

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 _____

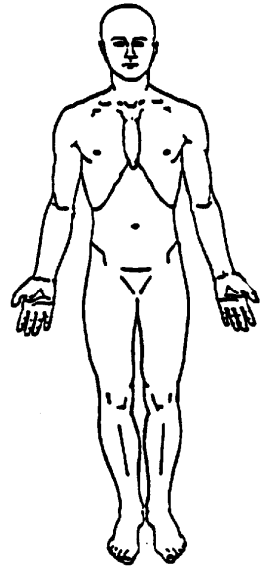
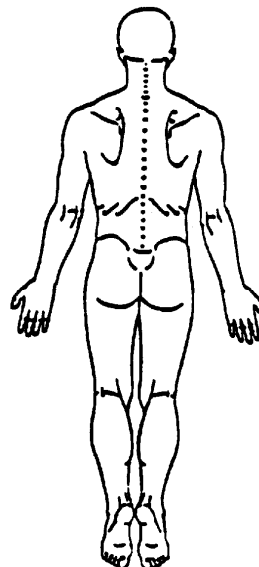
Please describe your current problems as best you can in your own words. Please include when, how, and where it happened: _____

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:

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

Additional Information _____

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.

I may request a copy of the Privacy Policies and Financial Policy at any time.

Patient Signature _____ Date _____
(Guardian if a minor)