Confidential Patient Health Record

Today's Date:___/____/_____

How did you hear about us? (Please Mark all that apply) **Family** **Friend** **Co-Worker** (Please list Name) _____

☐ SBC Ameritech ☐ Yellow Book ☐ Verizon ☐ Yellow pages ☐ Close to home/work ☐ Drove by

☐ Insurance Plan ☐ Newspaper ☐ Radio ☐ Movie Theater ☐ Web Page ☐ Screening ☐ Lecture

Personal Information

First:_____ **Middle:**_____ **Last:** _____ **Sex: Male / Female**

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____ **Country:** _____

Home Phone: (_____)_____-_____ **Cell Phone:** (_____)_____-_____

Status: ☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed** ☐**Separated** **Birth Date:** _____/_____/_____ **Age:**_____

Social Security #: _____-_____-_____ **Fax #:** (_____)_____-_____

Driver's License #: _____ **State:** _____ **Work #:** (_____)_____-_____

Spouses Name: _____ **Email Address:** _____

Children (Names and Ages): _____

Emergency Contact

Name: _____ **Phone Number:** (_____)_____-_____

Address: _____

Relationship: ☐**Spouse** ☐**Relative** ☐**Friend** ☐**Other** _____

Current Health Condition

Unwanted Condition (Why you are here today?):_____

_____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → →

When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? ☐**Yes** ☐**No.** **When?** _____

Is the Condition: ☐**Auto Related** ☐**Job Related** ☐**Home Injury**

☐**Slip or Fall** ☐**Lifting** ☐**Slept Wrong** ☐**Unknown Cause** ☐**Other**

Explain: _____

_____

Date of Accident: _____ **Time of Accident**: _____ **am /pm**

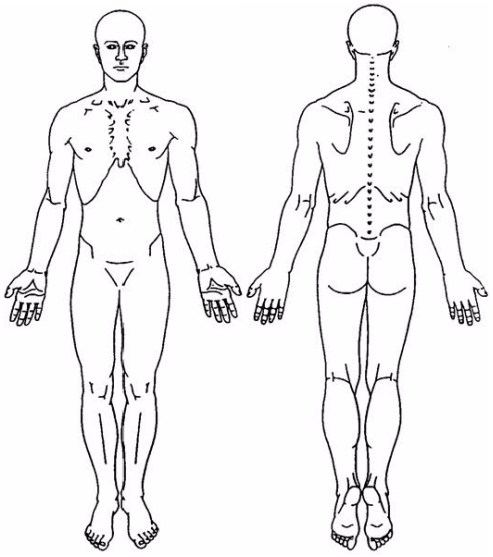
Condition/Pain STARTED on what Date: _____

Have you seen other doctors for THIS CONDITION? ☐**Yes** ☐**No**

If yes, Who? (Name) _____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

Key: A=Ache B=Burning N = Numbness P = Pain



Type of Treatment: _____ **Were you satisfied with the results of your treatment?** ☐**Yes** ☐**No**

Explain: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

Medication	Dosage	For What Condition?	How long have you been taking this?

Do you wear any of the following? Heel Lifts Innersoles Arch Supports Orthotics Other_____

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Chiropractic Care: **I have not previously seen a Chiropractor OR Fill in the information BELOW.**

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Were you satisfied with your care? Yes No. Why? _____

_____

Childhood Illness (es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

_____

_____

_____

Adult Illness (es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

_____

_____

_____

Surgery (ies): **LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

_____

_____

_____

Females ONLY: **Mark all that apply below.**

I AM: currently pregnant NOT pregnant unsure

Past Pregnancy History: C-section vaginal delivery miscarriage

Injury (ies): **Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

back injury	broken bones	fall (severe)	fracture
disability (ies)	head injury	loss of consciousness	joint injury
laceration (severe)	motor vehicle accident	soft tissue injury	other: _____

Social History: **Mark all that apply below.**

Tobacco: Do not use Tobacco Do not smoke cigars, cigarettes or pipe Live with a smoker Quit smoking

Smoke: # ____ packs per Day Week Month; Chew: #_____cans per Day Week Year

Pop/Soda: #_____cans per Day Week; Coffee: #_____cups per Day Week;

How many glasses of water a day do you drink _____

Employment Information

Business Name: _____ Occupation/Job Title: _____

Business Address: _____ Name of Supervisor: _____

Business Phone: (_____)_____-_____ Type of Work: _____

Insurance Information:

Who Is Responsible For Your Bill? YOU and… (mark appropriate box(es)) Myself ONLY

Spouse Worker's Comp Auto Insurance Medicare Medicaid Other (be specific):_____

Personal Health Insurance Carrier: _____ Health ID #: _____Group #: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's Social Security #: _____-_____-_____ Primary Care Physician: _____

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date:____/____/_____Time: _____am/pm

Carrier: _____ Policy # _____

Carriers Phone #: (_____) _____-_____ Adjuster: _____

Claim #: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: _____ Patient's Signature: _____ Date: _____

Consent to treat a Minor: _____ Date: _____

Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information

Patient Print Name: _____ Date: _____

Patient's Signature: _____ Date: _____