East Hampton Chiropractic

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WELCOME TO OUR OFFICE

Welcome! Our efforts are to make your experience here helpful, friendly, and informative. To achieve this, please fill in the information below.

Name _____

Previous Chiropractic care:

Whom? _____

Where? _____

How Long? _____

Who referred you here?

Name _____

Relation _____

Today we will determine if we can help you. In order to do that, we need to do the following:

1) Review your health history
2) Perform an examination
3) If necessary, perform and X-ray examination
4) Explain how chiropractic can help you

CONFIDENTIAL HEALTH INFORMATION

DATE _____

NAME _____Phone (h)_____(w)_____(c)_____

ADDRESS_____ CITY_____ ZIP CODE_____

E-MAIL_____ AGE _____ DATE OF BIRTH _____

OCCUPATION_____ EMPLOYER_____

MARITAL STATUS_____ NAME OF SPOUSE_____

AGES OF CHILDREN_____ EMERGENCY CONTACT NAME & PHONE _____

REASON FOR CONTACTING THIS OFFICE: (please be specific)

_____
_____
_____

If there is a complaint or problem currently, please answer the following:

When did it start? _____
Have you ever had these symptoms before? _____
Are your symptoms _____getting worse _____coming and going ____constant?
Are your symptoms interfering with your _____work _____sleep _____daily routine ____other?
What aggravates your symptoms? _____
Have you consulted other doctors for these symptoms? _____ If so, whom_____
_____

Please list significant health problems you have had in the past. _____

_____
_____
_____

Please list any falls, injuries or accidents you have had. Include playing contact sports._____

_____
_____
_____

Have you ever broken bones? ____yes ___no If yes, how? ___ _____

Have you had any surgeries or operations in the past? (include dates)_____

_____
_____
_____

Please list any medication you currently take (including birth control pills).

_____
_____
_____

Please list any family history of health problems including conditions that are not related to the spine.

_____
_____
_____
_____

HEALTH HISTORY:
MARK (1) for *past* condition
MARK (2) for *current* condition

MUSCULO-SKELETAL SYSTEM

____ Low back problems
____ Pain between shoulder
____ Neck problems
____ Arm problems
____ Leg problems
____ Swollen joints
____ Painful joints
____ Stiff joints
____ Sore muscles
____ Weak muscles
____ Walking problems
____ Ruptures
____ Broken bones

GENITO-URINARY SYSTEM

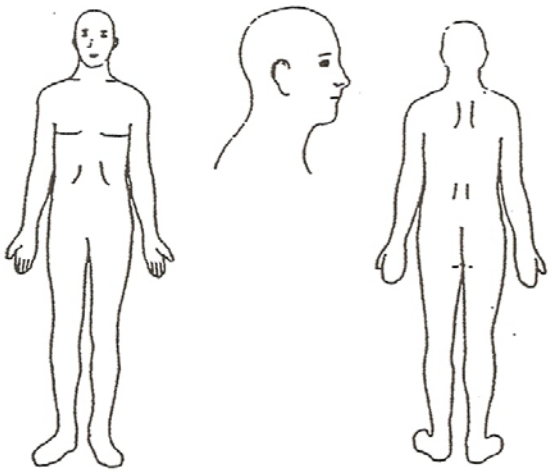
____ Bladder trouble
____ Excessive urination
____ Scanty urination
____ Painful urination
____ Discolored urine

FEMALE

____ Vaginal discharge
____ Vaginal bleeding
____ Vaginal pain
____ Breast pain
____ Lumps on breast

Are you pregnant?
____ Yes ____ No

Please mark your areas of pain on the figures below



GASTRO-INTESTINAL SYSTEM

____ Poor appetite
____ Excessive hunger
____ Difficult chewing
____ Difficult swallowing
____ Excessive thirst
____ Nausea
____ Vomiting food
____ Vomiting blood
____ Abdominal pain
____ Diarrhea
____ Constipation
____ Black stool
____ Bloody stool
____ Hemorrhoids
____ Liver trouble
____ Gall bladder problems
____ Weight trouble

NERVOUS SYSTEM

____ Numbness
____ Loss of feeling
____ Paralysis
____ Dizziness
____ Fainting
____ Headaches
____ Muscle jerking
____ Convulsions
____ Forgetfulness
____ Confusion
____ Depression

CARDIO-VASCULAR-RESPIRATORY

____ Chest pain
____ Pain over heart
____ Difficult breathing
____ Persistent cough
____ Coughing phlegm
____ Coughing blood
____ Rapid heartbeat
____ Blood pressure problems
____ Heart problems
____ Lung problems
____ Varicose Veins

EYE, EAR, NOSE AND THROAT

____ Eye strain
____ Eye inflamation
____ Vision problems
____ Ear pain
____ Ear noises
____ Ear Discharge
____ Hearing loss
____ Nose pain
____ Nose bleeding
____ Nose discharge
____ Difficult breathing thru nose
____ Sore gums
____ Dental problems
____ Sore mouth
____ Sore throat
____ Hoarseness
____ Difficult speech

HABITS:	Heavy	Moderate	Light	None
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury □ Yes □ No

Do you have Health Insurance? □ Yes □ No If yes:

Insured's Name (if not patient)_____Phone_____
Policy Holder (i.e. Employer) _____ _____Phone_____
Address _____Zip _____
Insurance Company _____ Phone_____
Address _____Zip _____
Name of Examiner or Agent (worker's comp. only) _____
Claim #_____Policy # _____If accident, Date_____
Attorney's Name _____Phone_____
Address_____Zip_____

Are you covered by Medicare? □ Yes □ No

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize _____Insurance Company to pay by check made out and mailed directly to East Hampton Chiropractic, the medical and surgical expenses benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services Rendered. This payment will not exceed my indebtedness to above mentioned assignee and I have agreed to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment.

Patient's Signature _____Date _____

OFFICE POLICY

I understand and agree that health and accident policies are an arrangement between an Insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the Insurance Company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me and charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____
Guardian or Spouse's Signature _____Date_____

I will be paying today by _____cash _____check _____credit card
Card Name/Number _____ Exp Date _____

This to certify that to the best of my knowledge I am NOT pregnant and the EHC has my permission tot take x-rays of me.

Patient's Signature _____ Date _____

I hereby give my consent to EHC to examine, x-ray and treat my child of ward
_____

Guardian's Signature _____Date _____