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_____

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 reguarding 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)	
Loss of bladder control		Spinal surgery	
Loss of bowel control		Common cold/flu	
Temporary loss of vision (one eye)		Carotid artery surgery	
Blood in urine		Breast removal	

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

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

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

Do you currently have any of the following?

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

Digestive System

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

Cardiovascular System

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

Pulmonary System

Musculoskeletal System

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

Nervous System

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

Genital/Urinary System

Special Senses

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

Male Reproductive System

Female Reproductive System

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

Patient Name:_____DOB:_____

Head/Neck Region

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

Blood, Lymphatic, Immunology, Allergy

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

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.