CHIROPRACTIC HEALTH AND WELLNESS

PATIENT INFORMATION AND HISTORY

1 Date:_____

PATIENT INFORMATION

Name:_____

Address:_____

City, State, Zip:_____

Date of Birth:_____ Age:_____

☐ Male ☐ Female ☐ _____ Sex at birth:_____

Cell 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 Medicare? ☐ Yes ☐ No

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 ID and insurance card(s) so we may scan in to your file.

3

PATIENT CONDITION

PRIMARY complaint (List only one):_____

When did this condition begin?_____ Was this condition the result of an accident or injury? ☐ Yes ☐ No

Please describe the cause of your current complaint:_____

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:

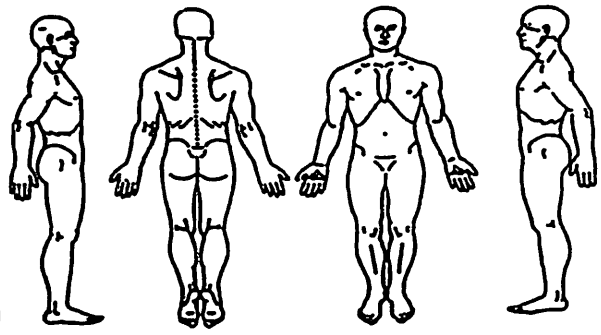
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

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? _____

PATIENT CONDITION (Continued)

SECONDARY complaint (list only one):_____

When did this condition begin?_____ Was this condition the result of an accident or injury? ☐ Yes ☐ No

Please describe the cause of your current complaint:_____

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:

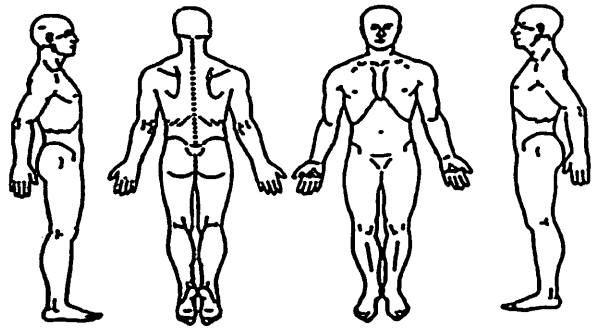
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

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:_____

If you have any additional complaints, please let your doctor know during the exam.

What are your top 3 health goals?

1.) _____

2.) _____

3.) _____

Is there anything else you would like the doctor to know? _____

_____

PERSONAL 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
( ) Other_____

( ) 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
( ) Gluten Intolerance
( ) Poor circulation
( ) Rheumatoid arthritis
( ) Sciatica
( ) Shingles
( ) Sinus infections

Males:
( ) Prostate problems

( ) Sleep issues
( ) Stroke
( ) Thyroid problems
( ) Tiredness/Fatigue
( ) TMJ/jaw pain
( ) Venereal disease
( ) Vertigo/dizziness
( ) Weight gain
( ) Weight loss

Females:
( ) PMS/Irregular cycle
( ) Infertility

Stressors:

( ) Smoking Packs/day:_____
( ) Coffee Cups/day:_____
( ) Alcohol Drinks/week:_____
( ) High stress level Reason: _____

Exercise:

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

Digestion:

Do you have any food sensitivities that you know of? ( )Y ( )N If yes, please list them:

_____

How often do you have a bowel movement? _____
Do you experience constipation? ( )Y ( )N Diarrhea? ( )Y ( )N If yes to either, please describe:

_____

How long have you been dealing with this?_____

Sleep:

How many hours of sleep to you get each night? _____
Do you wake up feeling rested? ( )Y ( )N
Do you have difficulty falling asleep? ( )Y ( )N
Do you have difficulty staying asleep? ( )Y ( )N

Medications/Supplements:

List any medications you are taking:

_____ _____
_____ _____
_____ _____
_____ _____

Vitamins/herbs/minerals:

_____ _____
_____ _____
_____ _____

Females:

Are you pregnant? ( ) Yes ( ) No ( ) Possibly
Beginning date of last menstrual cycle:_____ Length of menstrual cycle:_____
Do you experience PMS symptoms? _____ If yes, please describe:_____
Are you peri-menopausal? ( ) Yes ( ) No Post-Menopause? ( ) Yes ( ) No If yes, how long_____

_____

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

FAMILY HEALTH HISTORY

Patient Name: _____ **Date:** _____

Please review the diseases and conditions listed below.
-Indicate CURRENT health issues of a family member with a "C".
-Indicate PAST health issues of a family member with a "P".
-Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	Siblings		Children		
	Age	Age	Age	Age	Age	Age	Age	Age
ADHD								
Allergies								
Arthritis								
Asthma								
Autism								
Back Trouble								
Bed Wetting								
Bursitis								
Cancer								
Chest Pain								
Colic								
Constipation								
Crohn Disease								
Depression								
Diabetes								
Diarrhea								
Disc Problems								
Down Syndrome								
Ear Infection								
Emotion Issues								
Emphysema								
Epilepsy								
Headaches								
Migraines								
Heartburn								
Heart Trouble								
High Blood Press								
IBS								
Indigestion								
Infertility								
Insomnia								
Kidney Trouble								
Neck Pain								
Neuritis								
Nervousness								
Pinched Nerve								
Scoliosis								
Sinus Trouble								
Other								

Additional Comments:

_____

_____

_____

Thank you!

5 *Please read all three sections carefully and sign in EACH section*

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's Name **Date** **Signature (if minor, parent's 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.

Print 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 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.

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