment voucher. Any payments made on these claims thereafter will be immediately refunded to you. Please keep in mind this office will not bill your card without first trying to contact you.

Personal Balance: Estimated personal portions are paid at the time of service.

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