Confidential Patient Information
(Please Print)

Patient Information

Acct#_____

Dr./Mr./Mrs./Ms./Miss (circle one) Marital status (circle one) M S W D

_____ _____ _____ _____

Last Name First Name Middle Initial Nick Name

_____ _____ _____ _____

Address City State Zip Code

Home phone#_____ Mobile Phone# _____

Email address _____

Social Security No._____ Date of Birth_____ Sex [ ] M [ ] F

Occupation _____ Employer_____

Work Address_____ Work Phone#_____

Person to contact in an emergency_____ Phone#_____

Responsible Party

Name of person responsible for payment of this account_____

Relationship to patient_____ Phone#_____

_____ _____ _____ _____

Address City State Zip Code

Insurance Information

If you have any insurance information please provide the staff with your insurance card and/or required forms.

Symptoms

1. What is your **number-one** problem or the **one area** of greatest pain?_____
2. Please rate the level of this pain on the following scale: **0 is no pain, 10 is severe pain** or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain. **0 1 2 3 4 5 6 7 8 9 10**
3. When did this problem/pain start?_____ [ ] Gradual [ ] Sudden [ ] Progressive
4. What do you think caused this problem?_____
5. How often do you experience the pain?
   - ___ 1-2 hours per day ___ About half of the day
   - ___ Most of the day ___ The pain never goes away
6. How does the pain affect your daily activities?
   - ___ It does not affect my daily activities ___ I have had to change how I do things
   - ___ I have had to stop doing some of my daily activities ___ I am unable to perform daily activities
7. What **increases** your pain?_____
8. What **decreases** your pain?_____
9. Have you ever experienced this problem before? [ ] Y [ ] N When?_____
10. List any other complaints currently bothering you and rate your pain level for each using the same scale as above.

a._____	0	1	2	3	4	5	6	7	8	9	10
b._____	0	1	2	3	4	5	6	7	8	9	10
c._____	0	1	2	3	4	5	6	7	8	9	10
d._____	0	1	2	3	4	5	6	7	8	9	10

11. Have you ever been involved in an automobile accident? [ ]Y [ ] N When?_____
Were you injured? [ ]Y [ ] N Please explain_____
12. Have you ever been injured at work? [ ]Y [ ] N When?_____
Please explain_____
13. List all medication you are currently taking *(prescribed and over the counter)* _____
_____
14. List all surgeries you have had *(with date)* _____
_____

If you have experienced any of the following conditions in the past mark a "**P**" on the line provided. If you are currently experiencing any of the following conditions please mark a "**C**" on the line provided. *(check all that apply)*

___ heart attack	___ stroke	___ arthritis	___ gall bladder trouble
___ diabetes	___ glaucoma	___ fainting spells	___ kidney stones
___ difficulty with urination	___ bloody stools	___ difficulty with bowel movements	
___ prostate trouble	___ anemia	___ cancer	___ asthma
___ AIDS	___ ulcers	___ diverticulosis	___ menstrual cramping
___ dizziness	___ loss of memory	___ chest pain	___ shortness of breath
___ constipation	___ diarrhea	___ general fatigue	___ sudden weight loss
___ nausea	___ muscle cramping	___ soreness in joints	___ loss of hearing
___ ears ringing	___ headache	___ migraine	___ epilepsy
___ gout	___ tuberculosis	___ syphilis	___ sprained ankle [ ] R [ ] L
___ knee/hip replacement	___ broken bones *(specify)*_____		

General Activities *(check all that apply)*

___ sleep on waterbed	___ read in bed	___ fall asleep in recliner/on couch
___ sleep on stomach	___ needlepoint/knitting	___ use two or more pillows to sleep with
___ sewing	___ lift weights/wt. mach.	___ play video games (_____ hrs per day)
___ exercise _____x/wk	___ jog _____x/wk	___ computer use (_____ hrs per day)
___ swim	___ use healthrider	___ watch television (_____ hrs per day)

Please add anything else you would like the doctor to know: _____
_____

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature_____ Date_____
(signature of parent if the patient is a minor)

Doctor's Comments:_____
_____
_____
_____
_____
_____

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.

Printed Name _____ Authorized Provider Representative _____

Signature _____ Date _____

Date _____

AUTOMOBILE ACCIDENT HISTORY FORM

NAME:_____ DATE:_____

DATE OF ACCIDENT:_____ TIME OF ACCIDENT:_____

CITY OF ACCIDENT:_____ STREET OF ACCIDENT:_____

ROAD CONDITIONS AT THE TIME OF ACCIDENT: WET DRY ICY OTHER_____

DID THE POLICE COME TO THE ACCIDENT? YES NO IS THERE A REPORT? YES NO

DID YOU GO TO THE HOSPITAL? YES NO
IF YES, NAME OF HOSPITAL:_____
HOW DID YOU GET TO HOSPITAL?_____
DID YOU HAVE X-RAYS? YES NO
WHAT PARTS OF BODY WERE X-RAYED?_____
WHAT DID THE HOSPITAL DO FOR YOUR INJURIES?_____
HOW LONG DID YOU STAY AT HOSPITAL?_____

WERE THERE ANY CUTS OR BRUISES? YES NO IF SO WHERE?_____
_____

WHERE WERE YOU SEATED IN VEHICLE?_____

WERE YOU AWARE OF THE APPROACHING COLLISION PRIOR TO IMPACT, OR DID IMPACT CATCH YOU BY SURPRISE? AWARE SURPRISE

DID YOU LOSE CONSCIOUSNESS (BLACK OUT) UPON ACCIDENT? YES NO HOW LONG:_____

DID YOU EXPERIENCE A FLASH OF LIGHT OR EXPLOSION IN HEAD? YES NO

DID YOU BECOME: CONFUSED DISORIENTED LIGHTHEADED DIZZY NAUSEATED BLURRED VISION RINGING/BUZZING IN EARS FROM THE ACCIDENT?

IF YOU STILL HAVE ANY OF THESE SYMPTOMS WHICH ONES?_____
_____

ARE YOU CURRENTLY SUFFERING FROM ANY OF THE FOLLOWING: IRRITABLE RESTLESSNESS DIFFICULTY CONCENTRATING SLEEPLESSNESS FORGETFULNESS LOSS OF MEMORY REDUCED TOLERANCE TO HEAT REDUCED TOLERANCE TO ALCOHOL

HOW FAR IS THE TOP OF THE HEADREST OR SEATBACK FROM THE TOP OF YOUR HEAD?
_____ INCHES ABOVE OR BELOW

WERE YOU WEARING YOUR SEATBELT? YES NO
IF YES, WAS IT A LAP SEATBELT_____ OR SHOULDER-LAP SET BELT?

LIST THE YEAR, MAKE AND MODEL OF THE VEHICLE YOU WERE IN:_____YEAR
_____MAKE _____MODEL

WAS YOUR CAR STOPPED AT THE TIME OF IMPACT? YES NO
IF YES, WAS THE DRIVER'S FOOT ALSO ON BRAKE? YES NO
IF NO, THEN ESTIMATE THE SPEED OF THE VEHICLE YOU WERE IN:_____MPH

IF YOUR VEHICLE WAS MOVING AT THE TIME OF IMPACT, WAS IT:
SLOWING DOWN? YES NO
GAINING SPEED? YES NO
TRAVELING AT A STEADY RATE OF SPEED? YES NO

ON WHAT PART OF THE AUTOMOBILE DID YOUR FOLLOWING BODY PARTS HIT?
HEAD HIT_____ CHEST HIT_____
RIGHT/LEFT SHOULDER HIT_____ RIGHT/LEFT ARM HIT_____
RIGHT/LEFT HIP HIT_____ RIGHT/LEFT KNEE HIT_____
RIGHT/LEFT KNEE HIT_____ OTHER_____

DID YOU RECEIVE ANY INJURY OR BRUISE FROM THE SEATBELT? YES NO
IF YES. THE DESCRIBE INJURY_____

WHAT IS THE ESTIMATED COST/DAMAGE TO THE VEHICLE YOU WERE IN? $_____

WHICH OF THE FOLLOWING CAR PARTS BROKE DURING ACCIDENT? (PLEASE CIRCLE)
WINDSHIELD FRONT SEAT BACK RIGHT/LEFT SIDE WINDOWS STEERING WHEEL
OTHER PARTS_____

WAS THE TRUNK OF YOUR BODY POINTED STRAIGHT FORWARD AT THE TIME OF ACCIDENT?
YES NO IF NO, HOW WAS IT TURNED?_____

WAS YOUR HEAD POINTED STRAIGHT FORWARD? YES NO IF NO, WHAT DIRECTION WAS IT TURNED AND BY HOW MUCH?_____

WHAT WAS THE YEAR, MAKE AND MODEL OF THE OTHER VEHICLE?
YEAR_____ MAKE_____ MODEL_____

WAS THE OTHER VEHICLE MOVING AT THE TIME OF ACCIDENT? YES NO
IF YES, WHAT WAS IT APPROXIMATE SPEED?_____MPH

IF THE OTHER VEHICLE WAS MOVING AT THE TIME OF ACCIDENT, WAS IT?
SLOWING DOWN GAINING SPEED TRAVELING AT A STEADY SPEED

PLEASE DESCRIBE TO THE BEST OF YOUR KNOWLEDGE. WHAT HAPPENED DURING THE ACCIDENT?_____
_____
_____