CRAN-MARS CHIROPRACTIC, INC.
WILLIAM F. CURRAN, D.C.

Dear Patient: Welcome to our office. Please complete the following questionnaire. Your answers will help us determine if Chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. This information is strictly confidential. Thank you.

NAME________________________________ DATE________________________________

STREET________________________________ DOB____________________ AGE__________

CITY____________________ ZIP__________ SOC. SEC. NUMBER________________________

HOME #______________ WORK #______________ MEDICAL DOCTOR________________________

PATIENT OCCUPATION________________________ MARITAL STATUS S M W D AGE OF CHILDREN__________

PATIENT EMPLOYER________________________ NAME OF SPOUSE________________________

EMPLOYER ADDRESS________________________ SPOUSE'S OCCUPATION________________________

WHO IS RESPONSIBLE FOR YOUR BILL?____

ARE YOU INSURED? _____ Yes _____ No Company________________________________

TYPE OF COVERAGE? _____ Group Health _____ Auto _____ Workers Comp. ____ Medicare _____ Other______________

PREVIOUS CHIROPRACTIC CARE? _____ Yes _____ No Date________________ Were X-rays taken? _____ Yes _____ No

WHO MAY WE THANK FOR REFERRING YOU?____

LIST PRESENT COMPLAINTS:____

____

WERE OTHER DOCTORS CONSULTED FOR THIS CONDITION? _____ Yes _____ No If Yes, please list below:

1. ________________________________ Diagnosis________________________________

2. ________________________________ Diagnosis________________________________

HAVE YOU BEEN TREATED FOR ANY OTHER HEALTH PROBLEMS IN THE LAST YEAR? _____ Yes _____ No If Yes, what?__________

____

CHECK SURGERIES YOU HAVE HAD: _____ Appendectomy _____ Tonsillectomy _____ Gall Bladder _____ Hernia _____ Female

Other:____

HAVE YOU HAD ANY BROKEN BONES OR DISLOCATIONS? _____ Yes _____ No Describe________________________

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? _____ Yes _____ No If Yes, when?________________________

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? _____ Yes _____ No

LIST SERIOUS ACCIDENTS OR FALLS:____

____

LIST ANY ALLERGEIS YOU HAVE:____

LIST ALL MEDICATION YOU ARE ALLERGIC TO:____

LIST MEDICATIONS YOU NOW TAKE:____

LIST VITAMINS YOU NOW TAKE:____

CHECK HABITS: _____ Tobacco _____ Alcohol _____ Exercise _____ Drugs

HAVE YOU SUFFERED FROM SUBSTANCE ABUSE? _____ Yes _____ No Please describe:________________________

DO YOU HAVE AN ADVANCED DIRECTIVE OR LIVING WILL? _____ Yes _____ No

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

_____	Alcoholism	_____	Cold Sores	_____	Gout	_____	Multiple Sclerosis	_____	Tuberculosis
_____	Anemia	_____	Diabetes	_____	Heart Disease	_____	Mumps	_____	Tumor
_____	Appendicitis	_____	Diphtheria	_____	Influenza	_____	Pleurisy	_____	Typhoid Fever
_____	Arteriosclerosis	_____	Eczema	_____	Lumbago	_____	Pneumonia	_____	Ulcers
_____	Arthritis	_____	Emphysema	_____	Malaria	_____	Polio	_____	Venereal Disease
_____	Asthma	_____	Epilepsy	_____	Measles	_____	Rheumatic Fever	_____	Whopping Cough
_____	Cancer	_____	Fever Blisters	_____	Mental Disorder	_____	Scarlet Fever		
_____	Chorea	_____	Goiter	_____	Miscarriage	_____	Stroke		

PLEASE CHECK THE APPROPRIATE BOX FOR ANY OF THE FOLLOWING SYMPTOMS WHICH YOU PRESENTLY HAVE OR HAD IN THE PAST. WE WANT ALL THE FACTS ABOUT YOUR HEALTH BEFORE WE ACCEPT YOUR CASE.

PRESENT	PAST	GENERAL	PRESENT	PAST	GASTRO-INTESTINAL	PRESENT	PAST	RESPIRATORY
		Allergy			Colon Trouble			Chest Pain
		Convulsions			Constipation			Chronic Cough
		Dizziness			Diarrhea			Difficulty Breathing
		Fainting			Difficult Digestion			Spitting Up Blood
		Headache			Distension of Abdomen			Spitting Up Phlegm
		Neuralgia			Gall Bladder Trouble			Wheezing
		Numbness			Hemorrhoids			**SKIN**
		Loss of Sleep			Liver Trouble			Bruise Easily
		Fevers			Pain Over Stomach			Dryness
		Nervousness			Vomiting of Blood			Skin Eruptions (Rash)
		Loss of Weight			**EYES/EARS/NOSE/ THROAT**			Varicose Veins
		MUSCLE & JOINT			Asthma			**GENITO/URINARY**
		Arthritis			Colds			Bed Wetting
		Bursitis			Deafness			Blood in Urine
		Foot Trouble			Ear Aches			Frequent Urination
		Low Back Pain			Ear Infections			Inability to Control Kidneys
		Neck Pain or Stiffness			Ear Noises			Kidney Infections or Stones
		Pain Between Shoulders			Eye Pain			Painful Urination
		PAIN /NUMBNESS IN:			Nasal Obstruction			Prostate Trouble
		Shoulders			Nosebleeds			Pus in Urine
		Arms			Sinus Infection			**FOR WOMEN ONLY**
		Elbows			**CARDIO/VASCULAR**			Congested Breasts
		Hands			Hardening of the Arteries			Cramps or Backache
		Hips			High Blood Pressure			Excessive Menstrual Flow
		Legs			Low Blood Pressure			Hot Flashes
		Knees			Pain Over Heart			Irregular Cycle
		Feet			Poor Circulation			Lumps in Breast
		Sciatica			Rapid Heart Beat			Menopausal Symptoms
		Spinal Curvature			Slow Heart Beat			Painful Menstruation
		Painful Tailbone			Swelling of Ankles			Vaginal Discharge
								Pregnant? ____Yes ____ No

IS ANY MEMBER OF YOUR FAMILY ILL OR DOCTORING WITH ANY CONDITION? (Describe)

RELATION	NAME	AGE	PRESENT SYMPTOMS	PREVIOUS SERIOUS ILLNESSES

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand 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 are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S SIGNATURE X______________________________ DATE X____________________

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

X ______________________________   ______________________________
Printed Name   Authorized Provider Representative

X ______________________________   ______________________________
Signature   Date

X ______________________________
Date

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Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

This notice is effective as of X____________________. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

X________________________
Patient name printed

X________________________
Date

X________________________
Patient Signature

____
Authorized Provider Representative

____
Personal Representative Printed

____
Personal Representative Signature

____
Description of personal representative's authority to act for the patient.

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