**DISCOVER CHIROPRACTIC HEALTH HISTORYPAIN**

Chief complaint and its location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What caused the onset?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of onset?\_\_\_\_ /\_\_\_\_ /\_\_\_\_ (Please list your most recent incident (minor or major) that prompted this visit.)

How often do you experience this pain? \_\_\_\_\_Constant \_\_\_\_\_Frequent \_\_\_\_\_Intermittent \_\_\_\_Occasional

On a scale of 0-10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate 6= Moderate to Severe

7 = Mildy Severe, Restrict Some Activity 8 = Severe, Limits Most Activity 9 = Very Severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

\_\_\_\_\_0 \_\_\_\_\_1 \_\_\_\_\_2 \_\_\_\_\_3 \_\_\_\_\_4 \_\_\_\_\_5 \_\_\_\_\_6 \_\_\_\_\_7 \_\_\_\_\_8 \_\_\_\_\_9 \_\_\_\_\_10

What is the least intense the symptom has been on a scale of 0 to 10?

\_\_\_\_\_0 \_\_\_\_\_1 \_\_\_\_\_2 \_\_\_\_\_3 \_\_\_\_\_4 \_\_\_\_\_5 \_\_\_\_\_6 \_\_\_\_\_7 \_\_\_\_\_8 \_\_\_\_\_9 \_\_\_\_\_10

What is the most intense the symptom has been on a scale of 0 to 10?

\_\_\_\_\_0 \_\_\_\_\_1 \_\_\_\_\_2 \_\_\_\_\_3 \_\_\_\_\_4 \_\_\_\_\_5 \_\_\_\_\_6 \_\_\_\_\_7 \_\_\_\_\_8 \_\_\_\_\_9 \_\_\_\_\_10

Please check those that apply · \_\_\_\_\_Inflexibility \_\_\_\_\_Stiffness \_\_\_\_\_Spasms \_\_\_\_\_Cramps

If this pain radiates or travels, please identify where to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SEVERITYQUALITY**

How would you best describe the sensation of the pain/symptom:

\_\_\_\_\_ Sharp \_\_\_\_\_ Stabbing \_\_\_\_\_ Aching \_\_\_\_\_ Pins & Needles \_\_\_\_\_ Pounding \_\_\_\_\_ Shooting

\_\_\_\_\_ Burning \_\_\_\_\_ Dull \_\_\_\_\_ Tingling/Numb \_\_\_\_\_ Throbbing \_\_\_\_\_ Crawling \_\_\_\_\_ Stinging

**MODIFYING FACTORS**

What aggravates the pain/symptom?

\_\_\_\_\_Sneezing \_\_\_\_\_Lifting \_\_\_\_\_Exercising \_\_\_\_\_Looking up/down \_\_\_\_\_Walking

\_\_\_\_\_Coughing \_\_\_\_\_Sitting \_\_\_\_\_Stooping \_\_\_\_\_Looking side/side \_\_\_\_\_Standing

\_\_\_\_\_Stress \_\_\_\_\_Driving \_\_\_\_\_Getting out of bed \_\_\_\_\_Pushing \_\_\_\_\_Pulling

\_\_\_\_\_Repetitive movement \_\_\_\_\_Carrying \_\_\_\_\_Straining at BM \_\_\_\_\_Climbing stairs \_\_\_\_\_Getting in/out of car

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What relieves this pain/symptom?

\_\_\_\_\_Resting \_\_\_\_\_Sleeping \_\_\_\_\_Lifting \_\_\_\_\_Exercising \_\_\_\_\_Looking up/down

\_\_\_\_\_Shower \_\_\_\_\_Advil \_\_\_\_\_Stooping \_\_\_\_\_Looking side/side \_\_\_\_\_Mineral Ice

\_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Over the past weeks/months this complaint is: \_\_\_\_\_Improving \_\_\_\_\_Getting worse \_\_\_\_\_About the same

Have you seen anyone for this condition? \_\_\_\_\_YES \_\_\_\_\_NO

**SECONDARY COMPLAINT & LOCATION**

**Location** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

\_\_\_\_\_0 \_\_\_\_\_1 \_\_\_\_\_2 \_\_\_\_\_3 \_\_\_\_\_4 \_\_\_\_\_5 \_\_\_\_\_6 \_\_\_\_\_7 \_\_\_\_\_8 \_\_\_\_\_9 \_\_\_\_\_10

0 = None 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate

6 = Moderate to Severe 7 = Mildly Severe, Restricts Some Activity 8 = Severe, Limits Most Activity

9 = Very Severe 10 = Excruciating**SECONDARY COMPLAINT & LOCATION**

How would you best describe the sensation of the pain/symptom:

\_\_\_\_\_ Sharp \_\_\_\_\_ Stabbing \_\_\_\_\_ Aching \_\_\_\_\_ Pins & Needles \_\_\_\_\_ Pounding \_\_\_\_\_ Shooting

\_\_\_\_\_ Burning \_\_\_\_\_ Dull \_\_\_\_\_ Tingling/Numb \_\_\_\_\_ Throbbing \_\_\_\_\_ Crawling \_\_\_\_\_ Stinging

Over the past weeks/months this complaint is: \_\_\_\_\_Improving \_\_\_\_\_Getting worse \_\_\_\_\_About the same

**THIRD COMPLAINT & LOCATION**

**Location** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

\_\_\_\_\_0 \_\_\_\_\_1 \_\_\_\_\_2 \_\_\_\_\_3 \_\_\_\_\_4 \_\_\_\_\_5 \_\_\_\_\_6 \_\_\_\_\_7 \_\_\_\_\_8 \_\_\_\_\_9 \_\_\_\_\_10

0 = None 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate

6 = Moderate to Severe 7 = Mildly Severe, Restricts Some Activity 8 = Severe, Limits Most Activity

9 = Very Severe 10 = Excruciating**SECONDARY COMPLAINT & LOCATION**

How would you best describe the sensation of the pain/symptom:

\_\_\_\_\_ Sharp \_\_\_\_\_ Stabbing \_\_\_\_\_ Aching \_\_\_\_\_ Pins & Needles \_\_\_\_\_ Pounding \_\_\_\_\_ Shooting

\_\_\_\_\_ Burning \_\_\_\_\_ Dull \_\_\_\_\_ Tingling/Numb \_\_\_\_\_ Throbbing \_\_\_\_\_ Crawling \_\_\_\_\_ Stinging

Over the past weeks/months this complaint is: \_\_\_\_\_Improving \_\_\_\_\_Getting worse \_\_\_\_\_About the same

**KEY VALUE QUESTIONS**

1. What is your pain keeping you from doing that is most important in your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. What do you enjoy doing most in your life?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTES / COMMENTS:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please place a checkmark by the condition that applies to you:**

**P** = Present • **N** = Not Present • **PP** = If it has ever been present in the past

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **P** | **N** | **PP** |  | **P** | **N** | **PP** |  |
|  |  |  | **Fatigue** |  |  |  | **Irritability** |
|  |  |  | **Fever** |  |  |  | **Depression** |
|  |  |  | **Chills** |  |  |  | **Memory Loss** |
|  |  |  | **Night Sweats** |  |  |  | **Headache** |
|  |  |  | **Fainting** |  |  |  | **Muscle Pain** |
|  |  |  | **Nervousness** |  |  |  | **Muscle Weakness** |
|  |  |  | **Concentration Loss** |  |  |  | **Muscle Cramps** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **P** | **N** | **PP** |  | **P** | **N** | **PP** |  |
|  |  |  | **Joint Stiffness** |  |  |  | **Seizures** |
|  |  |  | **Spinal Curvature** |  |  |  | **Dizziness** |
|  |  |  | **Back Pain** |  |  |  | **Tremors** |
|  |  |  | **Hot Joints** |  |  |  | **Loss of Sensation** |
|  |  |  | **Joint Swelling** |  |  |  | **Loss of Coordination** |
|  |  |  | **Stiff Neck** |  |  |  | **Paralysis** |
|  |  |  | **Lumps/ Masses** |  |  |  | **Difficulty of Speech** |

**P** = Present • **N** = Not Present • **PP** = If it has ever been present in the past • Do the same for your family

**Family History Key: F =** Father • **M =** Mother • **B =** Brother • **S =** Sister • **GF =** Grandfather • **GM =** Grandmother

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| P | N | PP | Past Problem | **When and Explanation of Condition** (use back if needed) | F | M | B | S | GF | GM |
|  |  |  | Cancer |  |  |  |  |  |  |  |
|  |  |  | Stroke |  |  |  |  |  |  |  |
|  |  |  | Thyroid Problems |  |  |  |  |  |  |  |
|  |  |  | Asthma |  |  |  |  |  |  |  |
|  |  |  | Heart Attack |  |  |  |  |  |  |  |
|  |  |  | HIV |  |  |  |  |  |  |  |
|  |  |  | Angina/Chest Pain |  |  |  |  |  |  |  |
|  |  |  | Athritis |  |  |  |  |  |  |  |
|  |  |  | Diabetes |  |  |  |  |  |  |  |
|  |  |  | Other |  |  |  |  |  |  |  |

**List any allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you have a pacemaker? \_\_\_\_\_YES \_\_\_\_\_NO

Are you Pregnant? \_\_\_\_\_YES \_\_\_\_\_NO

Do you think you may be pregnant? \_\_\_\_\_YES \_\_\_\_\_NO

**PLEASE LIST PAST SURGERIES:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_

**REVIEW OF SYSTEMS**

**SYSTEM REVIEWED**

o Allergic / Immunologic o Genitourinary o Cardiovascular o Hematological / Lymphatic

o Constitutional o Integumentary o Ears / Nose / Mouth o Musculoskeletal

o Endocrine o Neurological o Eyes o Psychiatric

o Gastrointestinal o Respiratory o All other system reviews negative

**FOR DOCTOR’S USE ONLY – PATIENT PLEASE PROCEED TO PAGE 4**

Notes /Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever taken:**

* Insulin
* Cortisone
* Thyroid Medicine
* Male/Female Hormones
* Blood Pressure
* Tranquilizers/Sedatives
* Birth Control

**List any other key slips, falls or accidents you’ve had from childhood to present: Date**

**1)**

**2)**

**3)**

**4)**

**5)**

**What medications are you currently taking? (Include Date)**

**1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Known allergies to medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Hospitalizations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient history was obtained from: \_\_\_\_\_Patient \_\_\_\_\_Father \_\_\_\_\_Mother \_\_\_\_\_Son \_\_\_\_\_Daughter

Marital Status: \_\_\_\_Married \_\_\_\_Divorced \_\_\_\_Single \_\_\_\_Separated \_\_\_\_Widowed

Number of Children: \_\_\_\_ Children’s Name(s):

Frequency of Exercise: \_\_\_\_Never \_\_\_\_Rarely \_\_\_\_Occasionally \_\_\_\_Moderately \_\_\_\_Regularly

Intensity of Exercise: \_\_\_\_Low Level \_\_\_\_Medium Level \_\_\_\_High Level \_\_\_\_Competition Level

Sufficient Rest: \_\_\_\_Never \_\_\_\_Rarely \_\_\_\_Occasionally \_\_\_\_Moderately

Hours of Sleep: \_\_\_\_6 \_\_\_\_8 \_\_\_\_10 \_\_\_\_More than 10

Well balanced diet: \_\_\_\_Never \_\_\_\_Rarely \_\_\_\_Occasionally \_\_\_\_Moderately

Do you smoke? \_\_\_\_No \_\_\_\_Occasionally \_\_\_\_1 to 2 \_\_\_\_2 to 3 \_\_\_\_4 to 5 \_\_\_\_More than 5 packs/day

Do you drink caffeinated beverages? \_\_\_\_No \_\_\_\_Occasionally \_\_\_\_1 to 2 \_\_\_\_2 to 3 \_\_\_\_4 to 5 \_\_\_\_More than 5 drinks/day

Do you drink alcoholic beverages? \_\_\_\_No \_\_\_\_Occasionally \_\_\_\_1 to 2 \_\_\_\_2 to 3 \_\_\_\_4 to 5 \_\_\_\_More than 5 drinks/day

Have you ever used street drugs? \_\_\_\_Yes \_\_\_\_No

Hobbies:

Notes / Comments:

**Welcome Form**

*WELCOME!... WE ARE HONORED YOU CHOSE US TO EVALUATE YOUR CONDITION.*

*SO WE MAY FILE YOUR INSURANCE FORMS FOR YOU, WOULD YOU PLEASE FILL OUT THE PERSONAL INFORMATION BELOW?*

*IF YOU NEED ASSISTANCE PLEASE INFORM THE FRONT DESK PERSON. THANK YOU!*

First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender Male Female

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_ ZIP \_\_\_\_\_\_\_\_

Social Security Number \_\_\_\_\_-\_\_\_\_\_ -\_\_\_\_\_\_\_ E-mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_ **Marital Status** S M W D

**Job Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Work Phone \_\_\_\_\_\_\_\_\_\_\_

**Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_** Spouse’s Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_

**Person responsible for this account Self or parent/guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of person on your health insurance card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of their employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children–Names & Ages\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In case of emergency, whom should we contact?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAMILY PHYSICIAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your primary complaint?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IS THIS WORKMAN’S COMPENSATION?\_\_\_\_\_**

**IS THIS PERSONAL INJURY?\_\_\_\_\_\_\_\_\_\_(Auto, Home, or other insurance responsible)**

**Patient Informed Consent**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the undersigned, consent to care at this clinic. I understand that I have the opportunity to discuss with the doctor and/or with other office personnel, the nature and purpose of chiropractic adjustments and progressive wellness. I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient above, for whom I am legally responsible) by the doctor of chiropractic and support team at Discover. I also understand that as is with all healthcare treatments, results are not guaranteed, there is no promise to cure and that there are some risks. Risks include, but are not limited to; aggravating and/or temporary increase in symptoms, muscle spasms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor’s judgment, based upon the facts then known, is in my best interests. I further understand that chiropractic adjustments and supportive treatment is designed to

reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures.

**Patient Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Medical Information Release Form

(HIPAA Release Form)

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_/\_\_\_/\_\_\_\_\_\_

***Release of Information***

Initial next to your selection.

\_\_\_\_ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

\_\_\_ Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Child(ren) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Information is not to be released to anyone.

\_\_\_ This **Release of Information** will remain in effect until terminated by me in writing.

***Messages***

Please call \_\_\_ my home \_\_\_ my work \_\_\_ my cell number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If unable to reach me:

\_\_\_ you may leave a detailed message

\_\_\_ please leave me a message asking me to return your call

\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The best time to reach me is (day)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ between (time)\_\_\_\_\_\_\_\_\_\_\_\_

***Please wait to sign in front of the office witness.***

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_

HIPAA PATIENT AUTHORIZATION FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Authorization and you are advised to do so. This authorization for release of information covers the period of healthcare from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_.

**The patient understands and agrees that:**

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this Authorization. The Clinic encourages all patients to review the Notice of Privacy Practices.

The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

All my medical records and protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes. The Clinic will not receive any payment from a third party for marketing purposes in connection with the use or disclosure of your PHI.

The Clinic or its business affiliates may use your PHI to contact you with appointment reminders and educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We **WILL NOT** ever sell or “SPAM” your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Authorization in writing at any time and all future disclosures that require the patient’s prior written authorization will then cease. See the Notice of Privacy Practices for additional details.

The Clinic may not condition your treatment or payment on whether you sign this Authorization.

Information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

**The Authorization was signed by:**

Printed Name – Patient or Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient

(if other than patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name – Clinic Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**For Internal Use:**

□ Patient Refused to Sign □ Patient unable to sign for the following reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Agreement**

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, HealthSource shall be entitled to reasonable attorney’s fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT’S / GUARDIAN’S SIGNATURE INSURED’S SIGNATURE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE

**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS**

 I assign, authorize, transfer and convey to Discover Chiropractic and Integrated Medicine all of my rights, title and interest to all of the insurance benefits to which I may be entitled according to my insurance policy with the companies noted to the extent necessary to provide for payment of my bill. I hereby designate, authorize, and convey to Discover Chiropractic and Integrated Medicine, to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan, including but not limited to with respect to internal appeals or litigation; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of the Employee Retirement Income Security Act of 1974 (“ERISA”), as provided in 29 *C.F.R.* §2560.5031(b)(4)), with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines or injunctive relief. By signing this form, I understand that Discover Chiropractic and Integrated Medicine is not assuming any obligation or duty to assert such rights and I agree to release any claim I might have relating to Provider’s exercise of such rights or the decision not to exercise such rights.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient                                                                                                                 Date

Policyholder/Insured                                                                                     Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT’S / GUARDIAN’S SIGNATURE DATE

****

**AD WAIVER**

**WELCOME TO DISCOVER CHIROPRACTIC**

We look forward to helping you. Since you responded to our Ad, it is important that you

clearly understand what is covered by the ad. The following is covered:

1. A consultation

2. An examination

3. Any necessary x-rays

4. A complete discussion of what we find and what treatment may help

There are no exclusions or conditions for this ad. We encourage your questions and we

do our best to strive and make your visit here very helpful to you. Thank you for coming

to Discover.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_