

Medical History Information

Last Name:				<input type="checkbox"/> Mr.		<input type="checkbox"/> Miss		Marital status (circle one)		
First Name:	Nickname:	Middle:			<input type="checkbox"/> Mrs.		<input type="checkbox"/> Ms.		Single / Mar / Div / Sep / Widow	
Spouse Name:		Emergency Contact #: _____ - _____ - _____		Can we contact you via email?						
Email:				Birth date:		Age:		Sex:		
Address:			City:			State:				
ZIP Code:		Social Security No.:		Home Phone: _____ - _____ - _____		Cell Phone: _____ - _____ - _____				
Occupation:		Employer:				Work phone:				
Date of Onset:		How problem began:								
Medical Care Information										
Do You Have a Family Doctor?:		<input type="checkbox"/> No		<input type="checkbox"/> Yes, Name of Doctor:						
Insurance Information										
<input type="checkbox"/> Major Medical		<input type="checkbox"/> Medicare		<input type="checkbox"/> Auto Insurance		<input type="checkbox"/> Attorney		<input type="checkbox"/> Cash Discount Card		
Primary Subscriber ID #:				Primary Group #:						
Secondary Subscriber ID #:				Secondary Group #:						
Attorney Name:				Attorney phone #:						
Please give a copy of ALL Insurance cards, accident reports, & attorney information to front desk to copy.										
Past Injuries/Accidents with dates:										
Past Hospitalizations/Surgery with dates:										
Please list all medications you are currently taking:										
Do you have any other illness not related to the reason you are here? <input type="checkbox"/> Yes <input type="checkbox"/> No List:										
How many children do you have? _____ How many live at home with you? _____										
Are they all healthy? <input type="checkbox"/> Yes <input type="checkbox"/> No If not please explain:										
Do you have any food or drug allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No List:										
How did you hear about us(Please give referral name)?										
<input type="checkbox"/> Friend _____ <input type="checkbox"/> Family _____ <input type="checkbox"/> Patient _____ <input type="checkbox"/> Alltell Winder <input type="checkbox"/> Jackson County <input type="checkbox"/> Monroe County <input type="checkbox"/> Barrow County										
If referred by a patient, may we thank them for referring you verbally and with a note that includes your name? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Authorization and Release of Records: I authorize the release of all my records and authorize the doctor to discuss my treatment with the following people: <input type="checkbox"/> Spouse _____ <input type="checkbox"/> Doctor _____ <input type="checkbox"/> Children _____ <input type="checkbox"/> Parents _____ <input type="checkbox"/> Other _____										
Present illness /Conditions:										
<input type="checkbox"/> AIDS		<input type="checkbox"/> Cancer		<input type="checkbox"/> Heart Problem		<input type="checkbox"/> Multiple Sclerosis		<input type="checkbox"/> Spinal Disc Disease		
<input type="checkbox"/> Allergies		<input type="checkbox"/> Pacemaker		<input type="checkbox"/> Cirrhosis/Hepatitis		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> High Blood Pressure		
<input type="checkbox"/> Anemia		<input type="checkbox"/> Diabetes		<input type="checkbox"/> HIV/ARC		<input type="checkbox"/> Prostate trouble		<input type="checkbox"/> Tuberculosis		
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Dislocated joints		<input type="checkbox"/> Kidney trouble		<input type="checkbox"/> Rheumatic fever		<input type="checkbox"/> Ulcer		
<input type="checkbox"/> Asthma		<input type="checkbox"/> Diverticulitis		<input type="checkbox"/> Low Blood Pressure		<input type="checkbox"/> Scoliosis		<input type="checkbox"/> Polio		
<input type="checkbox"/> Thyroid Trouble		<input type="checkbox"/> Recent Fever		<input type="checkbox"/> Stroke		<input type="checkbox"/> Vision Problems		<input type="checkbox"/> Weight Gain/Loss		
<input type="checkbox"/> Menstrual Problem		<input type="checkbox"/> Birth Control		<input type="checkbox"/> Dizziness/Fainting		<input type="checkbox"/> Currently Pregnant # weeks _____				
<input type="checkbox"/> Bone fracture		<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mental/ Emotional Difficulty		<input type="checkbox"/> Sinus trouble		<input type="checkbox"/> STD'S		
Other:										
Family History of illness:										
<input type="checkbox"/> AIDS		<input type="checkbox"/> Cancer		<input type="checkbox"/> Multiple Sclerosis		<input type="checkbox"/> Spinal Disc Disease		<input type="checkbox"/> STD'S		<input type="checkbox"/> Stroke
<input type="checkbox"/> Allergies		<input type="checkbox"/> Bone fracture		<input type="checkbox"/> Heart Problem		<input type="checkbox"/> Low Blood Pressure		<input type="checkbox"/> Sinus trouble		<input type="checkbox"/> Ulcer

<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Polio
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Asthma
Other: _____					
Type of Cancer:		<input type="checkbox"/> Breast	<input type="checkbox"/> Lung	<input type="checkbox"/> Other: _____	
Social History:					
Alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per week? _____		Cigarettes? <input type="checkbox"/> No <input type="checkbox"/> Yes Packs per day?_	Caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per day? _____	Exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes Hrs per wk? _____ (circle one) Light / Moderate / Strenuous	
Misc.: _____					

I authorize you to leave messages at my home. I authorize you to mail reminders, bills, birthday cards, and special event notifications to my mailing address, including postcards.

I certify that the above information is complete and accurate to the best of my knowledge. I authorize payment of insurance benefits directly to the chiropractor and/or chiropractor office. I understand and agree to allow this chiropractic office to use their Patient Medical History Information for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all cost of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

Patients Signature: _____
Guardians Signature: _____

Date: _____
Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

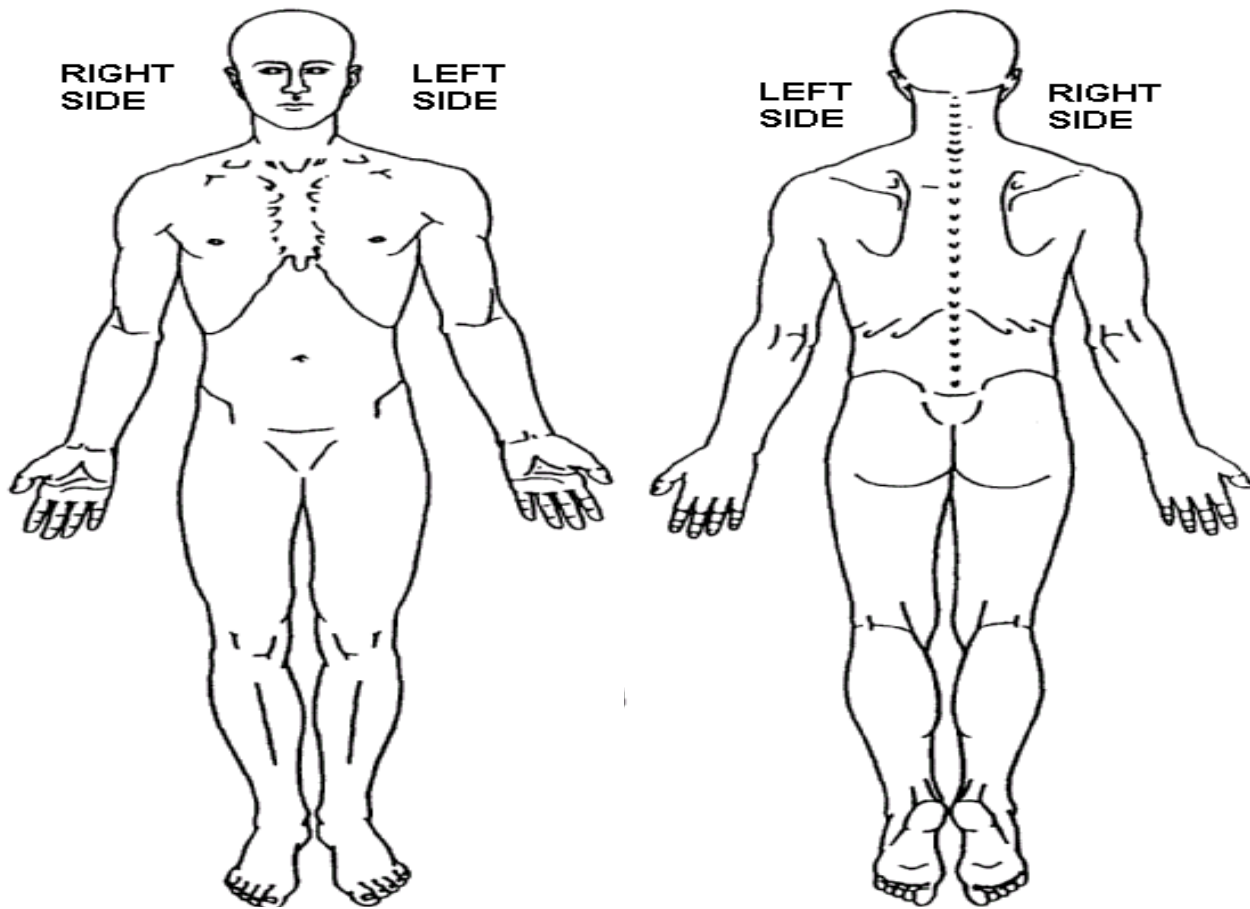
I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patients Signature: _____
Guardians Signature: _____

Date: _____
Date: _____

Patient Name: _____ Acct #: _____

SHADE THE AREAS OF YOUR BODY WHICH YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

- Headache
 Neck Pain
 Mid- back Pain
 Low back Pain
 Other _____

WHAT IS YOUR PAIN LEVEL TODAY? (CIRCLE)

NO PAIN 1 2 3 4 5 6 7 8 9 10 EXTREME PAIN

How often are your symptoms present?
 0-25%
 26-50%
 51-75%
 76-100%
 Can you perform your daily activities?
 Yes
 No (Describe any current activity limitations) _____

Have you had spinal X-rays, MRI, CT Scan?
 No
 Yes Date(s) taken _____

What areas were taken? _____

Patient Signature: _____ Date: _____