**Spinal Care Associates**

**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 can begin any health care treatment we need you to read and sign this consent 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 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 purposes of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this Chiropractic office to submit requested PHI of 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 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 to the patient in this office.

 4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for 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 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 given care.

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Parent or Guardian Date

**Pertinent Data**

**Patient’s Attorney Information**

Attorney Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Firm: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MED PAY Information**

Patient’s Auto Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Adjustor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Third Party Insurance Information**

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Adjustor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of Information**

I give Spinal Care Associates permission to talk to the following people about my records/treatment (please print):

|  |  |  |
| --- | --- | --- |
| **Name**  | **Relationship to Patient** | **Best Contact Number** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization and Assignment of Benefits**

1. You are to release any information you deem appropriate concerning my health condition to an insurance company, attorney or adjuster in order to process any claim for reimbursement of charges to the doctor and/or clinic by me.

2. I authorize and assign the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you in part upon the charges made for services.

3. I give assignment and lien against any claims against a third party whose negligence may have caused the patient’s injury, up to the amount of the bill for treatment.

4. In the event any insurance company, obligated by contractual agreement to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that when all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

5. I waiver the statute of limitations regarding my doctor’s right to recover.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTOMOBILE ACCIDENT QUESTIONNAIRE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_Today’s Date: \_\_\_\_\_\_\_\_\_\_

1. Date of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ A.M./P.M.

2. Describe the collision in your own words: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. In what city/town and state did the accident occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Where were you seated? Driver Front Passenger Rear Passenger (Right/Left/Center)

5. Who was the driver? (If not you): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. What type of vehicle were you in? (Make & Model): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. What type was the other vehicle? (Make & Model): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Was your vehicle initially struck by another vehicle? Yes No

9. Did your vehicle initially strike the other vehicle? Yes No

10. What was your collision with? Another Vehicle Motorcycle Tree

 Guardrail Pedestrian

11. What type of collision? Rear-End Collision Passenger-Side Driver-Side

 Head- On Front-End Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. How fast were you driving? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MPH Stopped

13. How fast was the other vehicle driving? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MPH Stopped

14. What were the road conditions like? Dry Wet Snowy Icy/Slick

15. What was the visibility at the time of the accident? Good Fair Poor

16. What was the weather like? Sunny Raining Snowing Dark

17. Were you wearing a seatbelt? Yes No

18. Where were you looking at the time of impact? Straight Ahead To the Right

 To the Left Down Up Backwards Rearview Mirror

19. Were you surprised by the impact? Yes No

20. Were you braced for the impact? Yes No

21. Did your seat have a head rest? Yes No Not Sure

22. Did any part of your body hit the interior of the vehicle? Yes No Not Sure

 If yes, which body part? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What did the body part hit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

23. How did you feel immediately after the accident? Stunned Dazed Confused

 Disoriented Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

24. Did you have pain immediately after the accident? Yes No

 If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

25. Did you lose consciousness? Yes No If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

26. Was your vehicle drivable after the accident? Yes No

 If no, how did you leave the accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

27. Did you go to the hospital? Yes No If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How did you get to the hospital? Ambulance Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Did you have any X-Rays, CT Scans or MRI’s taken? Yes No

 Were any medications or medical supplies prescribed to you? Yes No

 If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

28. Have you miss any time from work as a result of this accident? Yes No

 If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

29. Do you have an attorney handling this case? Yes No

 If yes, please list name, address and phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergy Name (latex, lidocaine, medications, food, etc.): Reactions and Symptoms:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Smoking Status: Current Every Day Current Some Days Former Never Start Year: \_\_\_\_\_\_ Quit Date:\_\_\_\_\_\_

Current Medications:

1. Drug Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Drug Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Frequency (e.g. once daily):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency (e.g. once daily):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Drug Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. Drug Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Frequency (e.g. once daily):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency (e.g. once daily):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

Alcohol Use:

 None Light Moderate Heavy

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

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Exercise: None Light

 Moderate Heavy

Recreational Drug Use:

 None Light Moderate Heavy

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

**Authorization for Release of Information**

Referred By:

**Other Patient Information**

Phone & Location:

Primary Care Physician’s Name:

**Primary Care Physician**

Emergency Contact Address:

Employer:

Emergency Contact Name & Phone Number:

E-Mail Address:

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

Preferred Phone:

 Home Work Cell

Cell Phone:

Work Phone:

Home Phone:

Zip Code:

State:

Address:

City:

Marital Status:

 Single Married Divorced Widowed Other

Social Security Number:

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

Sex:

 M F

Date of Birth:

Nickname:

Patient’s Last Name: First: MI:

**Patient Information**

Today’s Date:

Confidential Patient Data

For consideration which I acknowledge, I grant to Spinal Care Associates the right to use my name, image, video and audio for marketing materials such as, but not limited to, Spinal Care Associates’ website, Facebook and Instagram.

 Yes No

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Family History** |
| Please indicate which conditions exist or have existed by marking the boxes below. |
|  | Self | Mother | Father | Sister | Brother | Son | Daughter |
| Arthritis |  |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |  |
| Blood Disorders |  |  |  |  |  |  |  |
| Dementia/Alzheimer’s |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |
| Stomach/Intestinal Disorders |  |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |  |
| Lung Disease |  |  |  |  |  |  |  |
| Neurological Disorders |  |  |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |  |  |
| Psychological/Mental Disorders |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |
| Other Patient Conditions |  |  |  |  |  |  |  |
| Unknown Conditions |  |  |  |  |  |  |  |
| **Comments/Explanations for any conditions marked above:** |
| **Please list any previous surgeries:** |
| **Please list your symptoms/pain from WORST to LEAST:****1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Cause of Pain (Example: Fall, Lifting, Gradual Onset, etc.):**

**Rate your pain when it is at its WORST (1-10, 10 being the worst):**

 **1 2 3 4 5 6 7 8 9 10**

**Please list any activities impaired by the pain/discomfort (Example: Lifting Children, House Work, Driving, etc.):**



**Pain Quality:**

* None
* Aching
* Burning
* Cramping
* Deep
* Dull
* Numbness
* Radiating

- Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Sharp
* Shooting
* Stiffness
* Tightness
* Tingling

**Pain Frequency:**

* Constant
* Frequent
* Intermittent
* Occasional
* Never

**Start of Pain:**

**\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**Have you had chiropractic care in the past?**

 Yes No

**Are you currently pregnant or is there a possibility you could be?**

 Yes No

C

Mark any areas of complaint

**Pain Aggravated By:**

Bending Driving

 Exercising Getting up/down

 House Work Increased Activity

 Lifting Looking Down

 Lying Down Overhead Activities

 Reaching Sitting

 Sneezing/Coughing Standing

 Walking None of the Above

**Pain Relieved By:**

 Exercise Heat

 Ice Lifting

 Lying Down Medication

 Resting Sitting

 Standing Stretching

 Walking None of the Above

Symptoms/Conditions:

**Other comments in regards to your symptoms:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**