Chiropractic Patient Information Update 2018

Date:_____ Patient File #_____-_____ **Legacy File #** _____

Name:_____ Cell: _____

Address:_____City:_____ State:_____ Zip:_____

Sex: Male/Female E-mail address:_____ Home/Alternate Phone:_____

Age:_____ Birth Date:_____ Social Security #_____Marital Status: Married Single Widowed Divorced

Occupation:_____ Employer:_____

Name of Nearest Relative or Emergency Contact:_____ Phone:_____ Relationship _____

Your Primary Doctor or Nurse Practitioner, City, State Phone _____

May we update your Primary Doctor about your care? Yes No

What is your communication Preference (pick 2)? Mail Cell Phone Home/Alternate Phone Email Text

Who referred you or How did you find us? Name _____ Patient Signs Radio Web/Internet Newspaper

HISTORY OF PRESENT ILLNESS:

Main Complaint: Purpose for this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Personal Injury _____Other_____

Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe:_____

Days lost from work:_____ Date of last physical examination:_____ Date of last Chiropractic Visit _____

HISTORY

Have you ever been diagnosed as having or have suffered from? If so, when?

PAST MEDICAL HISTORY

___Broken/Fractured Bones
___RheumArthritis/Osteoarthritis
___High Blood Pressure
___Headaches/Migraines
___Neck Pain/Stiff Neck
___Back Pain
___Dizziness
___Pace Maker
___Strokes
___Cancer
___Diabetes
___Shoulder/Neck/Arm Pain
___Sudden Weight Loss/Gain
___Numbness in Fingers or Toes
___Weakness in Extremities
___Muscle Spasms
___HIV Positive
___Women: Are you pregnant?

SURGERIES/HOSPITALIZATIONS

_____ _____
_____ _____
_____ _____
_____ _____

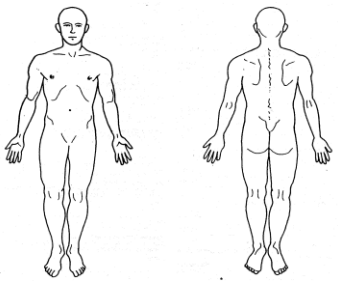
CAR ACCIDENTS

_____ _____
_____ _____

FAMILY HISTORY

___Osteoarthritis (715.0)
___Diabetes (250)
___Stroke (V171)
___Rheumatoid Arthritis (714.0)
___ Neck Pain (723.1)
___ Low Back Pain (724.2)
___ Sciatica (724.3)
___ Disc Degeneration
___ Headaches (784.0)
___ Migraine (346.00)
___ Scoliosis (737.30)
___ Cancer

MARK YOUR AREAS OF CONCERN



What are You Taking Meds for:

_____
_____
_____
_____

SOCIAL HISTORY

Do you drink alcoholic beverages? No Yes Socially
Do you smoke? Never No Yes, Current
___Packs/day, for ___years
Former Smoker? No Yes (When did you quit?_____)

INFORMED CONSENT TO TREAT: I understand and am informed that, in the practice of chiropractic medicine there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that I may revoke this consent at anytime verbally or in writing to the doctor. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the procedures outlined by my doctor of chiropractic in my treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

AUTHORIZATION AND RELEASE: 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 payors 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.

PRIVACY NOTICE: 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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Parent or Guardian's Signature Authorizing Care:_____ Date:_____