**University Chiropractic and Wellness**

**PERSONAL HISTORY**

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BEST PHONE NUMBER TO REACH YOU: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TXT REMINDER? Y / N

E-MAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BIRTHDATE (MM/DD/YYYY):\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_ SEX: \_\_\_\_\_\_ HEIGHT/WEIGHT: \_\_\_\_\_\_\_

NAME OF EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TYPE OF WORK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF INSURANCE COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF SPOUSE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SPOUSE’S EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMERGENCY CONTACT PH. #: \_\_\_\_\_\_\_\_\_\_\_\_\_

WHO IS RESPONSIBLE FOR YOUR BILL?

\_\_\_ INSURANCE \_\_\_ AUTO INSURANCE \_\_\_ OTHER

\_\_\_ WORKER’S COMPENSATION \_\_\_ SELF

**PAST HEALTH HISTORY**

PLEASE CHECK AND/OR DESCRIBE THE FOLLOWING (IF APPLICABLE):

OPERATIONS (SPINAL OR JOINT): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ACCIDENTS OR FALLS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HABITS: Sleep (hours) \_\_\_\_ Exercise (days per week) \_\_\_\_\_ Caffeine (days per week) \_\_\_\_\_

Alcohol (days per week) \_\_\_\_ Tobacco (days per week) \_\_\_\_\_

CURRENT MEDICATIONS (PLEASE DESCRIBE IF APPLICABLE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU PREGNANT? Y/N  **IF YES**, HOW FAR ALONG ARE YOU? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU UNDERSTAND THAT CHIROPRACTIC IS A DRUGLESS, NON-SURGICAL FORM OF HEALTH CARE? Y/N

**University Chiropractic and Wellness**

**CURRENT HEALTH CONDITION**

PURPOSE OF THIS APPOINTMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU TAKING MEDICATION FOR **THIS** CONDITION (EX: PAIN KILLERS)? Y/N

HAVE YOU SEEN ANOTHER DOCTOR FOR THIS CONDITION? Y/N

* IF YES, WHO? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RESULTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHEN DID THIS CONDITION BEGIN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ IS THIS AN ONGOING PROBLEM? Y/N

IS THE CONDITION…. \_\_\_\_ JOB-RELATED \_\_\_\_ FROM AN AUTO ACCIDENT

DATE OF ACCIDENT (IF APPLICABLE): \_\_\_\_\_\_\_\_\_\_

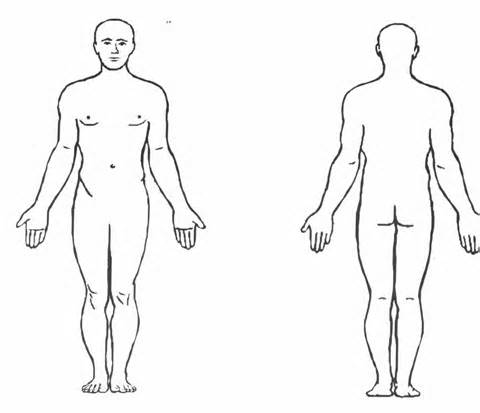
**Please circle all of the following symptoms/conditions you have now.**

**Please underline all of the following symptoms/conditions you have had previously.**

|  |  |
| --- | --- |
| Headaches  Neck pain and/or stiffness  Fainting/dizziness  Pins/needles in arms/hands/fingers  Numbness in arms/hands/fingers  Pain in arms/hands fingers  Back pain  Pins/needles in legs/feet/toes  Numbness in legs/feet/toes  Pain in legs/feet/toes  Chest pain/previous heart attack  High blood pressure  Pain between shoulder blades | Asthma  Frequent colds  Sinus trouble  Loss of sleep  Weight Loss  Difficulty breathing  Stomach pain  Joint swelling  Constipation or diarrhea  Faulty Posture  Spinal curvature  Epilepsy  Cancer |

**University Chiropractic and Wellness**

**PAIN QUESTIONNAIRE**



What is your **current** pain level? \_\_\_/10

What is your pain level at its **best**? \_\_\_/10

What is your pain level at its **worst**? \_\_\_/10

How much of the day do you have pain?

\_\_\_ 25% \_\_\_ 50% \_\_\_ 75% \_\_\_ 100%

How many days of the week do you have pain?

\_\_\_\_\_\_\_\_\_\_\_\_

What types of activities **aggravate** your symptom(s)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What types of activities **improve** your symptom(s)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mark on the above figure where your pain is located.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any additional comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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



**University Chiropractic and Wellness**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

This notice is effective as of \_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_

**HIPPA**

I have read the Notice of Privacy Practices and understand my rights contained in the notice.

By way of my signature, I provide University Chiropractic and Wellness with my authorization and consent to use and disclose my protected health care information with the purpose of treatment, payment, and health care operations as described in the Notice of Privacy Practices.

**VIDEO SURVEILLANCE**

The waiting room of our office is equipped with one video camera for safety purposes. We store these recordings in electronic format for 7-10 days but we do not make or keep videotapes of these recordings. The waiting room is the only room with video surveillance.  
By way of my signature, I acknowledge the use of video surveillance.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Signature of Witness Date

for Facility



**University Chiropractic and Wellness**

University Chiropractic and Wellness offers a “free first visit” that includes the following:

* Consultation with the doctor
* Exam with the doctor consisting of palpatory and range of motion testing
* One set of X-rays (if needed)
* Fifteen minute massage with a licensed massage therapist

If the doctor feels that you could benefit from chiropractic treatment, most insurance companies cover further exams, X-rays, and treatment. We will need to make a copy of your insurance card so that our insurance specialist can verify your chiropractic coverage.

By signing this, I understand the “free first visit” offer. I also understand that if I receive more treatment than what is listed under the "free first visit" then I waive the free visit.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature

**\*\*\*Due to federal guidelines, Medicare/Medicaid/Workman’s Compensation restrictions, this free offer is not available to these participants.\*\*\***

