PATIENT HEALTH HISTORY

Date _____

Name:_____ Age:_____ Date of Birth:_____ Sex: M___F___
Address:_____ City:_____State:_____ Zip: _____
Phone (Home):_____ (Work):_____ (Cell):_____ Marital Status: S__ M__ D__ W__
Occupation:_____ Social Security Number: _____
Employer:_____ Driver's License Number:_____
Spouse's Name:_____ Spouse's Age:____ Spouse's Date of Birth: _____
Spouse's Occupation:_____ Spouse's Social Security Number: _____
Spouse's Employer:_____ Spouse's Phone (Work): _____
Insured's Name:_____ Insured's Phone:_____ Insured's Date of Birth:_____
Insurance Company:_____ Spouse's Insurance Company: _____
Circle which applies to you HRA HSA Flex Spending Account Is it company or personally funded?_____
Balance in this account_____
How did you hear about this office:_____ Referred by: _____
Past Chiropractic Care: Yes__ No__ When?_____ Doctor's Name:_____ Results:_____

Are your present problems due to an injury? Yes__ No__ On Job__ Auto Accident__ Personal Injury__ Other: _____
Has the accident been reported? Yes__ No__ To Employer__ Auto Carrier__ Other: _____
Are you now or' have you ever been disabled? (Service or Work)? Yes__ No__ When?_____
Have you retained an attorney? Yes__ No__ Name & Address:_____

List any accidents or falls and dates: Auto:_____ Recreation:_____
Sports:_____ Work Related:_____ Other: _____
List any broken bones (fracture) or dislocations: _____
Ever on crutches? Yes__ No__ Why? _____
Were you ever knocked unconscious? Yes__ No__ (If yes, please explain): _____
Have you ever had Xrays taken? Yes__ No__ When?_____ By Whom? _____
For what ailments were these Xrays made? _____
Do you wear orthotics or heel lifts? Yes__ No__ Fitted by whom? _____When? _____
Do you suffer from any condition other than that for which you are now consulting us? Yes_____ No __
Are you presently taking any medication, prescription, over-the-counter, home remedies, vitamins, minerals, etc?
(Please list)_____

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OPERATIONS AND PROCEDURES

___I have never had any operations or surgeries

DATE		DATE		DATE	
_____	Vaccinations	_____	Spinal Taps/Injections	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach

Other _____

I understand and agree that if I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. Further, I understand that this health care provider will/will not prepare reports and forms to assist in reimbursement from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my personal responsibility for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the doctor to examine and treat my condition as he/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 to the Doctor for imaging is for examination onlyand the negativeswill remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature:_____ Date:_____

CURRENT COMPLAINT HISTORY
(PATIENT)

Patient Name: _____ Date: _____

Please check all boxes that apply to your condition and fill in the spaces that describe your present complaint(s). Also, the information you provide concerning past symptoms will help in assisting the doctor to better understand your present complaints and total health picture.

Please list your present complaint(s) and mark your level of pain today for each complaint – If you have more than one area of complaint, list them in order of most severe to least severe.

1. _____ Duration – (How Long / Date): _____ # of Previous Episodes: ____
   (*Please circle one.*) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)
2. _____ Duration – (How Long / Date): _____ # of Previous Episodes: ____
   (*Please circle one.*) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)
3. _____ Duration – (How Long / Date): _____ # of Previous Episodes: ____
   (*Please circle one.*) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Has anyone treated you for this episode? ❑Yes ❑No If yes, by whom? _____

How did your symptoms begin?
❑Immediately after a specific incident ❑After multiple Incidents ❑Gradually developed over time ❑Other _____

What makes your symptoms better?
❑Nothing ❑Lying down ❑Standing ❑Sitting ❑Movement/Exercise ❑Other _____

What makes your symptoms worse?
❑Nothing ❑Lying down ❑Standing ❑Sitting ❑Movement/Exercise ❑Other _____

Are your symptoms?
❑Decreasing ❑Increasing
❑Not Changing ❑Other _____

Description of pain or symptoms:
❑Sharp ❑Shooting
❑Dull ❑Burning
❑Ache ❑Numb
❑Weakness ❑Tingling
❑Throbbing ❑Other_____

Does your pain move or radiate?
❑Yes ❑No Where _____

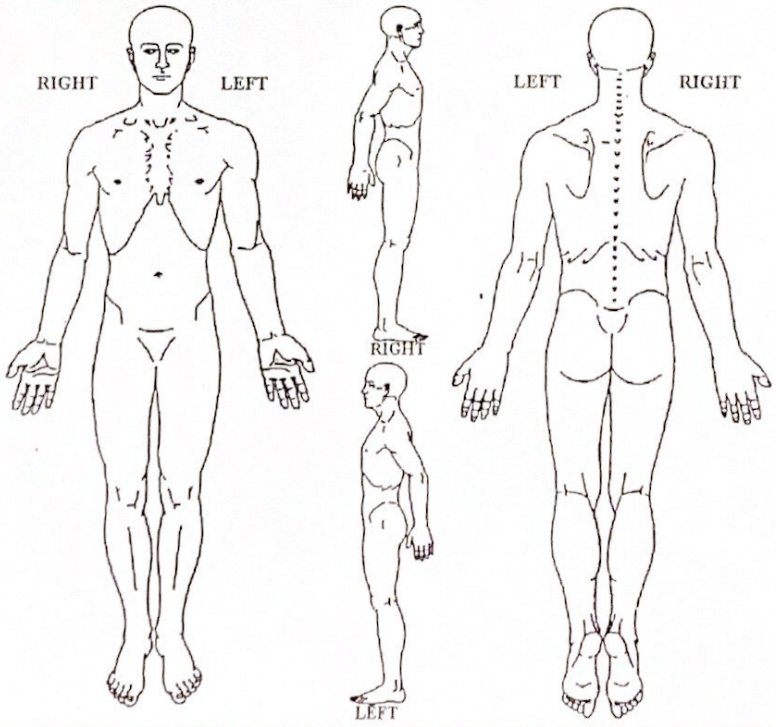
Check the best and worse times of the day for your pain:

Worse	Best
❑First Awake	❑First Awake
❑Morning	❑Morning
❑Afternoon	❑Afternoon
❑Evening	❑Evening
❑Nighttime	❑Nighttime
❑Other	❑Other

Frequency of pain or symptoms:
❑Constant (76 – 100%)
❑Frequent (51 – 75%)
❑Occasional (26 – 50%)
❑Intermittent (25% or less)

SHOW US YOUR PAIN
USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SYMPTOMS TODAY

KEY: A = ACHE B = BURNING N = NUMBNESS P = PINS & NEEDLES
S = STABBING X = STIFFNESS T = THROBBING O = OTHER



How many days out of an average week are you in pain? (Please circle one.) 1 2 3 4 5 6 7

How much time during the day are you in pain?
❑less than 1 hour ❑1 to 6 hours ❑6 to 12 hours ❑12 to 18 hours ❑18 to 24 hours ❑24 hours

Patient's/Guardian's Signature: _____ Date: _____

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AUTHORIZATION AND RELEASE

patient's name _____ contract number _____

( )

( )

AUTHORIZATION TO RELEASE INFORMATION

I authorize the doctor and his staff named below to release any information deemed appropriate concerning my physical condition and treatment to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a photostatic copy of this agreement shall serve as the original.

signature _____ witness _____ date _____

AUTHORIZATION TO PAY DOCTOR/CLINIC

I hereby authorize and direct payment of any medical and surgical expense benefits allowable to the doctor/clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photostatic copy of this agreement shall serve as the original.

signature _____ witness _____ date _____

Authorization to Pay
Release Authorization
is granted to
Physician Tax ID

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CONSENT FOR TREATMENT
AND
AUTHORIZATION TO PERFORM X-RAYS

Date_____ Time _____ AM PM

I have been informed by Dr._____ that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness).

I authorize Dr. _____ to perform such radiographic examination necessary to diagnose and to administer whatever treatment is deemed necessary to treat my present problem (or illness).

Signed:_____

Witness:_____

To the best of my knowledge I am NOT pregnant and the above named Doctor has my permission to x-ray me for diagnostic interpretation.

Signed:_____

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