Patient Information Form

Patient Information

Patient Last Name:_____First:_____MI:_____
Address:_____City:_____State/Zip:_____
Home Phone:_____Cell Phone:_____# of Children:_____
SSN:_____Patient DOB:_____Age:_____Marital Status:_____
Email Address:_____
Would you like text message and/or email reminders of your appointments?_____
If you would like text message reminders, please write your mobile carrier_____
Patient Occupation:_____Employer:_____
Employer Address:_____Work Phone:_____

Emergency Contact Information

Contact Name:_____Relationship:_____
Address:_____City:_____State/Zip:_____
Home Phone:_____Work Phone:_____Cell Phone:_____

Insurance Information

Do you have insurance?_____
Would you like us to bill your insurance for you?_____
If yes to both questions, please provide us your card to take a copy of.

Referral/Purpose

How were you referred?_____
Purpose of this appointment_____
Have you ever had same/similar condition? Describe:_____
_____
Days lost from work?_____

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 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.

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 that you do not want to receive your medical records, please inform the office.

Patient's Signature:_____Date:_____

Parent/Guardian Signature:_____Date:_____

Case History

Review or Systems

Do you have skin, hair, or nail problems? _____
Do you have mouth and/or throat problems?_____
Do you have nose and/or sinus problems?_____
Do you have ear problems?_____
Do you have eye problems?_____
Do you have chest or lung (breathing) problems?_____
Do you Smoke?_____ Cigarettes per day?_____ How long have you smoked?_____
Do you have heart and/or blood vessel problems?_____
Do you have blood or lymph node problems?_____
Do you have digestive problems?_____
Do you have genital problems? (Ex. Prostate, testicular, vaginal)?_____
Do you have urinary (including kidney or bladder) problems?_____
Do you have any gland and/or hormone problems?_____
Do you have allergy or immunity problems?_____
Do you have any muscle, tendon, or ligament problems?_____
Do you have any bone or joint diseases (Ex. osteoporosis, arthritis)?_____
Do you have any nervous system, disease and/or mental health problems?_____

Past History

List any diseases that you have had in the past, including childhood disease:_____
_____
Tell us if you have ever been diagnosed as having a particular condition such as diabetes, AIDS, ect.:_____
_____
Have you suffered any physical injuries, such as falls or blows, auto accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken, or cracked bones?_____
_____
_____
_____
List any surgeries you have had. (Including appendix, tonsils, ear tubes, and wisdom teeth):_____
_____Date:_____
_____Date:_____
_____Date:_____
_____Date:_____
Have you ever been hospitalized for any reason other than surgery?_____
Medications: Please list all prescriptions/non-prescriptions medication you are taking on a regular and/or occasional basis_____

Social History

In what position do you usually sleep and how well?_____
Do you exercise on a regular basis?_____
How do you spend your spare time?_____
Do you use: Caffeine?_____Tobacco?_____Nicotine?_____Recreation drugs?_____Alcohol?_____
Please describe your work type: Physical labor?_____Driver?_____
Clerical?_____Factory?_____Homemaker?_____
Describe your physical demands: Heavy?_____Moderate?_____Mild?_____Sedentary?_____
Please describe your work stress level: High?_____Medium?_____Low?_____
Your diet is: Balanced:☐_____Fair:☐_____Poor:☐_____Excessive:☐_____Rstrctd:☐_____

Family History

Are there any diseases or conditions that are common among your family members?_____
_____

Current Treating Physicians

Primary Care Physicians:_____Phone #:_____
OB/GYN:_____Phone #:_____
Dentist:_____Phone #:_____

Any Additional Information

_____
_____
_____
_____