Date: / /

Chart #: _____

Patient Health History & Application for Treatment

Section A – Intake Information [ ] Please complete all information below IN FULL and CORRECT if necessary.

Please indicate the type of care desired: ☐Temporary Relief ☐Lasting Correction ☐Doctor, Please Suggest

First Name_____ **Middle Initial**_____ **Last Name**_____

Address _____

City _____ **State** _____ **Zip Code** _____

Date of Birth ____/____/____ **Gender:** ☐ Male ☐ Female **Family Physician**_____

Marital Status *(check one)* ☐ Single ☐ Married ☐ Other **SSN** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Email _____

By providing my email address, I authorize my doctor to contact me via the email address provided.

Contact Method Preference *(check one)* ☐ Text* ☐ Home Phone ☐ Work Phone ☐ Cell Phone
(For appointment reminders, etc.) **With text messaging, standard messaging rates may apply.*

Name of Spouse *(if applicable)*_____ **Their Daytime Phone**_____

Relative (for emergency) _____ **Their Phone** _____

Where are you Employed? _____ *(if N/A, may check one)* ☐ Retired ☐ Student

Are you Pregnant? ☐ Yes ☐ No ☐ Unsure If Yes, OB/GYN: _____ Ages of Children at Home: _____

Section B – Major Complaint [ ]

Please mark the exact location of your pain or condition on the diagram below. Also describe the type and frequency of your condition. For example, dull, sharp, constant, off & on, when standing, when sitting, etc.

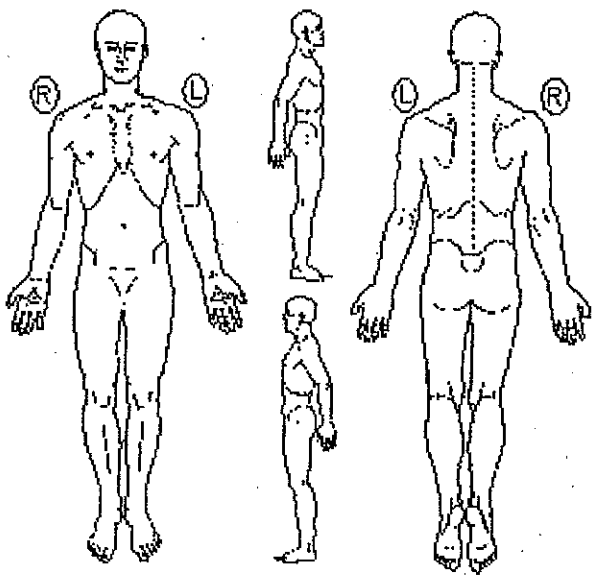
MAJOR COMPLAINT
(Please briefly describe only your major problem)

_____
_____
_____
_____

Please do not write below this line.

❶ /10	❷ /10
O	O
P	P
Q	Q
R	R
S	S
T	T
❸ /10	❹ /10
O	O
P	P
Q	Q
R	R
S	S
T	T

COMPLETE THESE DIAGRAMS



Section C Continued [ ]

Are you currently taking any medications? If *No*, check here: ☐ If *Yes*, please report any current medications below:

	Name	Dose	Units	Quantity	Frequency	Form	Method	When Started
Ex	*Maxalt*	*20*	*Mg*	*2 Pills*	*2x Daily*	*Tablet*	*By Mouth*	*August 2011*
1								
2								
3								
4								
5								
6								

If you need more room, please check here ☐ and continue on the back side of this sheet.

Has any doctor diagnosed you with Diabetes presently? ☐ Yes ☐ No If yes, what kind? ☐ Type I ☐ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ☐ Yes ☐ No ☐ Not Sure

If yes, other comments regarding Diabetes: _____

What is your current approximate height and weight? Height: _____ Weight: _____

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tion D [ ] Consent of Professional Services and Release of Information

I voluntarily hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services complaints, insurance companies, worker compensation carriers, welfare funds, or the patient's employer. If you would like to have a more detailed account of our policies and procedures concerning the privacy of 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.

I authorize payment of insurance benefits directly to this clinic or doctors. I understand that I am responsible for all costs of healthcare services, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

As with all health services, there may be risks involved with receiving treatment in this or any other office. Please rest assured that all precautionary and indicated measures, diagnostic tests, and relevant orthopedic testing will be performed, with your permission, to minimize this risk. By signing below you authorize treatment and acknowledge that you understand these inherent risks, with the understanding of the information offered above, and consent to allow necessary services and treatment according to the doctor's recommendations.

Fees are payable at the time examination, X-rays, or any other treatments are received, unless other arrangements are made in advance. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information provided.

Signature: _____ Date: _____

Please have a parent/guardian sign if patient is under 18 years of age.

:ction B – Major Complaint – Contin) First Name_____ st Name_____

When and How did your current condition develop? _____

_____

Is there anything you do that makes your condition worse? _____

_____

Is there anything you do that makes your condition better? _____

_____

How has this condition affected your life? _____

_____

Please list any and all surgeries (spinal and otherwise) _____

_____

Briefly list *any other* health problems:_____

_____

Shoe Size: _____ **Width:** ☐ Narrow ☐ Medium ☐ Wide **Your Activity Level:** ☐ Intense ☐ Moderate ☐ Light

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tion C [ ]

Verification Question *(choose only one question by circling the question, then give the answer to that question below)*

☐ What is the name of your favorite pet? ☐ In what city were you born? ☐ What high school did you attend?

☐ What is your favorite movie? ☐ What is your mother's maiden name? ☐ On what street did you grow up?

☐ What was the make of your first car? ☐ When is your anniversary?

Verification Answer to the Chosen question: _____

Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? ☐ Current every day ☐ Current sometimes smoker

☐ Former smoker ☐ Never been a smoker

If yes, what is your level of interest in quitting smoking?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No interest *Very Interested*

Do you have any allergies to medications? If *No*, check here: ☐ If *Yes*, please report medication & your reaction:

1) Medication: _____ Reaction to it: _____

2) Medication: _____ Reaction to it: _____

Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Japanese ☐ Vietnamese ☐ Other

Race: ☐ Black/African American ☐ Asian ☐ White ☐ Hispanic or Latino ☐ American Indian

☐ Other ☐ I choose not to specify