CHIROPRACTIC HEALING & WELLNESS CENTER

PATIENT INFORMATION

WELCOME! Please allow our staff to photocopy your driver's license & all available insurance cards.

PLEASE PRINT

Full Name_____Gender: M F Home phone_____

Address_____City_____State_____Zip_____

Age_____Birth Date_____ Martial Status: S M W D SEP No. Children_____

SS#_____Cell Phone # _____

Your employer_____Your Occupation_____

Employer Address_____City_____State_____Zip_____

Work Phone_____ E-mail_____

Do you have health insurance where you work? **Y N** Plan/Group #_____

Insurance Company_____

Name of Spouse, Parent, or Guardian_____Age____Birthdate___SS#_____
Spouse's employer_____Work Phone_____
Does your spouse have health insurance at work? **Y N** Plan/Group #_____
Insurance Company_____

How did you find out about our office?_____
Describe the major complaints that brought you to our office:_____
_____
Is your condition due to an accident or work injury? **Y N** Date of Accident:_____

I (we) agree to pay for the services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photo static copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed by indebtedness to the assignee. I agree that a photo static copy of this agreement shall serve as the original.

Patient's Signature_____Date_____
Spouse's or Guardian's Signature_____Date_____

We file your primary insurance at no charge to you. Filings for policies in addition to your primary coverage are completed *for a fee and as time permits.*
Payment Options (Please Indicate): **Cash Check MasterCard Visa American Express**

PATIENT CONFIDENTIAL HEALTH HISTORY

Full Name_____Date_____
Height_____Weight_____Race_____

The items below may relate to your current condition. In the space before each item, enter (y) if you CURRENTLY have the problem and (P) if you have had it so severely in the past that it affect your health.

General
1._____Fever
2._____Chills
3._____Night sweats
4._____Loss of Sleep
5._____Fatigue
6._____Nervousness
7._____Weight Loss or Gain
8._____Allergies
9._____Bleeding Problems
10._____Anemia
11._____Diabetes
12._____Cancer
13._____Thyroid Disease/Goiter
14._____Alcoholism
15._____Drug Abuse

Ear, Eye,Nose, Throat
16._____Poor Vision
17._____Pain in Eye(s)
18._____Deafness/Hearing Problems
19._____Nosebleeds
20._____Nose Problems
21._____Sinus Trouble
22._____Dental Problems
23._____Hoarseness
24._____Tonsilectomy

Gastrointestinal
25._____Poor Appetite
26._____Poor Digestion
27._____Difficulty Swallowing
28._____Belching or Gas
29._____Frequent Nausea
30._____Vomiting
31._____Vomiting Blood
32._____Pain over Abdomen
33._____Ulcers
34._____Black or Bloody Stool
35._____Liver Problems
36._____Gall Bladder Problems
37._____Jaundice
38._____Hernia
39._____Diarrhea
40._____Constipation
41._____Hemorrhoids
42._____Appendicitis

MEN Only
43._____Testicular Pain/Swelling
44._____Prostate Problems

Respiratory
45._____Difficulty breathing
46._____Chronic cough
47._____Spitting Phlegm
48._____Spitting Blood
49._____Wheezing/Asthma
50._____Pneumonia
51._____Tuberculosis

Cardiovascular
52._____Irregular Heartbeat
53._____High Blood Pressure
54._____Pain Over Heart
55._____Previous Heart Trouble
56._____Ankle Swelling
57._____Varicose Veins

Genitourinary
60._____Frequent Urination
61._____Painful Urination
62._____Blood in Urine
63._____Kidney Disease
64._____Urinary Infection
65._____Inability to Control Urine
66._____Difficulty Starting Urine flow
67._____Get up at Night to Urinate
68._____Breast Lump or Pain
69._____Veneral Infection
70._____Sexual Difficulties

Skin
71._____Itching
72._____Bruise Easily
73._____Change in Mole(s)
74._____Skin Cancer
75._____Scars Location

Neurologic
76._____Weakness
77._____Twitching
78._____Tremors
79._____Headache
80._____Fainting
81._____Dizziness
82._____Convulsions
83._____Epilepsy/Seizures
84._____Numbness/Tingling

85._____Arm/Leg Pain
86._____Mental Disorder

Musculoskeletal
87._____Neck stiffness
88._____Pain between shoulders
89._____Low Back Pain
90._____Swollen Joints
91._____Painful Joints
92._____Muscle Aches/Soreness
93._____Spinal Curvature

WOMEN Only
94._____Painful Periods
95._____Excessive Flow
96._____Irregular Cycles
97._____Vaginal Burning/Itching
98._____Hot Flashes
99._____**Date Last Period Began**

Exercise

100.____NONE
101.____1-2 times/week
102.____3-5 times/week
103.____6-7 times/week

HABITS
104.____Smoking___#packs/day
105.____Drinking
106.____Recreational Drug Use
107.____Caffeine

FAMILY HISTORY
DO NOT INCLUDE YOURSELF
Include information on brothers sisters, parents & grandparents
108._____Diabetes
109._____Thyroid Disease
110._____Tuberculosis
111._____Kidney Disease
112._____High Blood Pressure
113._____Heart Disease
114._____Cancer
115._____Muscle,Bone,Nerve Disease
116._____Lung Disease
117._____Ulcers
118._____Arthritis
119._____Seizures/Stroke

MISCELLANEOUS_____
_____
_____

PATIENT CONFIDENTIAL HEALTH HISTORY

Full Name_____Date_____

Past History

List any diseases you've had in the past including childhood diseases:_____

_____

Have you ever suffered any physical injuries such as falls/blows, automobile accidents, whiplash, concussion, or head injury, strains, sprains, lacerations, dislocations, broken or cracked bones?_____

_____

List ANY Surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth, etc.):

_____DATE:_____

_____DATE:_____

_____DATE:_____

Have you ever been hospitalized for any reason other than surgery? **Y N** _____DATE:_____

MEDICATIONS: Please list all medications (prescription and non-prescription) you are currently taking or on an occasional basis:_____

_____

Your **DIET** is: **BALANCED FAIR POOR EXCESSIVE RESTRICTED**

Please describe your work:

TYPE: **Professional Physical Labor Driver Clerical Factory Homemaker**

PHYSICAL DEMANDS: **Heavy Moderate Mild Sedentary**

STRESS LEVEL: **High Medium Low**

Additional Questions:

Do you have problems with reoccurring headaches? **Y N**

Are you losing weight without trying? **Y N**

Does your pain wake you up at night? **Y N**

Have you had a change in bowel or bladder habits? **Y N**

Have you recently had any unusual bleeding or discharge? **Y N**

Women Only: Could you be pregnant? **Y N**

Current Condition:

What pain or condition that you have right now is the worst?_____

How long has it bothered you?_____When was the latest episode of the problem?_____

Vertebral subluxation can irritate different fibers within the nerves. Describe your pain(sharp, dull,burning, aching, etc.)_____

Subluxations can put pressure on the nerves and spinal cord which can be constant or occasional. Which do you feel?_____

Pressure on the spinal cord and nerves can be worse in the AM or PM, which one is harder for you?_____

Does the pain radiate into an extremity or stay in one area?_____

What makes it feel better?_____What makes it worse?_____

PLEASE CIRCLE THE NUMBER THAT BEST REPRESENTS THE INTENSITY OF YOUR PAIN

PAIN SCALE

0 1 2 3 4 5 6 7 8 9 10

NO PAIN MODERATE PAIN SEVERE PAIN

I certify that the information I provided is true and accurate to the best of my knowledge.

Patient Signature_____Date:_____