

Confidential Patient Health Record
(Application for Care)

PERSONAL INFORMATION

Full Name _____ Address _____
City _____ State _____ Zip/Postal Code _____
Home Phone(_____) _____ Birth Date ____ / ____ / ____ Age ____ Sex M F
Daytime/Work Phone (_____) _____ eMail Address _____
SS# _____ - _____ - _____ Drivers Lisc. # _____ # of Children _____
Occupation _____ Business/Employer _____
Marital Status Mar Sin Wid Div Referred by? _____
Activities: Hobbies/Interest _____
Name/# of Emergency Contact _____ Relationship _____

CURRENT HEALTH CONDITION

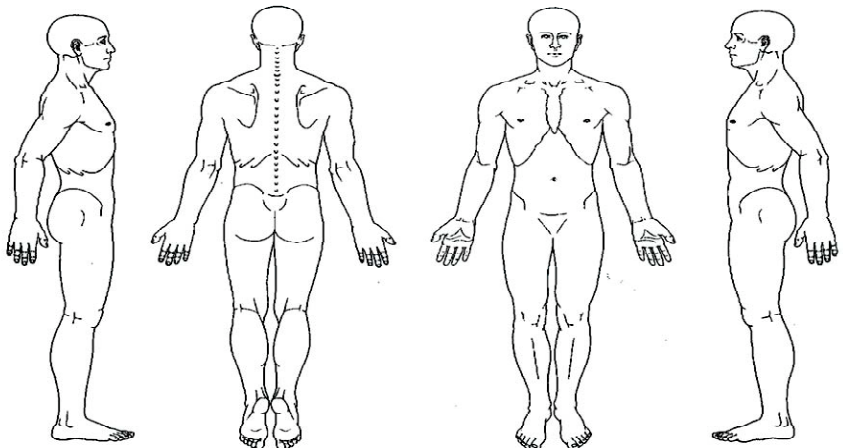
Purpose of your visit _____
Other doctors seen for this condition Yes No Pls indicate? _____
Type of treatment _____ Results _____
When did this condition begin _____
Is this condition Job Related Auto Accident Home Injury Fall Other _____
Pain Scale: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain
Please list all medications you are currently taking for this condition: _____

For this condition have you had: X-Ray MRI CT. Do you wear shoe inserts? Yes No
Does your condition interfere with: Work Sleep Other Activities of Daily Living
Have you had symptoms like this before? Yes No. If Yes, Please describe _____

Do you suffer from ANY CONDITIONS other than that which you are now consulting? Yes No
If yes, please describe _____

Please show areas of:

- Main Pain - *
- Secondary Pain - o
- Numbness - ///
- Pins & Needles - :::
- Skin lesions/Scarring - >>>
- Fracture - XX
- Weakness - ##



Patient's Signature



Date: _____

Confidential Patient Health Record

PAST HEALTH HISTORY

Please check any that apply:

- Appendectomy
- Tonsillectomy
- Gall Bladder Removal
- Hernia
- Broken Bones Pls Indicate _____
- Spinal Surgery(Back or Neck)
- Auto Accidents - __Past Year __-5 Yrs __+5 Yrs
- Other _____
- Major accidents or falls _____
- Hospitalizations (Other than Above) _____

Previous Chiropractic Care

- None
- Dr's Name & Approx. Date of Last Visit _____

What expectation do you have as a result of your care here: Pain Releif Feel Better Improve Quality of Life

- Other: _____

Below are list of diseases which my seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | |
|--|--|--|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> AIDS / HIV Positive | <input type="checkbox"/> Pleurisy | |

HEALTH HABITS

- Alcohol (>1 drinks per week)
- Cigarettes
- Exercise (> 2X Week)
- How would you rate your Nutrition?
- Excellent Fair Poor
- Sleep? ____ Hours Quality E F P

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD IN THE PAST 6 MONTHS:

Musculo-Skeletal

- Low Back Pain
- Walking Problems
- General Stiffness
- Muscle Stiffness or Spasms
- Swollen Joints
- Pain in Legs or Feet
- Sciatica

Gastro-Intestinal

- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Gall Bladder Problems
- Abdominal Cramps
- Indigestion
- Gas / Bloating after Meals
- Heart burn

Nervous System

- Loss of Balance
- Numbness Paralysis
- Dizziness
- Numbness or Tingling in Extremities

General

- Fatigue / Low Energy
- Allergies / Hay Fever
- Headaches

Genito-Uriary

- Bladder Trouble
- Kidney Trouble

Family History

- Diabetes/Kidney Disease
- High Blood Pressure/Cholesterol
- Heart Attack/Disease
- Stroke
- Aneurysm
- Cancer
- Arthritis
- Osteoporosis

Females Only

- Menstrual Irregularity
- Menstrual Cramps
- Other Problems _____
- WHEN was your last Period?

Are you Pregnant?

- Yes No Not Sure

Cardio-Vascular

- Shortness of Breath
- High Blood Pressure
- Irregular Heartbeat
- Lung Problems / Congestion
- Heart Problems
- Ankle Swelling
- Asthma

EENT

- Vision Problems
- Sore Throat
- Earache
- Hearing Difficulty
- Sinus Trouble
- Ringing in Ears

Patient's Signature: _____

X

Date: _____

Confidential Patient Health Record

INSURANCE INFORMATION

Who is Responsible for Your Bill? You Spouse Parent/Guardian Insurance Other: _____

Patient's Name: _____ SS#: _____ - _____ - _____ DOB _____

(if different)
Insured's Name: _____ SS#: _____ - _____ - _____ DOB _____

Primary Insurance

Insurance Company: _____

Address: _____

Phone: (_____) _____ Policy Type (Group, Private, Med Pay): _____

Policy #: _____ Group #: _____

Secondary Insurance (If Any)

Insurance Company: _____

Address: _____

Phone: (_____) _____ Policy Type (Group, Private, Med Pay): _____

Policy #: _____ Group #: _____

Medicare

No Coverage Yes - Medicare ID#: _____

INSURANCE POLICY, RETURNED CHECKS & COLLECTION POLICY

PLEASE READ CAREFULLY AND SIGN BELOW

I (we) agree to pay for services rendered for the above mentioned patient as the charge is incurred. I fully understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree all services rendered are charged directly to me and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable. I have been advised and concur. Past due accounts will bear interest at 1% per month on the past due balance. I am responsible for cost required to enforce collection of my account, including but not limited to collection fees, attorney fees and court costs. Returned checks are collected automatically & there is a fee associated.

Patient's Signature  _____ Date _____

How will payment be made?

Cash: ___ Check ___ Credit Card ___ Health Insurance ___ Workers Comp. ___ Auto Insurance Policy ___