

Date: _____

PATIENT INFORMATION

Name _____ Sex M F Birthdate _____
last first middle initial

Address _____
street/p.o. box city state zip

Marital Status Single Married Widowed Separated Divorced

Social Security # _____

Occupation _____ Work Phone: _____

Primary Phone _____ Email address: _____

EMERGENCY CONTACT

Name _____ Relationship _____
last middle initial first

Primary Phone _____ Secondary Phone _____

EMPLOYER INFORMATION

Employer _____

Address _____
street/p.o. box city state zip

Phone _____

SPOUSE/PARENT INFORMATION

Name _____ Phone Number: _____

Who may we thank for referring you? _____

PATIENT CONDITION

Reason for visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? _____

Mark an X on the picture where you experience pain, numbness or tingling.

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

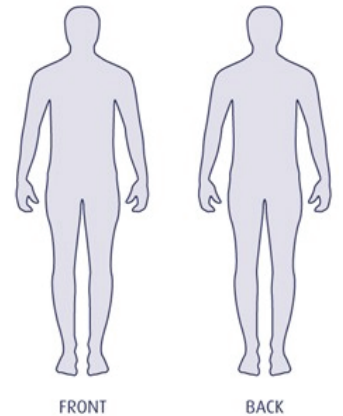
Type of pain (check all that apply) Sharp Dull Throbbing Numbness Aching
 Shooting Burning Tingling Cramps Stiffness
 Swelling Other: _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with (check all that apply) Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform (check all that apply) Sitting Standing Walking Bending Lying Down



HEALTH HISTORY

What treatment have you already received for this condition?

Medications Surgery Physical Therapy Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition

Date of last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

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

AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors/Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No	Polio <input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____
Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No	Measles <input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Headaches		

EXERCISE

None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

Smoking
 Alcohol
 Coffee/Caffeine Drinks
 High Stress Level

Packs per day _____
 Drinks per week _____
 Cups per day _____
 Reason _____

Are you pregnant? Yes No if so, Due date: _____

INJURIES/SURGERIES YOU HAVE HAD	description	date
Falls	_____	_____
Head injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

INSURANCE INFORMATION

** If this is a personal injury assignment, please skip to "Personal Injury Information"*

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Company _____

Member Number _____ Group _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ Social Security Number _____

Relationship to Patient _____

Insurance Company _____

Member Number _____ Group _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Damon Butler all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ Date _____
Responsible Party Signature

Relationship to Patient _____

ACCIDENT INFORMATION

What was the date of the accident?

Type of accident _____

* PERSONAL INJURY INFORMATION

Attorney Name OR Insurance Adjustor _____

Address _____

Phone _____ Email address: _____

Responsible Insurance Company _____

Claim Number _____

Insured _____

street/p.o. box

city

state

zip

Patient's Auto Insurance Company _____

Primary Phone _____ Email address _____

Policy _____

Will will accept assignment from your attorney for your chiropractic treatment. We will supply your attorney with an evaluation of your condition, progress reports, and final evaluation along with your bill. You are responsible for your bill if you dismiss your attorney or if this office is not paid directly by your attorney or the responsible insurance company.

Patient Signature _____ Date _____

PATIENT HEALTH INFORMATION CONSENT

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 or your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

PATIENT'S SIGNATURE _____ DATE _____

PARENT/GUARDIAN'S SIGNATURE _____ DATE _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illness or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Central Chiropractic Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

PATIENT'S SIGNATURE _____ DATE _____

PARENT/GUARDIAN'S SIGNATURE _____ DATE _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Central Chiropractic Center to use and/or disclose all medical records and bills to the entities below:

REQUESTOR NAME: _____

PATIENT'S NAME _____ D.O.A.: _____

PATIENT ADDRESS _____

DATE OF BIRTH: _____ SS#: _____

This authorization shall expire upon this expiration date: _____.
If I fail to specify an expiration date, this authorization will expire one (1) year from the date on which it was signed.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to Central Chiropractic Center. I understand that the revocation will not apply to information that has already been released to this authorization. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may refuse to sign this authorization and it is strictly voluntary.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

I have read the above and authorize the disclosure of the protected health information as stated.

A photocopy of this authorization is to be accepted and given the same effect as the original.

Signature of Patient/Legal Representative Date

If signed by legal representative, relationship to patient: _____

Signature of Witness Date