DATE________________________

PATIENT NAME____

ADDRESS____

CITY______________________________STATE_______ZIP___________

SOCIAL SECURITY NUMBER________________________________

EMAIL____

GENDER__________AGE___________BIRTHDATE__________________

MARRIED____________DIVORCED____________SINGLE_____________

MINOR_____________SEPARATED___________WIDOWED___________

OCCUPATION____

PAITENT EMPLOYER/SCHOOL___________________________________

WHOM MAY WE THANK FOR REFERRING YOU? ______________________

HOME PHONE____

CELL PHONE____

MAY WE TEXT YOU WITH APPOINTMENT REMINDERS? _______________

EMERGENCY CONTACT PERSON___________________________________

RELATIONSHIP__________________PHONE NUMBER_______________

ADDITIONAL QUESTIONS

IS YOUR CONDITION CAUSED BY AN ACCIDENT? __________________

ARE YOU PREGNANT? ___________DUE DATE______________________

PLEASE GIVE PHOTO ID AND INSURANCE CARD TO RECEPTION FOR COPIES

INSURANCE

WHO IS RESPONSIBLE FOR ACCOUNT______________________________

RELATIONSHIP TO PATIENT____________________________________

POLICY HOLDER'S BIRTHDATE__________________________________

INSURANCE CO.____

IS PATIENT COVERED BY ADDITIONAL INS? ______________________

IF YES,
POLICY HOLDER NAME____

RELATIONSHIP TO PATIENT____________________________________

POLICY HOLDER'S BIRTHDATE__________________________________

INSURANCE CO.____

ASSIGNMENT AND RELEASE

I certify that I, and or my dependent(s) have insurance coverage with the insurance company(ies) listed above, and assign directly to Dr. Brandon Jackson, Dr. Garrett Jackson, Dr. Jessi Smith, or Dr. Ryan McCain, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I authorize the use of my signature on all insurance submissions. True Health Chiropractic may use my healthcare information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent is valid for up to 7 years after the date signed below and/or until I change insurance policies.

____
Signature of patient, parent, guardian, or representative

____
Print name of the above signed

Stay Active and Healthy

True Health Chiropractic

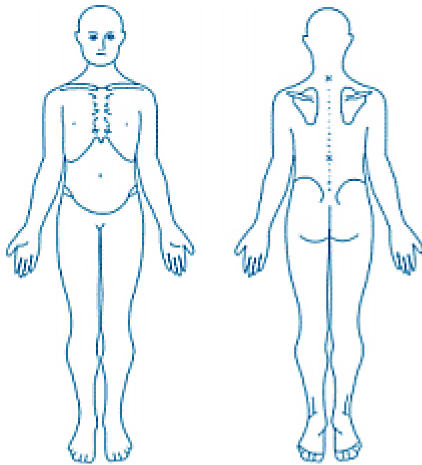
PATIENT HEALTH HISTORY/MEDICAL CONDITIONS

REASON FOR VISIT:

WHEN DID SYMPTOMS FIRST APPEAR? ____

IS IT PROGRESSIVELY GETTING WORSE? ___________________ **RATE THE SEVERITY OF YOUR PAIN:** 1 *(BEING LEAST)* - 10 *(BEING WORST)*_______________________________

MARK AN X ON THE PICTURE WHERE YOU CONTINUE TO HAVE TINGLING, NUMBNESS, OR PAIN



TYPE OF PAIN: ***MARK X ON ALL THAT APPLY***

NUMBNESS_________TINGLING_________ACHING_________STABBING_________

SHARP________DULL________SHOOTING_______THROBBING_______CRAMPS_____

STIFFNESS______SWELLING_______BURNING_______OTHER_________

HOW OFTEN DO YOU HAVE THIS PAIN: ***(CIRCLE ONE)***

CONSTANT FREQUENT OCCASIONAL RARELY COMES AND GOES

DOES IT INTERFERE WITH: ***(YES OR NO)***

WORK________ACTIVITY_______SLEEP_________

ACTIVITIES OR MOVEMENTS THAT ARE DIFFICULT TO PERFORM: (YES OR NO)

SITTING______STANDING______BENDING_____LYING DOWN_____WALKING____

WHAT TREATMENT HAVE YOU ALREADY HAD FOR THIS CONDITION?

PRIMARY CARE DOCTOR'S NAME: ____

PRIMARY CARE DOCTOR'S LOCATION: ____

DATE OF LAST: PHYSICAL__________X-RAY____________

ANY OTHER TESTS DONE, PLEASE DESCRIBE AND LIST DATE: ***(MONTH/YEAR)***

CHECK ALL THAT YOU PRESENTLY OR PREVIOUSLY DEALT WITH:

AIDS/HIV_____ALCOHOLSIM_____ALLERGIES_____ANOREXIA_____ARTHRITIS____

ASTHMA_____BREAST LUMP_____BRONCHITIS_____BULIMIA_____CANCER______

CHICKEN POX_____DIABETES_____EMPHYSEMA_____EPILEPSY_____GOITER______

GONORRHEA_____GOUT_____HEART DISEASE_____HEPATITIS_____HERNIA______

HERNIATED DISC_____HERPES_____HIGH CHOLESTEROL_____

HIGH BLOOD PRESSURE______KIDNEY DISEASE_______

LIVER DISEASE_____MIGRAINES______MISCARRIAGE_____MONONUCLEOSIS_____

MS_____OSTEOPOROSIS_____PACEMAKER_____PARKINSON'S____PNEUMONIA____

PROSTATE PROBLEM______PSYCHIATRIC CARE______RA_____STROKE____

SLEEP APNEA_____THYROID_____TONSILITIS_____TB_____TUMORS/GROWTHS_____

ULCERS____VENEREAL DISEASE_____ OTHER________________________

CIRCLE ALL THAT APPLY:

EXERCISE: INTENSE MODERATE OCCASIONAL NONE

WORK: SITTING STANDING LIGHT LABOR HEAVY LABOR

HABITS: SMOKING ALCOHOL CAFFEINE HIGH STRESS LEVEL

INJURIES/SURGERIES

FALLS______________________________HEAD TRAUMA________________________

FRACTURES__________________________DISLOCATIONS_________________________

SURGERIES____

MEDICATIONS/VITAMINS/SUPPLEMENTS:

Stay Active and Healthy

True Health Chiropractic

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name________________________________ Date______________

Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request and is located on this office's website, StayTrueChiro.com.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

By___________________________________

Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By___________________________________

Signature of Parent/Guardian (circle one)