We are very glad that you are here!

Please take a moment and let us know how you heard about us

____ Friend _____

____ Google

____ Newspaper

____ Radio

____ Facebook

____ Other _____

Thank you!

PATIENT INFORMATION Date: _____

Patient name: _____ DOB: _____

Prefer to be called: _____ | Male / Female | Minor / Single / Married / Divorced / Widowed |

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Medical doctor: _____ Phone number: _____

EMPLOYER INFORMATION

Employer name: _____ Supervisor: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance: _____ Adjuster name: _____

IN EVENT OF AN EMERGENCY

Contact name: _____ Relationship: _____

Home phone: _____ Cell phone: _____

Our office policy requires payment at the time services are rendered, unless other arrangements are made. The patient is responsible for legal/collection agency fees, as well as interest charges or other expenses if the balance remains unpaid past 90 days of treatment. The staff and provider are authorized to perform necessary services during diagnosis and treatment.

By signing below, I acknowledge that I have received a copy of the summary of privacy notice. I also understand the information stated above. The information provided is the most current and accurate to my knowledge. It is my responsibility to update this office of any changes.

Signature: _____ Date:_____

Email: _____

CANCELLATION/NO SHOW POLICY:

Appointments canceled with less than 24-hour notice or missed appointments may incur a fee. Repeated

last-minute cancellations may result in scheduling limitations.

☐ I understand and accept the cancellation/no show policy

_____ _____

Parent/guardian signature Date

REASON FOR VISIT

Reason for today's visit: ☐ Emergency ☐ New Injury ☐ Chronic Pain ☐ Wellness
Are you in pain? _____ If yes rate your pain: 1 2 3 4 5 6 7 8 9 10
Is this injury the result of: ☐ Auto Accident ☐ Work ☐ Routine/Household Activity ☐ Play/Sports
When did the accident/injury happen? ___/___/___ Where did your injury occur? _____

Explain what happened in your own words: _____

_____

Is your condition: ☐ Getting worse ☐ Constant ☐ Comes and goes

Is your condition interfering with your: ☐ Work ☐ Sleep ☐ Routine

If so, how? _____

PLEASE CIRCLE THE AREAS YOU ARE HAVING TROUBLE WITH

Has a similar incident ever happened before?

If so, please explain: _____

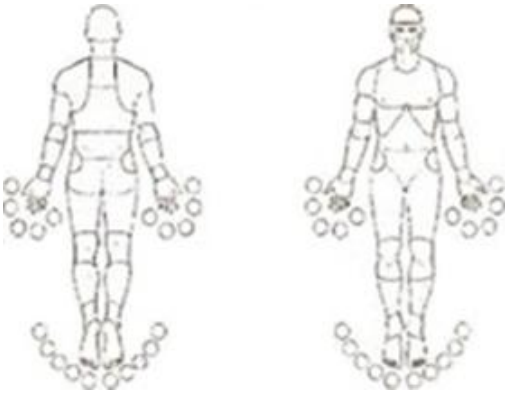
Have you been treated by a medical physician for this condition?

☐ Yes ☐ No Where? _____

Have you ever been treated by a chiropractor?

☐ Yes ☐ No Clinic name: _____

Phone #: _____



HEALTH HISTORY

Are you taking any of the following medications?

☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Other _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

☐ Heart attack/Stroke	☐ Fainting/Seizures/Epilepsy	☐ Glaucoma
☐ Artificial valves	☐ Chemotherapy	☐ Emphysema/asthma
☐ Shingles	☐ Heart murmur	☐ Mitral valve prolapse
☐ High/low blood pressure	☐ Frequent neck pain	☐ HIV+/AIDS
☐ Ulcers/colitis	☐ Rheumatic fever	☐ Kidney problems
☐ Difficulty breathing	☐ Sinus problems	☐ Tuberculosis
☐ Heart surg./pacemaker	☐ Lower back problems	☐ Arthritis
☐ Alcohol/Drug abuse	☐ Congenital heart defect	☐ Psychiatric problems
☐ Cancer	☐ Hepatitis	
☐ Severe/frequent headaches	☐ Artificial bones/joints/implants	

List surgeries with dates: _____

Allergies: _____ Family health history: _____

Do you take supplements/vitamins? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Wks: ____

HIPAA Compliance Patient Consent Form

Our notice of privacy practices provides information about how we may use or disclose protected health information.

The notice contains a patients' rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified on your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time, and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? ☐ Yes ☐ No

If YES, please name the members allowed: _____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Emergency contact: _____ Phone #: _____