Patient History

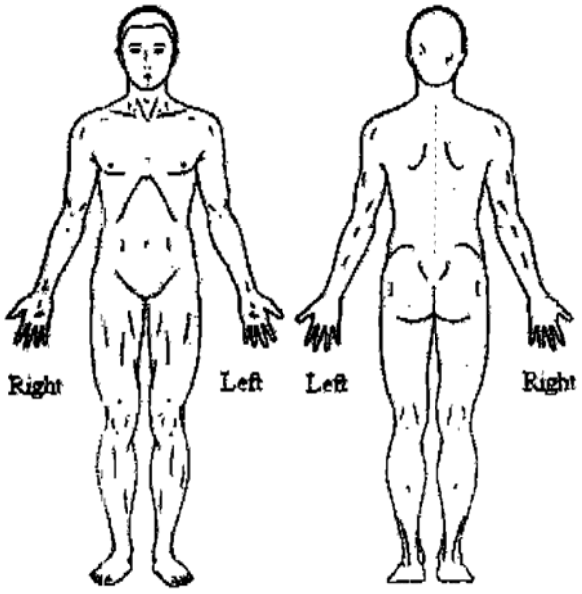
Name_____ Date_____
Address_____ State_____ Zip_____
H. Phone (_____)_____ W. Phone_____ Date of Birth_____ Age_____
Referred by_____ Social Security #_____
Occupation_____ Employer_____
Marital Status S M D W Spouse Name_____
Number of Children/Ages_____ Spouses Occupation_____
Have you ever received Chiropractic Care? Yes No

Please circle for each of the following:		Patient Comment If answer is Yes	Chiropractor's Comments
1. Regarding your Birth Process:			
Was the delivery long/difficult?	Y N		
Forceps or extraction used?	Y N		
Cesarean/ C-Section?	Y N		
Breach/ cephalic?	Y N		
Home birth?	Y N		
Hospital birth?	Y N		
Mother given drugs during delivery?	Y N		
Was labor induced?	Y N		
2. Growth and Development/ Childhood:			
Were you breast fed?	Y N		
Health education?	Y N		
Childhood illnesses?	Y N		
Ear infections/ Colic/ Asthma?	Y N		
Attention Deficit?	Y N		
Antibiotics?	Y N		
Drugs, prescription, OTC, recreational?	Y N		
Surgery?	Y N		
Hospitalizations?	Y N		
Sports or other physical activities	Y N		
Injuries during sports?	Y N		
Auto accidents?	Y N		
Did you have other traumas?	Y N		
Did you ever break any bones?	Y N		
3. Current Health Habits:			
Did/do you smoke?	Y N		
Did/do you drink alcohol?	Y N		
Diet, do you eat healthy foods?	Y N		
Have you been in accidents/trauma?	Y N		
Have you had surgery?	Y N		
Drugs, prescription, OTC, recreational?	Y N		
Dental problems?	Y N		
Eye problems?	Y N		
Hearing problems?	Y N		
Exercise regularly?	Y N		
Did/do you have occupational stress?	Y N		
Drive? Daily time spent driving	Y N		
Physical stress?	Y N		
Emotional/Mental stress?	Y N		
Hobbies/Sports injuries?	Y N		
Do you sleep well, hours of sleep?	Y N		
Sleeping posture? O side O stomach O back			

Symptoms and Present State of Health

Present Complaint/Reason for Seeking Care in this Office:
Major_____
Pain or Problem started on_____
Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other_____
Does this pain shoot, radiate, or travel in your body? Where?_____
Are you experiencing numbness or tingling in any area of your body? Where?_____
Since it began, is it: O Same O Better O Worst
What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____

Is this condition worse during certain times of the day?_____
Is this condition interfering with Work?_____ Sleep?_____ Routine?_____ Other?_____
Is this condition progressively getting worse?_____
Other Doctors seen for this condition_____
Any home remedies? _____
Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Using the symbols below, mark on the pictures where you feel pain.



Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	///
Pins, Needles	+++
Other _____	^^^

Please mark any of the following conditions or symptoms that you have now or have experienced:

Other Symptoms:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps
O Jaw/TMJ Problems	O Cold Feet	O Menopause

Are you under medical care for any condition?_____
What Medications are you taking?_____
How long?_____ Have you had surgery?_____ What?_____ When?_____
What side effects have you experienced from the drugs and surgery?_____
Females Only – Date last Menstrual Period began on_____ Are you possibly Pregnant?_____

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.
Patient Signature_____ Date_____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, diagnostic x-rays, physical therapy techniques, on me (or on the patient named below for which I am legally responsible) by the licensed doctors of chiropractic at this office.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (a one in three million chance). We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known, are in the best interest.

I have had an opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having being informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

_____

Printed name of patient

_____ _____

Signature of Patient Date

_____ _____

Signature of patient's representative (if minor) Date

CHIROPRACTIC AUTHORIZATION RELEASE & EXPLANATION

CONSENT FOR CHIROPRACTIC TREATMENT

[ ] I hereby request and authorize Dr. _____ at Southern 788 Medical Center to perform diagnostic tests and render chiropractic adjustments and other treatment. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

[ ] I Authorize Payment of Any Medical Benefits from _____ to be Paid Directly to This Chiropractic Clinic for Any Service Rendered to Me.

AUTHORIZATION AND ASSIGNMENT

[ ] In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payments to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to have been made to collect sums due for the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies' proceeds, whether it be all or part of what is due, I personally owe you.
4. I hereby waive the statue of limitations on collection regarding my case and care.
5. I further agree that this Authorization and Assignment is irrevocable until all money owed are paid in full.

MEDICAL RECORDS RELEASE

[ ] KNOW ALL MEN BY THESE PRESENTS: That I, _____, hereby authorize the release of my medical/chiropractic records or copies of the same to such parties the doctor may deem necessary as it relates to my case, and do hereby hold harmless anyone from such actions.

DATE _____

SIGNATURE _____

WITNESS _____