Patient Health History

Date	I.D. #

Name: _____ Age: _____ Date of Birth: _____ Sex: ❑M❑F

Address: _____ City: _____ State:____ Zip: _____

Phone (Home): _____ (Work): _____ (Cell):_____

Marital Status: ❑S ❑M ❑D ❑W Number of Children: _____

Occupation: _____ Social Security Number: _____

Employer: _____ Driver's License Number: _____

Spouse's Name: _____ Spouse's Age: _____ Spouse's Date of Birth: _____

Spouse's Occupation: _____ Spouse's Social Security Number: _____

Spouse's Employer: _____ Spouse's Phone (Work): _____

Insured's Name: _____ Insured's Phone: _____ Insured's Date of Birth: _____

Insurance Company: _____ Spouse's Insurance Company: _____

How did you hear about this office: _____ Referred by: _____

Past Chiropractic Care: ❑Yes ❑No When? _____ Doctor's Name: _____ Results: _____

Are your present problems due to an injury? ❑Yes ❑No ❑On Job ❑Auto Accident ❑Personal Injury ❑Other: _____

Has the accident been reported? ❑Yes ❑No ❑To Employer ❑Auto Carrier ❑Other: _____

Insurance Company:_____ Claim #:_____

Address:_____

Where do you feel the problem: _____

_____

What is your major complaint: _____

_____

List any accidents or falls and dates: ❑Auto: _____ ❑Recreation: _____

❑Sports: _____ ❑Work Related: _____ ❑Other: _____

List any broken bones (fractures) or dislocations: _____

Ever on crutches? ❑Yes ❑No Why? _____

Were you ever knocked unconscious? ❑Yes ❑No (If yes, please explain): _____

Have you ever had X-rays taken? ❑Yes ❑No When? _____ By Whom? _____

For what ailments were these X-rays made? _____

Do you wear orthotics or heel lifts? ❑Yes ❑No Fitted by whom? _____ When? _____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No _____

Are you presently taking any medication, prescription, over-the-counter, home remedies, vitamins, minerals, etc?

(Please list) _____

OPERATIONS AND PROCEDURES

❑ I have never had any operations or surgeries

DATE		DATE		DATE	
_____	Vaccinations	_____	Spinal Taps/Injections	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach

Other _____

HABITS

❑Smoking Packs/day: _____

❑Drinking Alcohol: (Cups/day) _____

❑Coffee Cups/Day: _____

❑Soft Drink Bottles or Cans/Day: _____

❑Water Cups/Day: _____

EXERCISE

❑None

❑Moderate

❑Daily

Type: _____

_____

FAMILY HISTORY

	Diabetes	Kidney	Cancer	Back
Mother	❑	❑	❑	❑
Father	❑	❑	❑	❑
Brother(s), # of_____	❑	❑	❑	❑
Sister(s), # of _____	❑	❑	❑	❑

▼ Please check any of the following that give you difficulty.

- ☐ Headaches
- ☐ Shooting head pains
- ☐ Sinus trouble
- ☐ Loss of smell
- ☐ Allergies
- ☐ Hayfever
- ☐ Asthma
- ☐ Loss of taste
- ☐ Tightness of throat
- ☐ Inflamation of throat
- ☐ Thyroid trouble
- ☐ Twitching of face
- ☐ Loss of memory
- ☐ Fatigue
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Loss of balance
- ☐ Ringing in ears
- ☐ Blurred vision
- ☐ Lights bother eyes
- ☐ Neck pain
- ☐ Muscle spasms in neck
- ☐ Grating in neck
- ☐ Tightness in shoulder muscles
- ☐ Pain in shoulder and arms
- ☐ Pins and needles in arms and hands
- ☐ Cold hands
- ☐ Chest pains
- ☐ Shortness of breath
- ☐ Mid-back pain
- ☐ Heart attacks
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Anemia
- ☐ Stomach trouble
- ☐ Nerves and nervousness
- ☐ Inner tension
- ☐ Irritability
- ☐ Cold sweats
- ☐ Gall bladder trouble
- ☐ Indigestion
- ☐ Intestinal gas
- ☐ Low back pain
- ☐ Numbness
- ☐ Constipation
- ☐ Kidney trouble
- ☐ Menstrual cramps and pain
- ☐ Menstrual irregularity
- ☐ Diabetes
- ☐ Cancer
- ☐ Sleeping problems
- ☐ Painful joints
- ☐ Swollen joints
- ☐ Pinched nerves in back
- ☐ Pins and needles in legs
- ☐ Cold feet
- ☐ Pains in legs and feet

Have you had chiropractic care before? No ☐ Yes ☐ When

Referred by

Please check one:

☐ I am interested in only symptomatic relief (feel better)

☐ I am interested in symptomatic relief maximum correction of my problem(s).

X-ray history for the past year

It is possible you are pregnant? Yes ☐ No ☐ Date of LMP:

▼ Who is responsible for this account?

Driver's License Number Social Security Number

Assignment

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient Signature Date

Release of Information

I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case; and hereby release this clinic of any consequence thereof.

Patient Signature Date

Financial Responsibility

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, copayment and any services rejected by my insurance company.

Patient Signature Date

Guardian/Parent Signature Authorizing Care Date

SHANER
CHIROPRACTIC
HEALTH CENTER P.C.
10985 Middlebelt Rd.
Livonia, Michigan 48150

CURRENT COMPLAINT HISTORY (PATIENT)

Patient Name: _____ **Date:** _____

The information you provide concerning <u>past</u> symptoms will help in assisting the doctor to better understand your present complaints and <u>total</u> health picture.

Has anyone treated you for this episode? ❑Yes ❑No If yes, by whom? _____

How did your **<u>symptoms begin?</u>**

❑Immediately after a specific incident ❑After multiple incidents ❑Gradually developed over time ❑Other _____

What makes your **<u>symptoms better?</u>**

❑Nothing ❑Lying down ❑Standing ❑Sitting ❑Movement/Exercise ❑Other _____

What makes your **<u>symptoms worse?</u>**

❑Nothing ❑Lying down ❑Standing ❑Sitting ❑Movement/Exercise ❑Other _____

<u>Description</u> of pain or symptoms:

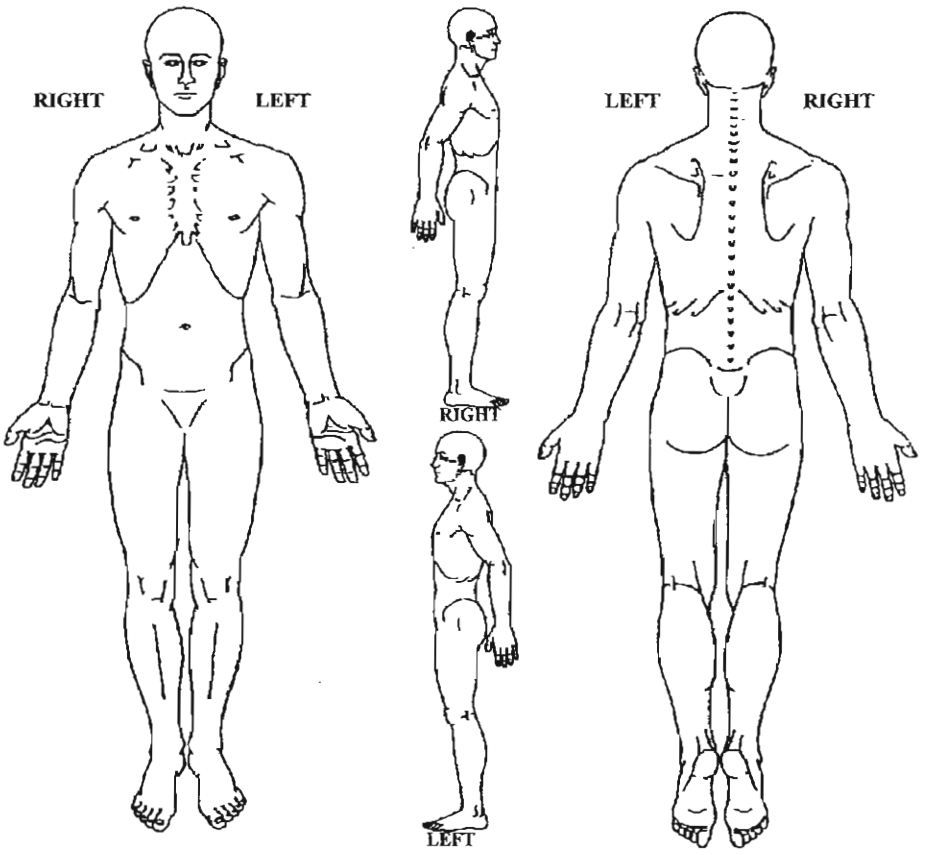
❑Sharp	❑Shooting
❑Dull	❑Burning
❑Ache	❑Numb
❑Weakness	❑Tingling
❑Throbbing	❑Other_____

Check the best and worst **times of the day** for your **pain**:

<u>Worse</u>	**<u>Best</u>**
❑First Awake	❑First Awake
❑Morning	❑Morning
❑Afternoon	❑Afternoon
❑Evening	❑Evening
❑Nighttime	❑Nighttime
❑Other	❑Other

SHOW US YOUR PAIN
AND LOCATION OF YOUR SYMPTOMS TODAY

PLEASE INDICATE ON THE DIAGRAMS BELOW WHERE YOU ARE FEELING PAIN.



Patient's/Guardian's Signature: _____ **Date:** _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

Patient_____ **Case #**_____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including x-rays on me (or on the patient named below, for whom I am legally responsible) at Shaner Chiropractic Health Center P.C.

1. The purpose of chiropractic care is to contribute to health by the location, analysis and correction of vertebral subluxations for the restoration of normal nerve functioning.

2. I understand that I will be examined and cared for by licensed doctors of chiropractic who are employed by Shaner Chiropractic Health Center P.C.

3. The Shaner Chiropractic Health Center uses only chiropractic methods that are taught in accredited chiropractic colleges, and appropriate techniques will be selected for my spine care based upon standard professional protocols.

4. Chiropractic adjustments are exceedingly safe when applied properly. However, I understand there are some risks to care including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all of the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure that the doctor feels at the time, based on the facts known, and in my best interests.

5. There is a small force introduced into the spine during an adjustment that may lead to temporary minor musculoskeletal discomfort.

6. The doctor will discuss any further risks inherent for my particular case during a report of findings procedure and document this discussion in my case record. Any questions that I may have will also be addressed at this time. I am an active participant in my chiropractic care, and am therefore invited to ask any questions or express any concerns that I may have.

7. I understand that my doctor may communicate by telephone call regarding appointments, care information or other details related to my care.

8. I understand that it is my responsibility to inform my doctor should I have a concern regarding the privacy of the area in which I receive care, my patient record or other communications related to my care; and that otherwise, Shaner Chiropractic Health Center P.C. personnel will make every reasonable effort to ensure my privacy.

9. I have read, or have had read to me, the above consent. By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of care now and in the future. I am free to withdraw my consent and discontinue care at any time.

_____ ___/___/_____

Patient/Guardian's Signature Date

_____ ___/___/_____

Doctor Date

SHANER CHIROPRACTIC HEALTH CENTER, P.C.
Notice of Privacy Practices Acknowledgement
Initial Uses Authorization Form

I acknowledge that Shaner Chiropractic Health Center's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Shaner Chiropractic Health Center's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Shaner Chiropractic Health Center. The Notice of Privacy Practices for Shaner Chiropractic Health Center is also provided upon request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Shaner Chiropractic Health Center's duties with respect to my protected information.

Shaner Chiropractic Health Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting Shaner Chiropractic Health Center and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Patient Name

_____

Relationship of Personal Representative

Staff complete only if NO signature is obtained and describe the good faith efforts made to obtain the individual's acknowledgement and the reasons why acknowledgement was not obtained.

___ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices Acknowledgement Initial Uses Authorization Form

___ Other _____

Staff Signature:_____ Date: _____