Chiropractic Patient Information Age(14 +)

Date: _______________

Personal Information

First: ______________________________ **Last:** _____________________ **Middle Initial:** _________

Birth Date: ____/____/_______ **Sex:** Male / Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced **Spouses Name:** __________________

Address: ____ **Apt #:**____________

City: ____________________________ **State:** ______ **Zip Code:** ____________

Home Phone: (_____)______-_____ **Cell Phone:** (_____)______-_____

Email Address: ____

How did you hear about us? ____

Emergency Contact

First: ______________________________ **Last:** ____

Phone: ____________________ **Relationship:** ____

Employment Information

Business Name: ___________________________________**Occupation:**______________________________

Insurance Information -- *if copy was made of your insurance card, please omit this section.*

Primary Insurance Co.:_____________________________ **Policy #/Group #:**_______________________

Secondary Insurance Co.:___________________________ **Policy #/Group #:**_______________________

Current Health Condition

Chief Complaint- What is your purpose for this appointment?____

____

Date symptoms appeared or accident happened:____

Is this due to: Auto_____ Work______ Trauma________Other____

Have you ever had the same or similar condition? ____

Days lost from work: ________________ Date of last physical examination: _________________________

Family Medical Doctor: _________________________Clinic Name/Address: ___________________________

Past Medical History

Have you ever been diagnosed as having or have suffered from? (Please mark any & all that apply)

__Broken or Fractured Bones __Osteoarthritis __Eating Disorder __Neurological disease
__Fibromyalgia __Depression __Rheumatoid Arthritis __Pace Maker
__Drug Addiction __Asthma __Strokes __Alcoholism
__ Allergies (Type?) __Cancer __Gall Bladder __High/Low Blood Pressure
__ADD __Migraines __Diabetes __Scoliosis
__Head Injury ___Seizures/Convulsions

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth and dates: ____

____

Have you been treated for any health condition by a physician in the last year? Yes_______ No________If yes, describe: ____

Have you previously seen a Chiropractor? __________ If so, how recently? _________________________________

Please list current medications:

Medication	Dosage	For what condition	For how long

<u>Family History</u>

Parents:

Father: living____ age_____ deceased_____ cause of death and age at death_____________________________

Mother: living____ age_____ deceased_____ cause of death and age at death_____________________________

Family Diseases (check any & all that apply and indicate **<u>F</u>**ather, **<u>M</u>**other, **<u>S</u>**<u>ibling</u>):

Tuberculosis____	Cancer____	Mental Illness____
Diabetes____	Asthma____	Heart Disease____
Stroke____	Kidney Disease____	Lung Disease____
Arthritis____	Liver Disease____	Parkinson's Disease____

Other____

<u>Social History</u>

Do you drink alcoholic beverages? ______ If so, how much per week? _________________________________

Do you use any tobacco products? ______ If so, how much per day? __________________

Do you take vitamin supplements?______ If so, please list:_______________________________________

Do you exercise?______ If so, what is the frequency & type of exercise?______________________________

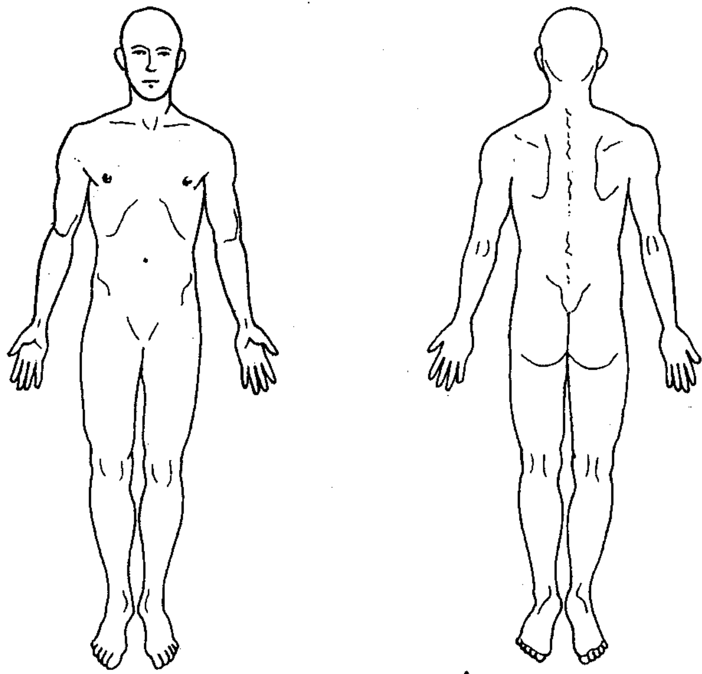
What are your hobbies?____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

Yes _____ No _____ Uncertain _____

Tell us where you hurt.

Mark the areas on your body where you feel your pain. Include all affected areas. Also, Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.



Ache > > > > > >
Numbness = = = = = =
Pins & Needles o o o o o o
Burning x x x x x x
Stabbing / / / / / /
Throbbing ~ ~ ~ ~ ~ ~

SUMMARY

1. What is your major symptom? ____

2. What does this prevent you from doing or enjoying? ______________________________________

3. If this is a recurrence, when was the first time you noticed this problem? ___________________

   How did it originally occur? ____

   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

4. How frequent is the condition? Constant _____ Frequent ____ Intermittent ____

5. Are there any other conditions or symptoms that may be related to your major symptom?

   Yes _____ No _____. If yes, describe: ____

   Are there other unrelated health problems? Yes _____ No _____. If yes, describe __________

   ____

6. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____

   Burning _____ Stabbing _____ Other ____

7. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _______

   ____________________. If no, what have you tried to do that has not helped? ______________

   ____

8. What makes the problem worse? Standing ____ Sitting ______ Lying ______ Bending _____

   Lifting _____ Twisting _____ Other ____

NO SYMPTOMS — EXTREME SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

Patient Acknowledgement and Receipt of

Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name ______________________________________ Date_________

Print Patient's Name

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 undersign 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.

By____________________________________

Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____________________________________

Signature of Parent/Guardian (circle one)

INFORMED CONSENT

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These compilations are extremely uncommon as chiropractic is one of the safest forms of healthcare available for musculoskeletal problems. They include, but are not limited to: muscle strain, disc and vertebral injury, strains, and costovertebral strain. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

Date____________________________ ____

Printed Patient Name

____

Signature of Patient

____

Signature of Parent or Guardian (if a minor)

UNITED HEALTH CHIROPRACTIC
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