CHIROPRACTIC HEALTH AND WELLNESS

PATIENT INFORMATION AND HISTORY

Date:____________________

1 PATIENT INFORMATION

Name:____
Address:____
City, State, Zip:____________________________________
Date of Birth:________________ Age:_____ ☐Male ☐Female
Best phone number to reach you:_______________________
Email:____
Best way to reach you: ☐ Phone ☐Email
How did you hear about our clinic?_____________________
Occupation:____
Employer:____
Parent's Name (If a minor):____________________________
☐ Single ☐Married ☐ Divorced ☐Widowed ☐ Partnered
Spouse/Partner's Name:_______________________________
# of Children:_____ Name(s):___________________________
IN CASE OF AN EMERGENCY, PLEASE CONTACT:
Name:_________________________ Relationship:___________
Home #:_________________ Cell:_________________________

2 ACCOUNT INFORMATION/INSURANCE

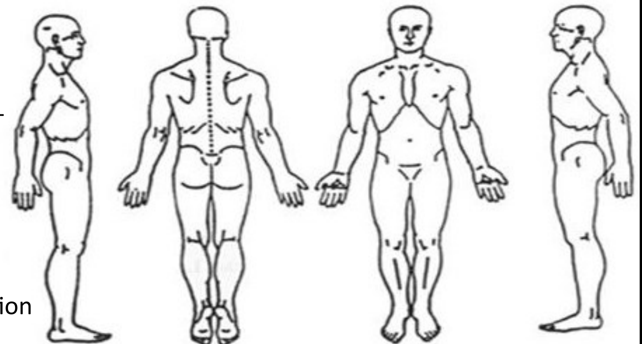
Who is financially responsible for this account?________________
Relationship to patient:____________________________________
Patient's insurance company:_______________________________
Subscriber's name:____
Relationship to patient ☐Self ☐Spouse ☐ Parent ☐ Other
Subscriber's date of birth:_________________________________
Insurance ID number:_______________________________________
Group/Claim number:_______________________________________

Is patient covered by additional insurance? ☐ Yes ☐ No
Insurance company:____
Secondary Ins ID number:___________________________________
Secondary Ins group number:________________________________
Is your condition due to an accident? ☐No ☐Yes Date:_______
Type of accident? ☐Auto ☐Work ☐ Home ☐ Other
To whom have your reported the accident?
☐ Your auto insurance ☐ Employer ☐Other
Please provide insurance card(s) so we may scan in to your file.

3 PATIENT CONDITION

What is your primary symptom/health issue?____
When did this condition begin?____
Have you had this problem before? ☐ Yes ☐ No If yes, when:________
How often do you feel it? ☐ Constant ☐ Daily ☐ Comes and goes
How does it feel? ☐Burning ☐ Sharp ☐ Shooting ☐ Dull ☐Aching
☐ Stiff ☐ Tingling ☐ Throbbing ☐ Swelling ☐Other_________
Circle below the severity of your pain on a scale of 0 to 10:
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)
What makes your condition better?_______________________
What makes your condition worse?_____________________________
Does it interfere with your ☐Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Please mark where it hurts



Activities/movements that are painful/difficult to perform:
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Driving ☐ Other:_____________
What other treatment have you had for this condition? ☐Chiropractic ☐ Medical ☐Physical Therapy ☐Surgery ☐ Other
Please describe the other doctor's treatment for your condition: ____
Previous chiropractic care? ☐No ☐ Yes Date:_________ ☐ Local ☐ Out of state:_____ Duration of treatment:_________
Is there anything else you would like the doctor to know about this condition? ______________________________________

What is your secondary symptom/health issue?____

When did this condition begin?____

Have you had this problem before? ☐ Yes ☐ No If yes, when:________

How often do you feel it? ☐ Constant ☐ Daily ☐ Comes and goes

How does it feel? ☐ Burning ☐ Sharp ☐ Shooting ☐ Dull ☐ Aching ☐ Stiff ☐ Tingling ☐ Throbbing ☐ Swelling ☐ Other_________

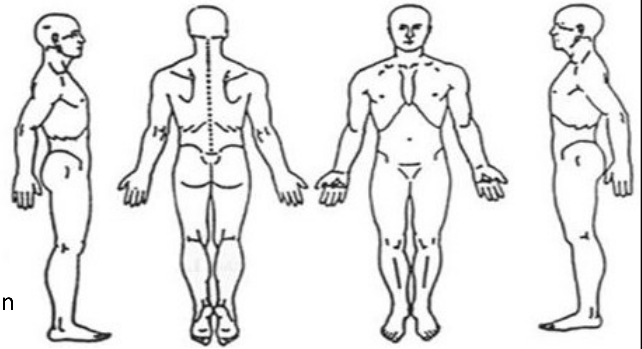
Circle below the severity of your pain on a scale of 0 to 10:

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

What makes your condition better?_______________________

What makes your condition worse?____________________________

Please mark where it hurts



Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities/movements that are painful/difficult to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Driving ☐ Other:_______________

What other treatment have you had for this condition? ☐ Chiropractic ☐ Medical ☐ Physical Therapy ☐ Surgery ☐ Other

Please describe the other doctor's treatment for your condition: ____

Previous chiropractic care? ☐ No ☐ Yes Date:_________ ☐ Local ☐ Out of state:_______ Duration of care:____________

Is there anything else you would like the doctor to know about this condition? ____

4 HEALTH HISTORY

Check any of the following conditions you have had:

( ) AIDS/HIV
( ) Allergies/Sinus
( ) Anxiety/Depression
( ) Arm/shoulder pain
( ) Arthritis
( ) Asthma
( ) Bladder problems
( ) Cancer
( ) Diabetes
( ) Digestive issues
( ) Ear ringing/pain
( ) Epilepsy
( ) Foot/ankle pain
( ) Hand/wrist pain
( ) Headaches
( ) Headaches—Migraine
( ) Heart disease
( ) Hemorrhoids
( ) Herniated disc
( ) High blood pressure
( ) Kidney problems
( ) Leg/knee pain
( ) Mid/low back pain
( ) Neck pain
( ) Numbness/tingling
( ) Osteoporosis
( ) PMS/irregular cycle
( ) Poor circulation
( ) Prostate problems
( ) Rheumatoid arthritis
( ) Sciatica
( ) Shingles
( ) Sinus infection
( ) Sleep issues
( ) Stroke
( ) Thyroid problems
( ) Tiredness/Fatigue
( ) TMJ/jaw pain
( ) Venereal disease
( ) Vertigo/dizziness
( ) Weight issues (gain/loss)
( ) Other______________

Stressors:

( ) Smoking Packs/day:__________ ( ) Coffee Cups/day:______________

( ) Alcohol Drinks/week:________ ( ) High stress level Reason: ____________________________________

Exercise:

( ) None ( ) Moderate ( ) Daily ( ) Heavy

List any medications you are taking:____

Vitamins/herbs/minerals:____

Females: Are you pregnant? ( ) Yes ( ) No ( ) Possibly Beginning of last menstrual cycle:_______________________

Have you had any:	**Description**	**Date**
Automobile/work related accidents:	___________________________	______________
Surgeries:	___________________________	______________
Broken bones:	___________________________	______________
Falls/Head injuries:	___________________________	

5 AUTHORIZATION AND AGREEMENT FOR PAYMENT OF SERVICES RENDERED

It is the policy of Chiropractic Health and Wellness to collect on the day of service for all services as they are rendered, unless other financial arrangements are made. ***I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT.*** As a courtesy, the clinic will submit claims to my insurance for all services and assist me in receiving any out-of-network benefits that I may be entitled to. I authorize Chiropractic Health & Wellness to release information regarding my treatment to any insurance company, attorney, and/or adjustor in order to process any claims for reimbursement of charges incurred by me.

_______________________________ Print patient name

______________ Date

_______________________________ Signature (if patient is a minor, parent signature)

Acknowledgement of Chiropractic Health and Wellness Center's Privacy Practices

I acknowledge that this clinic's Notice of Privacy Practice's has been made available to me either online or in the clinic. I also understand that this Notice is available by request.

______________________________ _______________ _______________________________________

Patient's Name **Date** **Signature (if minor, parent's signature**

Chiropractic Health and Wellness Center's

Informed Consent for Examination and Treatment

This document explains some potential risks associated with chiropractic care. Please read this information carefully and let our staff know if you have any questions.

The doctors and staff of Chiropractic Health and Wellness Center will do everything to assist you with your health or your condition. Please be aware that, as with all healthcare systems, we cannot guarantee a cure or resolution of your problem.

While chiropractic care is remarkably safe, there are some associated risks. We feel that you need to be fully informed about these risks before consenting to treatment.

Soreness – Chiropractic adjustments and associated therapies may sometimes cause post-treatment soreness. While soreness is usually mild and temporary, please tell your doctor if you experience this.

Soft Tissue Injury – Rarely, chiropractic treatment may aggravate a disk injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

Rib Injury – Adjustments to the mid back, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk for fracture. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns – Heat generated by physical therapy modalities may cause minor burns to the skin. This is rare, but if it occurs you should report it to your doctor.

Stroke – Stroke is the most serious complication of chiropractic care, but fortunately its occurrence is extremely rare. The most recent studies estimate that the incidence of stroke is one in five million neck adjustments.

Other Complications – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

We will make every reasonable effort during examination to screen for potential risks. Please be aware that if you have a condition that would otherwise not come to our attention, it is your responsibility to inform the doctor.

I, the undersigned, agree that I have read, or have had read to me, and understand the information stated above. I hereby authorize the doctors and staff of Chiropractic Health and Wellness Center (CHWC) to perform examination procedures and administer treatment to me, or to the person listed below for whom I serve as legal guardian. I understand that all procedures and treatment will be explained to me before they are performed, and that I have the right to refuse any such procedures.

______________________________ _______________ _______________________________________

Patient's Name **Date** **Signature (if minor, parent's signature)**