Brentwood Chiropractic Center, PC

Patient History

Last Name_____ First Name_____ Date of Birth_____

Street Address_____City/Town_____State____ Zip Code_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____ Can we contact you by email Y N

Your Occupation_____ Who can we thank for referring you?_____

Employer:_____ Employers Address:_____

Primary Insurance Company_____Policy Number_____

Secondary Insurance Company_____Policy Number_____

What Brings You to Our Office?

Complaint_____

Date when symptom first appeared_____

How did it happen?_____

What makes it worse?_____

What makes it better?_____

Type of Pain ____Sharp ___Dull ___Ache ___Burn ___Throb

Does the pain radiate into your ____Arm ___Leg ____Does not radiate

Do you experience numbness Y N If yes, where?_____

Any other concerns you would like to discuss with Dr. Herrick?_____

_____

Please list all previous treatments for this condition:

Treating Physician_____ Dates of Treatment_____

Type of Treatment or Drugs Prescribed_____

Please list all past surgeries_____ When_____

Please list all previous accidents or falls_____ When_____

Are you taking any medications or supplements? Y N If yes please list below: If you can't remember the name of the drug, please indicate what you take it for.

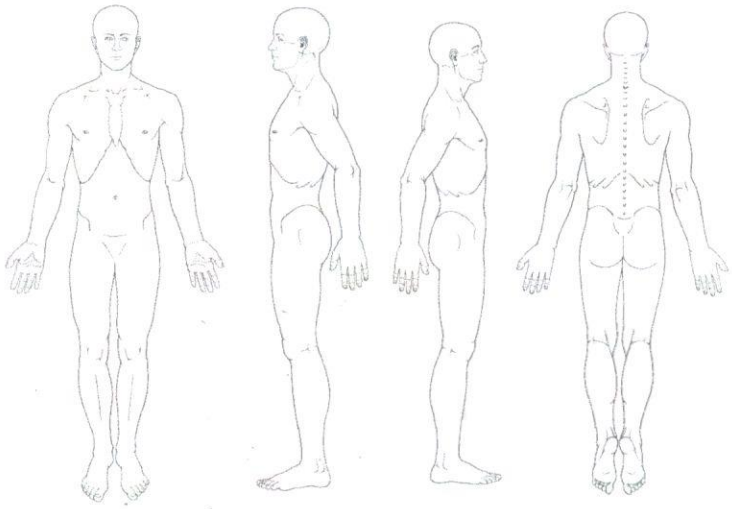
_____

_____

****Patient Signature**_____ Date_____

Pain Chart

Please Place an X Where You Are Experiencing Pain



Pain Scale: Please put an X on the line below describing intensity of your pain **RIGHT NOW**

No Pain_____Unbearable Pain

How often do you experience this pain?_____

Y N Any illness or injury in the last 5 years?

Y N Head/Brain injuries or disorders

Y N Eye disorders or impaired vision

Y N Seizures or Epilepsy

Y N Muscular Disease

Y N Nervous or Psychiatric disorders

Y N Sleep disorders

Y N Spinal injury or disease

Y N Heart Disease or Heart Attack

Y N Kidney Disease

Y N Ear Disorders

Y N High Blood Pressure

Y N Shortness of breath

Y N Loss of consciousness

Y N Stroke or Paralysis

Y N Regular or frequent alcohol use

Y N Lung Disease, Emphysema, bronchitis

Y N Narcotic or habit forming drug use

Y N Liver Disease

Y N Digestive Problems

Y N Diabetes

Y N Fainting

Accident Information

Will you be treating for a Workers Compensation Injury? Y N If Yes, date of injury_____

Employer_____ Supervisor Name_____ Telephone # _____

Employers Address_____

Did you fill out an accident report?_____

How many days did you miss from work? _____

Will you be treating for a Motor Vehicle Accident? Y N If Yes, date of injury_____

State of your Accident_____ Who is YOUR auto insurance?_____

What is your claim #?_____ Who is the claims adjustor?_____

Please sign ALL authorizations below

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – NOT between my insurance company and this office. I am responsible for obtaining appropriate referrals and understanding what my chiropractic benefit is. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports to assist in collecting from my insurance company.

I authorize Brentwood Chiropractic Center, PC to receive direct payment by my insurance company or my attorney.

If mine is a regular health insurance case, I agree to pay my copayment at the time of service or the percentage of service as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care as determined by my treating chiropractor, any fees for professional services will be immediately due and payable.

****Patient's Signature**: _____ Date: _____

Guardian's Signature Authorizing Care _____ Date: _____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-Rays by the Doctor of Chiropractic named above.

Chiropractic procedures, as well as many other types of health care, are associated with potential risks in the delivery of treatment such as but not limited to burns, post treatment soreness, fractures, dislocations, sprains, stroke. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

****Patient's Signature** _____ Date: _____

Guardian's Signature Authorizing Care: _____Date: _____

Form Notice of Privacy Practice Summary

This summary discloses how health information about you may be used. Brentwood Chiropractic Center uses health information about you for treatment, to obtain payment for treatment with your authorization as required, for administrative purposes, and to evaluate the quality of care that you receive. Brentwood Chiropractic Center will not disclose your information to others unless you tell us to do us, or unless the law authorizes us to do so. Brentwood Chiropractic Center may use your information to provide appointment reminders, information about treatment alternatives, birthday postcards, recall postcards or other health related issues. Brentwood Chiropractic may add my name to their referral board in their waiting area thanking me for spreading the word of chiropractic if I do so to refer friends and family. You may complain to the Privacy Officer, Dr. William Herrick and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint. Brentwood Chiropractic Center must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if they were unable to agree to the requested restriction on how by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted by law.

****Patient Signature**_____Date:_____

Guardian Signature Authorizing Care_____ Date:_____