PATIENT INFORMATION

Full Name:____ Date of Birth:____/____/______ Nickname:___________________

Address:____City:___________________________State:________Zip:________

Cell Phone:_____________________ Email:__________________________ **SSN#**:____-____-_______ Gender: ▢ M ▢ F

Where do you work?____ Marital Status: ▢ S ▢ M ▢ D ▢ W

How did you hear about our office?

▢ Website ▢ Google ▢ Lunch and Learn ▢ Community Event ▢ Facebook ▢Patient Referral:_________________________

Have you ever had chiropractic care before? ▢ Yes ▢ No Were you pleased? ▢ Yes ▢ No

INSURANCE INFORMATION

How are you insured?

▢ Through my Employer ▢ Medicare ▢ Medicaid ▢ Individual Policy, not through an Employer ▢ N/A

If the policy is through someone other than the patient, please provide the following:

Policy Holder Name:_____________________________ Date of Birth:____/____/______ Relationship:_____________________

AUTHORIZATIONS AND ACKNOWLEDGMENTS

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law**. INITIALS:_______**

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. **INITIALS**:_______

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information: ____

FAMILY & SOCIAL HISTORY AND REVIEW OF SYSTEMS

How often do you drink alcohol:_______________ Do you smoke? ▢ Yes, how much:_________ ▢ No

FEMALE PATIENTS: Are you currently pregnant? ▢ Yes ▢ No Date of last cycle:____/_____/_______

Check those involving family and include identification: **M = mother, F = father, S = sibling, G = grandparent**

Cancer, type:____________ **M F S G**	Liver Disease **M F S G**	Neck Problems **M F S G**
Heart Disease **M F S G**	Scoliosis **M F S G**	Back Problems **M F S G**
Lung Problems **M F S G**	Osteoarthritis **M F S G**	High Cholesterol **M F S G**
Seizures **M F S G**	Diabetes **M F S G**	Rheumatoid Arthritis **M F S G**
Depression **M F S G**	High Blood Pressure **M F S G**	Osteoporosis **M F S G**

Please list any medication or supplements you are taking:____

Do you have any of the following?

Constitutional: fever, chills, night sweats, loss of appetite, unexplained weight loss/gain ▢ **YES** ▢ **NO**

Eyes/Vision: cataracts, blindness, double vision, light sensitivity, blind spots, tearing, Non-allergy based itching, burning or dryness ▢ **YES** ▢ **NO**

Ears, Nose & Throat: fainting, history of head injury, runny nose, dizziness, frequent sore throats, loss of smell or hearing, chronic sinus infections, ear discharge or pain, nosebleeds ▢ **YES** ▢ **NO**

Respiration: cough, shortness of breath, wheezing, asthma, coughing up blood or sputum ▢ **YES** ▢ **NO**

Cardiovascular: high or low blood pressure, varicose veins, shortness of breath laying down or with exertion, heart murmur, palpitations, ulcers ▢ **YES** ▢ **NO**

Gastrointestinal: belching, difficulty swallowing, abdominal pain, black/tarry stools, heartburn, ulcers, constipation or diarrhea, hemorrhoids, rectal bleeding ▢ **YES** ▢ **NO**
Female: Frequent urination, abnormal discharge, breast lumps or pain, abnormal cramping ▢ **YES** ▢ **NO**
Male: Burning or frequent urination, prostate issues, ED, hesitancy or urine retention ▢ **YES** ▢ **NO**

IMPACT ON DAILY ACTIVITIES:

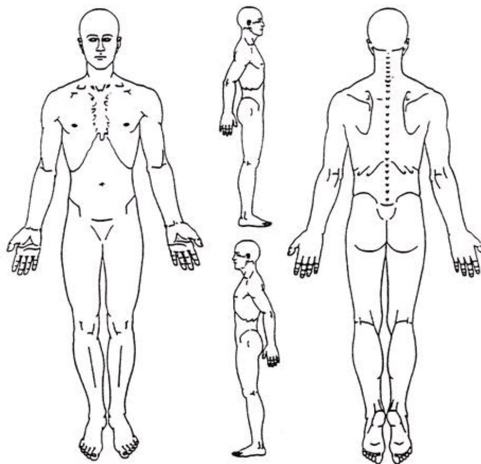
I can DRIVE:	▢ Unable	▢ 10 Minutes	▢ 30 minutes	▢ 60 minutes	▢ No Limitation	
I can CARRY:	▢ **Unable**	▢ **Light Weight**	▢ **Medium Weight**	▢ **Heavy Weight**	▢ **No Limitation**	
I can SLEEP:	▢ Unable	▢ Losing 3-5 Hours	▢ Losing 2-3 Hours	▢ Losing 1-2 Hours	▢ No Limitation	
I can STAND:	▢ **Unable**	▢ **Less than 10 Minutes**	▢ **15 Minutes**	▢ **30 minutes**	▢ **60 minutes**	▢ **No Limitation**
I can SIT:	▢ Unable	▢ 1 Hour	▢ 2 Hours	▢ 4 Hours	▢ 8 Hours	▢ No Limitation
I can WALK:	▢ **Unable**	▢ **10 Feet**	▢ **100 Feet**	▢ **½ Mile**	▢ **1 Mile**	▢ **No limitation**
I can do HOUSEWORK:	▢ Unable	▢ 10 Minutes	▢ 15 Minutes	▢ 30 Minutes	▢ 60 Minutes	▢ No Limitation
I can BEND:	▢ **Unable**	▢ **¼ of the way**	▢ **½ of the way**	▢ **¾ of the way**	▢ **No Limitation**	

HEALTH HISTORY (patient must complete ALL sections)

Please indicate where you feel pain using:
A = Aching, B = Burning, C = Cramping, N = Numbness,
P = Pins/Needles, T = Throbbing

What is the current ***INTENSITY*** of this complaint?
1 2 3 4 5 6 7 8 9 10

What ***PERCENTAGE*** of the day is this present?
0 10 20 30 40 50 60 70 80 90 100



How did this happen?____

How long have you had this?____________________________________

What makes it feel better?_____________________________________

What makes it feel worse?_____________________________________

This negatively impacts my: ▢ Ability to Work ▢ Decision Making ▢ Productivity ▢ Attitude ▢ Energy at the end of the day

How does this affect your life?
- ▢ Lose patience with your spouse or children
- ▢ Restricted household duties
- ▢ Hinders ability to exercise/play
- ▢ Hinders ability to participate in hobbies/recreation

In the event that we can help, what is your level of commitment to correcting your problem(s)?

1 2 3 4 5 6 7 8 9 10

By signing below, I acknowledge that the above information is true and accurate to my knowledge

Patient Signature:____________________ Name:____________________ Date:________

Staff Use Only:	Doctor Use Only:

INTERNAL USE ONLY*: Doctor signature indicates that the PFSH and ROS was verbally reviewed with the patient during consultation*

Office Use Only : CA2 CA4 *Doctor signature:*____________________ *Date:*__________