

**CONFIDENTIAL PATIENT INFORMATION**

Please print legibly

Date \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Parent/Guardian \_\_\_\_\_  Male  Female Age \_\_\_\_\_

Address \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Mailing Address (if different from above) \_\_\_\_\_ Cell Phone \_\_\_\_\_

\_\_\_\_\_ Work Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status - M S D W Spouse Name \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact (if other than spouse) \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

E-Mail \_\_\_\_\_ Your email will never be sold for commercial use

Is it okay to contact you by e-mail?  Yes  No

Whom may we thank for referring you to our office? \_\_\_\_\_

Is this injury /illness work-related? YES / NO / UNSURE Have you reported it to your employer? YES / NO

If yes: Supervisor's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Is this injury/illness related to an automobile accident? YES / NO (If yes, please provide info below)

Auto Ins. Co. \_\_\_\_\_ Agent \_\_\_\_\_

Policy # \_\_\_\_\_ Claim # \_\_\_\_\_ Phone \_\_\_\_\_

Please describe your current problems as best you can in your own words. Please include when, how, and where it happened: \_\_\_\_\_

\_\_\_\_\_

Please indicate on the diagram any aches, pains, etc...

A = Ache D = Dull S = Sharp T = Tingling N = Numb

List other doctors/location seen for these conditions:

\_\_\_\_\_

\_\_\_\_\_

What are your goals pertaining to these conditions? For example, you would like to be able to walk a mile.

\_\_\_\_\_

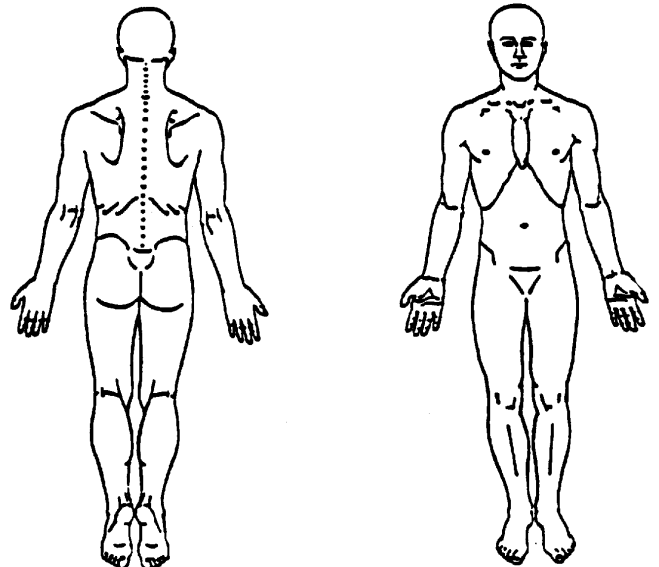
\_\_\_\_\_

Any other concerns you have? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Prior History**

Are you currently under the care of a physician? Y N Name: \_\_\_\_\_  
 Date of last exam \_\_\_\_\_ Date of last x-ray \_\_\_\_\_  
 Prior hospitalization \_\_\_\_\_  
 Any current medications \_\_\_\_\_  
 Any surgeries? Type \_\_\_\_\_ When \_\_\_\_\_  
                           Type \_\_\_\_\_ When \_\_\_\_\_  
                           Type \_\_\_\_\_ When \_\_\_\_\_  
 Do you smoke? Y N How much? \_\_\_\_\_  
 Do you drink alcohol? Y N How much? \_\_\_\_\_  
 How do you spend most of your day?  standing  sitting  walking  other \_\_\_\_\_

**Review of Systems – Please check if you have any of the following NOW or IN THE PAST.**

<input type="checkbox"/> Headache	<input type="checkbox"/> Fatigue	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Multiple sclerosis	Please list any other diagnosis:
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Numbness in arm/hand	<input type="checkbox"/> Spinal curvature	
<input type="checkbox"/> Shingles	<input type="checkbox"/> Cancer	<input type="checkbox"/> Numbness in leg/feet	<input type="checkbox"/> Nervousness	
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pregnant at this time	<input type="checkbox"/> Heart attack	
<input type="checkbox"/> Stiff neck	<input type="checkbox"/> Sinus	<input type="checkbox"/> Pain between shoulders	<input type="checkbox"/> Swollen joints	
<input type="checkbox"/> Backache	<input type="checkbox"/> Migraine	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Carpal tunnel	

**Family History – Please check any conditions that any blood relatives have been diagnosed with.**

<input type="checkbox"/> Arthritis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Other: _____							

**Chiropractic History** Doctor \_\_\_\_\_ City /State \_\_\_\_\_  
 (Most Recent) Clinic \_\_\_\_\_ Phone \_\_\_\_\_  
 Treatment for \_\_\_\_\_ Last Seen \_\_\_\_\_  
 Number of Visits \_\_\_\_\_ How long were you under care? \_\_\_\_\_  
 Reason for discontinuing care \_\_\_\_\_  
 Any prior problems with adjustments we should know about? \_\_\_\_\_

If you have seen more than one Chiropractor, please list the details below

\_\_\_\_\_

\_\_\_\_\_

Discover Chiropractic has a written policy in order to ensure the privacy of your medical information. Would you like a copy of the Privacy Policy?  Yes  No

We will do our best to inform you of the cost of services before they are rendered. If at any time you have questions, please ask a member of our staff. Would you like a copy of the Financial Policy?  Yes  No

**Consent to Treat**

I hereby authorize Discover Chiropractic to administer treatment and perform such general procedures as the attending doctor may deem necessary to myself/my child.

**Authorization of Assignment**

My records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I authorize Discover Chiropractic to release any information requested by any insurance company, attorney or any doctor that is relative to my examination and treatment. I also authorize the payment of medical benefits directly to Discover Chiropractic.

I certify that I provided the above information to the best of my knowledge. I understand and agree that insurance policies are an arrangement between the insurance carrier and myself. I further understand that all services rendered are charged directly to me and that I am personally responsible for payment of my entire bill should my insurance coverage not include any portion of the charges for any reason.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (Guardian if a minor)