

CONFIDENTIAL HEALTH INFORMATION



Please allow our staff to photocopy your driver's license and insurance details.

All information you supply is confidential.
We comply with all federal privacy standards.
Please print clearly.

TODAY'S DATE (MM/DD/YYYY)

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	MARITAL STATUS: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> SEP
SOCIAL SECURITY NUMBER:	GENDER: <input type="checkbox"/> M <input type="checkbox"/> F
SPOUSE'S NAME:	
CHILD'S NAME & AGE	
CHILD'S NAME & AGE	
CHILD'S NAME & AGE	
EMERGENCY CONTACT:	
PHONE:	
OCCUPATION	
EMPLOYER	
ADDRESS:	
CITY:	STATE/ZIP CODE:
WORK PHONE	MAY WE CONTACT YOU AT WORK? <input type="checkbox"/> Y <input type="checkbox"/> N
INSURANCE CARRIER	
WHO CARRIES THIS POLICY? <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT	
POLICY NUMBER:	
INSURED'S NAME:	
INSURED'S EMPLOYER	
ADDRESS:	
CITY:	STATE/ZIP CODE:
EMPLOYER'S PHONE:	

PATIENT NAME: _____ DR.'S INITIALS: _____

Describe the Reason for visit:

Is the condition due to an accident? Y N Date of accident: _____

Type of Accident: Auto Work Home Other When did this concern begin? _____

Has this concern: Gotten Worse Stayed Constant Comes and Goes

Has this concern occurred before: Y N Please Explain: _____

Have you seen other doctors for this concern? Y N Please Explain: _____

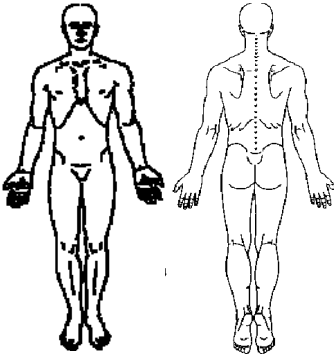
Doctor's Name: _____ Results: Good Bad Indifferent

6. What does it feel like? 7. Where does it hurt?

Numbness
Tingling
Stiffness
Dull
Aching
Cramps
Nagging
Sharp
Burning
Shooting
Throbbing
Stabbing
Other: _____

Intensity (How extreme are your current symptoms?)

0 10
Absent *Uncomfortable* *Agonizing*



8. Does it affect other areas of your body? Y N
 To what areas does the pain radiate, shoot, or travel? _____

9. What makes it better or worse, such as time of day, movements, certain activities, etc.
 What tends to worsen the problem? _____
 What tends to lessen the problem? _____

10. What have you done to relieve the symptoms?

Prescription medication Surgery Ice Over-the-Counter Drugs
Acupuncture Heat Homeopathic remedies
Chiropractic Physical Therapy Massage
Other: _____

11. What else should the Doctor know about your current condition? _____

12. How does your current condition interfere with your:

Work or Career: _____

Recreational Activities: _____

Household Responsibilities: _____

Personal Relationships: _____

Review of symptoms:
 Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please check the box beside any condition that you've had or currently have and initial to the right.

Musculoskeletal		_____ Initials		
Had	Have	Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Wrist Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TMJ Issues
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hip disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Posture
				<input type="checkbox"/> None

Confidential Health Information

PATIENT NAME: _____ DR.'S INITIALS: _____

Review of symptoms: (cont'd)					
Neurological		_____ Initials			
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Depression	None		
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Pins and Needles
			<input type="checkbox"/>	<input type="checkbox"/>	Numbness
Cardiovascular		_____ Initials			
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Angina <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bruising <input type="checkbox"/>
Respiratory		_____ Initials			
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia <input type="checkbox"/>
Digestive		_____ Initials			
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia/Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Constipation <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Food Sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea <input type="checkbox"/>
Sensory		_____ Initials			
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Ear Infection <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Loss of smell <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Loss of taste <input type="checkbox"/>
Dermatology		_____ Initials			
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Acne <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Hair Loss <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Rash <input type="checkbox"/>
Endocrine		_____ Initials			
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Issues	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Infection <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Immune Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Glands <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Low Energy <input type="checkbox"/>
Genitourinary		_____ Initials			
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Issues <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Erectile dysfunction <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	PMS Symptoms <input type="checkbox"/>
Constitutional		_____ Initials			
Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Low Libido	<input type="checkbox"/>	<input type="checkbox"/>	Sudden Weight Changes <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Weakness <input type="checkbox"/>

Confidential Health Information

PATIENT NAME: _____ DR.'S INITIALS: _____

PERSONAL

Illnesses- Check the illnesses you have had in the past or have now.

Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Malaria
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Measles
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Polio
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	STD
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Typhoid Fever
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

OPERATIONS

Surgical interventions, which may or may not have included hospitalization.

<input type="checkbox"/> Appendix Removal <input type="checkbox"/> Bypass Surgery <input type="checkbox"/> Cancer <input type="checkbox"/> Cosmetic Surgery <input type="checkbox"/> Elective Surgery: _____ <input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Hysterectomy <input type="checkbox"/> Pacemaker <input type="checkbox"/> Spine: _____ <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Vasectomy <input type="checkbox"/> Other: _____
--	---

TREATMENTS

Check the boxes you've received in the past or are receiving currently.

Past	Currently		Past	Currently	
<input type="checkbox"/>	<input type="checkbox"/>	Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	Homeopathy
<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Hormone Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/>	Inhaler
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Massage Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Physical Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Chiropractic Care	<input type="checkbox"/>	<input type="checkbox"/>	Nutritional Supplements
<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Herbs	<input type="checkbox"/>	<input type="checkbox"/>	Medications

INJURIES

Have you ever...

<input type="checkbox"/> Had a fractured or broken bone <input type="checkbox"/> Had a spine or nerve disorder <input type="checkbox"/> Been knocked unconscious <input type="checkbox"/> Been injured in an accident	<input type="checkbox"/> Used a crutch for support <input type="checkbox"/> Used a neck or back brace <input type="checkbox"/> Received a tattoo <input type="checkbox"/> Had a body piercing
--	--

Confidential Health Information

PATIENT NAME: _____ DR.'S INITIALS: _____

FAMILY							
Relative	Age (if living)	State of Health		Illnesses	Age at Death	Cause of Death	
		Good	Poor			Natural	Illness
Mother	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Father	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Sister 1	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Sister 2	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Brother 1	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Brother 2	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Are there any other hereditary health issues that you know about?

SOCIAL

Tell the Doctor about your health habits and stress levels.

Alcohol Use	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	How much? _____	Prayer or meditation?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Coffee Use	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	How much? _____	Job Pressure/Stress?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Tobacco Use	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	How much? _____	Financial Stress?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Exercising	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	How much? _____			
Pain Relievers	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	How much? _____			
Soft Drinks	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	How much? _____			
Water Intake	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	How much? _____			

Hobbies: _____

Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals

What would be the most significant thing that you could do to improve your health?

In addition to the main reason for your visit today, what additional health goals do you have?

Confidential Health Information

PATIENT NAME: _____ DR.'S INITIALS: _____

CHIROPRACTIC EXPERIENCE

Have you seen or heard of our office because of (✓ all that apply)
 Drive by/Sign Phone Book Newspaper MD Website Mailing Community Event
 Referred by a Friend or Relative _____
 Other: _____

Have you been adjusted by a chiropractor before? Y N

If yes, what was the reason for those visits?

Doctor's Name:	Approximate date of last visit:
----------------	---------------------------------

Has any member of your family ever seen a chiropractor ? Y N

ACKNOWLEDGEMENTS

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

_____ **Initials** **I instruct the chiropractor to deliver the care that in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

_____ **Initials** **I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.**
Date of last menstrual period (MM/DD/YYYY): _____

_____ **Initials** **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office.**

_____ **Initials** **To the best of my ability, the information I have supplied is complete and truthful.. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name:

--	--

Date (MM/DD/YYYY) Signature

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
 - You may inspect and receive copies of your records within 30 days with a request.
 - You may request to view changes to your records.
 - In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.
- I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:*
- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
 - Obtain payment from third party payers.
 - Conduct normal healthcare operations such as quality assessments and physician's certifications.
- I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.*

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
------------------------------	--------------------------

SIGNATURE:	DATE:
------------	-------

Confidential Health Information