

Date: \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_ Sex  M  F Birthdate \_\_\_\_\_  
last middle initial first

Address \_\_\_\_\_  
street/p.o. box city state zip

Marital Status  Single  Married  Widowed  Separated  Divorced

Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_

Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_

## 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 INFORMATION

Name \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

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). \_\_\_\_\_

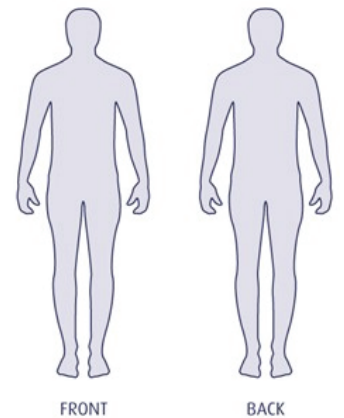
Type of pain (check all that apply)  Sharp  Dull  Throbbing  Numbness  Aching  
 Shooting  Burning  Tingling  Cramps  Stiffness  
 Swelling  Other: \_\_\_\_\_

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

\_\_\_\_\_

Pharmacy #: \_\_\_\_\_



## 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 \_\_\_\_\_

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 \_\_\_\_\_

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