Parrish Chiropractic Center, P.C.

Confidential Patient History

Personal History

Today's Date ____________

Patient's Name _________________________________ Soc. Sec. # ____________________

Address _________________________Apt. #____ City ____________ State ____ Zip ______

Age ________ Birth Date ______________ Marital Status: M S D W # Children ______

Cell Phone _______________ Work Phone _______________ Home Phone ______________

Email Address ____

Occupation _________________________ Employer __________________________________

Spouse's Name ______________________ Spouse's Employer ________________________

How Did You Hear About Us? ____

Current Health Condition

Major Complaint(s): ____

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Other Doctors Seen For This Condition? ☐ Yes ☐ No Who? __________________________

Type of Treatment: ____________________________ Results: ________________________

When Did This Condition Begin? __________________ Has It Occurred Before? ☐ Yes ☐ No

Is This Condition Getting: ☐ Better ☐ Worse ☐ Same

Cause of Condition: ☐ Unknown ☐ Work Injury ☐ Auto Accident ☐ Fall ☐ Other____________

Date of Accident: _______________ Reported To Employer &/or Insurance Co.? ☐ Yes ☐ No

Women: Are You Pregnant At This Time? ☐ Yes ☐ No

What Medications Are You Taking? ____

Please List Any Other Health Conditions? ____

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Health History

Previous Chiropractic Care? ☐ None ☐ Yes - Doctor's Name: ________________________

Check Any That You Currently Experience or Have Had During The Past 6 Months:

☐ Headaches	☐ Low Back Pain	☐ Asthma	☐ High Blood Pressure
☐ Neck Pain	☐ Pelvis/Hip/Leg Pain	☐ Allergies	☐ Nausea/Vomiting
☐ Shoulder Pain	☐ Numbness/Tingling	☐ Diabetes	☐ Dizziness
☐ Arm Pain	☐ Fatigue	☐ Cancer	☐ Nervousness
☐ Mid Back Pain	☐ Digestive Disorders	☐ Heart Problems	☐ Mental Disorders

Please List Any Major Surgical Operations and Year Occurred: ______________________

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Why Chiropractic? People go to chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort **(relief care)**. Others are interested in having the *cause* of their problem corrected *as well as their symptoms* relieved **(corrective care)**. Dr. Parrish will consider your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

☐ Relief Care ☐ Corrective Care ☐ Check here if you want the Doctor to select the type of care most appropriate for your condition.

Insurance Information

Do You Have Health Insurance? ☐ Yes ☐ No

Name(s) of Insurance Company(s) ___________________________________Policy # __________________

Consent to receive Email and/or Text Messages

I consent to receiving appointment reminders, notification of office closings, or other general healthcare related communications/information via email and/or texts to my cell phone from Parrish Chiropractic Center, P.C. I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

Patient's Signature: **X** _________________________________ Cell Phone Carrier Name _______________

Payment Acknowledgment (please Sign)

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office 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 Doctor's Office will be credited to my account on 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 and treatment, any fees for professional services rendered me or my dependent will be immediately due and payable. Outstanding balances over 30 days may be assessed interest charges at the rate of 1.5% monthly.

The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature: **X** ____ Date __________________

Guardian or Spouse's
Signature Authorizing Care: ____ Date __________________

I hereby authorize and direct my insurance benefits to be paid directly to the Doctor. I am financially responsible for non-covered services.

Patient's Signature: **X** ____ Date___________________