



CHIROPRACTIC HEALTH AND WELLNESS PATIENT INFORMATION AND HISTORY

Date: _____

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PATIENT INFORMATION

Name: _____
 Address: _____
 City, State, Zip: _____
 Date of Birth: _____ Age: ____ Male Female
 Best phone number to reach you: _____
 Email: _____
 Best way to reach you: Phone Email
 How did you hear about our clinic? _____
 Occupation: _____
 Employer: _____
 Parent's Name (If a minor): _____
 Single Married Divorced Widowed Partnered
 Spouse/Partner's Name: _____
 # of Children: ____ Name(s): _____
 IN CASE OF AN EMERGENCY, PLEASE CONTACT:
 Name: _____ Relationship: _____
 Home #: _____ Cell: _____

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ACCOUNT INFORMATION/INSURANCE

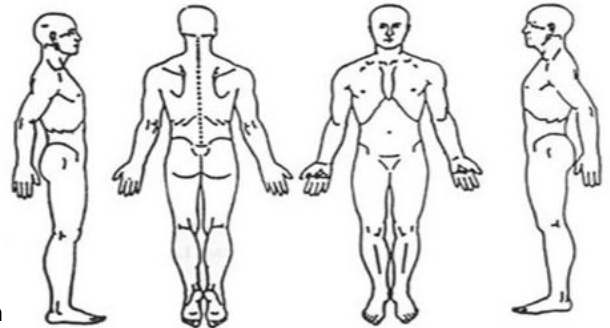
Who is financially responsible for this account? _____
 Relationship to patient: _____
 Patient's insurance company: _____
 Subscriber's name: _____
 Relationship to patient Self Spouse Parent Other
 Subscriber's date of birth: _____
 Insurance ID number: _____
 Group/Claim number: _____
 Is patient covered by Medicare? Yes No
 Is patient covered by additional insurance? Yes No
 Insurance company: _____
 Secondary Ins ID number: _____
 Secondary Ins group number: _____
 Is your condition due to an accident? No Yes Date: _____
 Type of accident? Auto Work Home Other
 To whom have you reported the accident?
 Your auto insurance Employer Other
Please provide ID and insurance card(s) so we may scan in to your file.

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PATIENT CONDITION

PRIMARY complaint (List only one): _____
 When did this condition begin? _____ Was this condition the result of an accident or injury? Yes No
 Please describe the cause of your current complaint: _____
 Have you had this problem before? Yes No If yes, when: _____
 How often do you feel it? Constant Daily Comes and goes
 How does it feel? Burning Sharp Shooting Dull Aching
 Stiff Tingling Throbbing Swelling Other _____
 Circle below the severity of your pain on a scale of 0 to 10:
 (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)
 What makes your condition better? _____
 What makes your condition worse? _____
 Does it interfere with your Work Sleep Daily Routine Recreation
 Activities/movements that are painful/difficult to perform:
 Sitting Standing Walking Bending Lying down Driving Other: _____
 What other treatment have you had for this condition? Chiropractic Medical Physical Therapy Surgery Other
 Please describe the other doctor's treatment for your condition: _____
 Previous chiropractic care? No Yes Date: _____ Local Out of state: _____ Duration of treatment: _____
 Is there anything else you would like the doctor to know about this condition? _____

Please mark where it hurts



PATIENT CONDITION (Continued)

SECONDARY compliant (list only one): _____

When did this condition begin? _____ Was this condition the result of an accident or injury? Yes No

Please describe the cause of your current complaint: _____

Have you had this problem before? Yes No If yes, when: _____

How often do you feel it? Constant Daily Comes and goes

How does it feel? Burning Sharp Shooting Dull Aching
 Stiff Tingling Throbbing Swelling Other _____

Circle below the severity of your pain on a scale of 0 to 10:
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

What makes your condition better? _____

What makes your condition worse? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities/movements that are painful/difficult to perform:
 Sitting Standing Walking Bending Lying down Driving Other: _____

What other treatment have you had for this condition? Chiropractic Medical Physical Therapy Surgery Other

Please describe the other doctor's treatment for your condition: _____

Previous chiropractic care? No Yes Date: _____ Local Out of state: _____ Duration of treatment: _____

Please mark where it hurts

ADDITIONAL complaint—if any (list only one): _____

When did this condition begin? _____ Was this condition the result of an accident or injury? Yes No

Please describe the cause of your current complaint: _____

Have you had this problem before? Yes No If yes, when: _____

How often do you feel it? Constant Daily Comes and goes

How does it feel? Burning Sharp Shooting Dull Aching
 Stiff Tingling Throbbing Swelling Other _____

Circle below the severity of your pain on a scale of 0 to 10:
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

What makes your condition better? _____

What makes your condition worse? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities/movements that are painful/difficult to perform:
 Sitting Standing Walking Bending Lying down Driving Other: _____

What other treatment have you had for this condition? Chiropractic Medical Physical Therapy Surgery Other

Please describe the other doctor's treatment for your condition: _____

Previous chiropractic care? No Yes Date: _____ Local Out of state: _____ Duration of treatment: _____

Please mark where it hurts

What are your health goals? _____

Is there anything else you would like the doctor to know? _____

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HEALTH HISTORY

Check any of the following conditions you have had:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mid/low back pain | <input type="checkbox"/> Sleep issues |
| <input type="checkbox"/> Allergies/Sinus | <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tiredness/Fatigue |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches—Migraine | <input type="checkbox"/> PMS/irregular cycle | <input type="checkbox"/> TMJ/jaw pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Vertigo/dizziness |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herniated disc | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Digestive issues | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Shingles | |
| <input type="checkbox"/> Ear ringing/pain | <input type="checkbox"/> Leg/knee pain | <input type="checkbox"/> Sinus Infection | |
| <input type="checkbox"/> Other _____ | | | |

Stressors:

- Smoking Packs/day: _____
- Coffee Cups/day: _____
- Alcohol Drinks/week: _____
- High stress level Reason: _____

Exercise:

- None Moderate Daily Heavy

List any medications you are taking:

_____	_____
_____	_____
_____	_____
_____	_____

Vitamins/herbs/minerals:

_____	_____
_____	_____
_____	_____

Females:

Are you pregnant? Yes No Possibly

Beginning of last menstrual cycle: _____

Have you had any:

	Description	Date
Automobile/work related accidents:	_____	_____
	_____	_____
Surgeries:	_____	_____
	_____	_____
Broken bones:	_____	_____
	_____	_____
Falls/Head injuries:	_____	_____

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Please read all three sections carefully and sign in EACH section

AUTHORIZATION AND AGREEMENT FOR PAYMENT OF SERVICES RENDERED

It is the policy of Chiropractic Health and Wellness to collect on the day of service for all services as they are rendered, unless other financial arrangements are made. **I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT.** As a courtesy, the clinic will submit claims to my insurance for all services and assist me in receiving any out-of-network benefits that I may be entitled to. I authorize Chiropractic Health & Wellness to release information regarding my treatment to any insurance company, attorney, and/or adjustor in order to process any claims for reimbursement of charges incurred by me.

Print Patient's Name

Date

Signature (if minor, parent's signature)

Acknowledgement of Chiropractic Health and Wellness Center's Privacy Practices

I acknowledge that this clinic's Notice of Privacy Practice's has been made available to me either online or in the clinic. I also understand that this Notice is available by request.

Print Patient's Name

Date

Signature (if minor, parent's signature)

**Chiropractic Health and Wellness Center's
Informed Consent for Examination and Treatment**

This document explains some potential risks associated with chiropractic care. Please read this information carefully and let our staff know if you have any questions. The doctors and staff of Chiropractic Health and Wellness Center will do everything to assist you with your health or your condition. Please be aware that, as with all healthcare systems, we cannot guarantee a cure or resolution of your problem. While chiropractic care is remarkably safe, there are some associated risks. We feel that you need to be fully informed about these risks before consenting to treatment.

- **Soreness** – Chiropractic adjustments and associated therapies may sometimes cause post-treatment soreness. While soreness is usually mild and temporary, please tell your doctor if you experience this.
- **Soft Tissue Injury** – Rarely, chiropractic treatment may aggravate a disk injury, or cause other minor joint, ligament, tendon or other soft tissue injury.
- **Rib Injury** – Adjustments to the mid back, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk for fracture. Treatment is performed carefully to minimize such risk.
- **Physical Therapy Burns** – Heat generated by physical therapy modalities may cause minor burns to the skin. This is rare, but if it occurs you should report it to your doctor.
- **Stroke** – Stroke is the most serious complication of chiropractic care, but fortunately its occurrence is extremely rare. The most recent studies estimate that the incidence of stroke is one in five million neck adjustments.
- **Other Complications** – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

We will make every reasonable effort during examination to screen for potential risks. Please be aware that if you have a condition that would otherwise not come to our attention, it is your responsibility to inform the doctor.

I, the undersigned, agree that I have read, or have had read to me, and understand the information stated above.

I hereby authorize the doctors and staff of Chiropractic Health and Wellness Center to perform examination procedures and administer treatment to me, or to the person listed below for whom I serve as legal guardian. I understand that all procedures and treatment will be explained to me before they are performed, and that I have the right to refuse any such procedures.

Print Patient's Name

Date

Signature (if minor, parent's signature)