ABOUT YOU

WHO MAY WE THANK FOR YOUR REFERRAL _____

YOUR NAME_____ BIRTHDATE ___/____/____ SS#_____

DATE OF INJURY _____/_____/_____ HOME ADDRESS _____

CITY _____STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

EMPLOYER _____ CELL PHONE _____CELL PROVIDER_____

MARITAL STATUS S M D W SPOUSE'S NAME _____

E-MAIL ADDRESS _____

FAMILY DOCTOR'S NAME _____ PHONE NUMBER_____

NAME OF INSURANCE HOLDER? SELF ___ OR INSURED'S NAME _____

THEIR D.O.B. _____/____/____ NEAREST RELATIVE NOT AT SAME ADDRESS _____

THEIR PHONE _____

EMERGENCY CONTACT NAME _____

RELATION _____ HOME PHONE _____

ADDRESS _____ WORK PHONE _____

INFORMED CONSENT

I understand and am informed that, as in all health care, and the practice of chiropractic there are some rare risks to treatment, including but not limited to, muscle strains and sprains, fractures, dislocations, disc injuries and stroke. Chiropractic care should never be considered a primary care treatment or substitute for your medical care.

I hereby directly request and authorize the use and assignment of my insurance benefits, benefits paid by any third party insurance, med. pay benefits, and/or rights directly to the provider of services. Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made. I understand that the physician will submit bills directly to the insurance company as a courtesy to the patient. It is the responsibility of the patient to know what his/ her benefits are and physician relies only on what the insurance company states the benefits are. Please be aware that the patient/ guardian is directly and fully responsible to this office and doctors for all bills submitted by them for services rendered by this facility, including any costs incurred for collection expenses at an additional 33.3% should it be necessary. I authorize the provider to release any information required to process insurance claims. I understand the above information, and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical or insurance status. If treatment is prematurely discontinued, a pro-rated refund may be issued if there is a credit balance after deductible and co-pays have been satisfied and all insurance reimbursement has been received by clinic. Any discounts made available to patient at anytime during care may not apply if care is terminated before treatment plan is completed. I also give consent to the performance of treatment and diagnostics that are deemed necessary by the doctor for my care at this facility. Nutritional counseling is not intended to be the primary treatment for any disease. We provide suggested programs to support the normal nutritional needs of the human body.

DATE _____ SIGNATURE X _____

WITNESS X_____

About You 2

Patient Name: _____

REVIEW OF SYSTEMS

Circle Yes or No for the following symptoms

Gastrointestinal			**HEENT**			**Neurological**		
Nausea	No	Yes	Sore Throat	No	Yes	Seizures	No	Yes
Vomiting	No	Yes	Hoarseness	No	Yes	Headaches	No	Yes
Heartburn	No	Yes						
Food sticking to throat	No	Yes	**Cardiovascular**			**Dermatology**		
Painful Swallowing	No	Yes	Abnormal Heart	No	Yes	Rash	No	Yes
Vomiting Blood	No	Yes	Rhythm					
			Chest Pain	No	Yes			
Black Stool	No	Yes	Palpitations	No	Yes	**Musculoskeletal**		
Red Blood in Stool	No	Yes				Joint Pain	No	Yes
Abdominal Pain	No	Yes	**Respiratory**			Arthritis	No	Yes
Constipation	No	Yes	Cough	No	Yes			
Diarrhea	No	Yes	Shortness of Breath	No	Yes	**Psychiatric**		
Loss of Appetite	No	Yes	on exertion			Dementia	No	Yes
Early Satiety (feeling full fast)	No	Yes	Wheezing	No	Yes	Depression	No	Yes
Bloating	No	Yes						
Constitutional			**Genitourinary**					
Recent Weight Gain	No	Yes	Frequent Urination	No	Yes			
# of Pounds _____			Kidney Failure	No	Yes			
Recent Weight Loss	No	Yes	Painful Urination	No	Yes			
# of Pounds _____			Menopause	No	Yes	If No, Date of last Menstrual Cycle		

_____

Are you taking any blood thinners (Coumadin/warfarin, Plavix, Pletal, Pradaxa, Xarelto, Eliquis, heparin, aspirin)? **Yes** **No**

CURRENT MEDICATION

_____ _____ _____

_____ _____ _____

_____ _____ _____

MEDICAL HISTORY

Ascities (extra fluid in abdomen)	No	Yes	High Blood Pressure	No	Yes
Asthma	No	Yes	Kidney Failure	No	Yes
Bleeding Disorder	No	Yes	Kidney Stones	No	Yes
Cancer (type _____)	No	Yes	Liver Disease	No	Yes
Congestive Heart Failure (CHF)	No	Yes	Migraine Headache	No	Yes
Coronary Artery Disease (CAD)	No	Yes	Pancreatitis	No	Yes
Depression	No	Yes	Peripheral Vascular Disease	No	Yes
Diabetes	No	Yes	Rheumatic Fever	No	Yes
Emphysema or COPD	No	Yes	Seizures	No	Yes
Endometriosis	No	Yes	Sleep Apnea	No	Yes
Gallstones	No	Yes	Stomach Ulcer	No	Yes
Heart Arrythmia	No	Yes	Stroke/TIA	No	Yes
Heart Attack (MI)	No	Yes	Thyroid Disease	No	Yes
Hepatitis	No	Yes	Valvular Heart Disease / Endocarditis	No	Yes

About You 3

Patient Name: _____

Medication Allergies/Intolerances

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Past Surgical History

Abdominal Surgery	No	Yes	Gallbladder Removal	No	Yes
List: _____			Heart Valve Replacement	No	Yes
Appendectomy	No	Yes	Hemorrhoid Removal	No	Yes
Cancer Surgery	No	Yes	Hip / Shoulder / Knee Replacement	No	Yes
List: _____			Hysterectomy	No	Yes
Coronary Artery Bypass (CABG)	No	Yes	Laparoscopy	No	Yes
Cosmetic Surgery	No	Yes	Pacemaker	No	Yes
List: _____			Salpingoophorectomy (BSO)	No	Yes
Defibrillator (copy of card)	No	Yes	(tube and ovary removal)		

Hospitalizations

_____
_____
_____

Family Medical History (Please list the relative and age)

Colon Cancer	No	Yes	_____
Colon Polyps	No	Yes	_____
Cancer of:	No	Yes	_____
Stroke/TIA	No	Yes	_____
Heart Disease / Heart Attack	No	Yes	_____
Lung Disease	No	Yes	_____
Autoimmune Disease	No	Yes	_____
Diabetes	No	Yes	_____

Social History

Alcohol Use: No Yes Days per Week / Month: _____ Number of Drinks: _____

Tobacco Use: Never Quit: _____ Current Type: _____ Amount: _____

Occupation: _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Date