Confidential Patient Information

Name _____ Birthdate _____ Sex (M / F) _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Email _____

Emergency Contact Name and Phone _____

**To my knowledge, I am not pregnant _____ (initials)

Authorizations

I, the undersigned, hereby authorize the doctor to administer such treatment, x-ray, therapy, and procedures as are considered medically necessary on the basis of findings during the course of said treatment. I hereby certify that I fully understand the authorization for chiropractic treatments, its advantages and possible complications, if any, as well as possible alternative modes of treatment. I certify that no guarantee or assurances have been made as to the results that may be obtained.

I, the undersigned, hereby authorize release of information to insurance companies, for purposes of treatment payment. I also authorize my insurance benefits be paid directly to the doctor. I acknowledge that I am fully responsible for payment of my bill.

Privacy Notice	**Initial**
The patient has a right to protected health information.	_____
Information collected about you will be kept confidential in our office.	_____
Reports may be sent to you in a non- encrypted email.	_____
Following practices utilized in our office: sign-in sheets, open treatment areas.	_____
Our full privacy policy can be found here.	_____
Our office can accommodate a patient's need for further privacy if needed.	_____

Patient Signature _____ DATE _____

Legal Guardian of Minor Signature _____

New Patient History

Name _____ Date _____

LIST CHIEF COMPLAINTS:

1)

2)

3)

HISTORY OF PRESENT PROBLEM:

Symptom #1:

Onset (when and how did it begin):
Have you had this pain in the past?
Palliative (makes the pain better):
Provocative (makes the pain worse):
Does the pain radiate anywhere? [YES / NO] If yes, where?
Rate the pain (0 = no pain, 10 = can't move): [0 1 2 3 4 5 6 7 8 9 10]
Is the pain constant or intermittent?
What time of day is the pain the worst?
Numbness or tingling? [YES / NO] If yes, where?

Symptom #2:

Onset (when and how did it begin):
Have you had this pain in the past?
Palliative (makes the pain better):
Provocative (makes the pain worse):
Does the pain radiate anywhere? [YES / NO] If yes, where?
Rate the pain (0 = no pain, 10 = can't move): [0 1 2 3 4 5 6 7 8 9 10]
Is the pain constant or intermittent?
What time of day is the pain the worst?
Numbness or tingling? [YES / NO] If yes, where?

Symptom #3:

Onset (when and how did it begin):
Have you had this pain in the past?
Palliative (makes the pain better):
Provocative (makes the pain worse):
Does the pain radiate anywhere? [YES / NO] If yes, where?
Rate the pain (0 = no pain, 10 = can't move): [0 1 2 3 4 5 6 7 8 9 10]
Is the pain constant or intermittent?
What time of day is the pain the worst?
Numbness or tingling? [YES / NO] If yes, where?

PAST MEDICAL HISTORY:

Have you ever been treated by a chiropractor in the past? [YES / NO]

Date of last adjustment: _____ .

Previous injuries/traumas/car accidents/broken bones? When?

Past Medical Treatments/surgeries/hospitalizations? When?

List any medications and supplements you currently take:

FAMILY HISTORY: list any significant family history

LIFESTYLE: Circle the best answer

Alcohol: None Light Moderate Heavy

Caffeine: None Light Moderate Heavy

Tobacco: None Light Moderate Heavy

Appetite: Poor Light Moderate Healthy

How many days/week do you exercise?_____

How many hours of sleep do you get each night? _____

PERSONAL AND SOCIAL HISTORY:

Work:

How many days a week? _____ How many hours do you work each day? _____

How many hours are sitting? _____ Standing? _____ Repetitive movements? YES NO

Personal:

Hobbies that require significant physical stress?

Repetitive stress?

REVIEW OF SYSTEMS: Circle any symptoms you are currently experiencing

Chest Lungs: shortness of breath, chronic coughing, emphysema, asthma, bronchitis, tuberculosis,

bronchiectasis or pneumonia

Eyes Ears Nose Throat: colds, deafness/ringing in the ears, enlarged glands, enlarged thyroid, eye pain,

failing vision, far sightedness, near sightedness, hay fever, nasal obstruction, nosebleeds, sinus infection,

tonsillitis

Skin Hair Nails: bruising easily, dryness, eczema, hives or allergy, psoriasis, rashes, shingles, brittle hair,

non-baldness patterned hair loss

Cardiovascular: hardening of arteries, high blood pressure, low blood pressure, dizziness, pain over heart, poor

circulation, rapid heartbeat, slow heartbeat, swelling of ankles

Gastro Intestinal: belching or gas, colitis, colon trouble, constipation, diarrhea, difficult digestion, distension

of abdomen, gallbladder trouble, jaundice, liver trouble, nausea, vomiting