PRING
CHIROPRACTIC
Healing and wellness through exceptional chiropractic care.

CONFIDENTIAL PATIENT INFORMATION

Home Phone (_______) ___________________

Date _______________ Work Phone (________) ___________________

Name ____ Cell Phone (________) ___________________

Address ____ Best **#** to contact you: Home Work Cell

City ______________________________ Zip ________________ Email ___________________________________

Age _____Birth Date _______/______/_______SS # ________- ______- ________ Marital: M S W D

Occupation ____ Employer ______________________________

Name of Spouse (Parent if Minor) _________________________ How many children? ______________________

Emergency Contact _____________________________________ Phone __________________________________

Whom may we thank for referring you? ____

Have you been to a Chiropractor before? Yes No If yes, when? ______________________________________

Name of most recent Chiropractor? ____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Yes No

Family medical doctor ___________________________________ Date of last exam _________________________

Do you have health insurance? Yes No

Name of Primary Insurance Company ____

Name of Secondary Insurance Company ____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs 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.

RELEASE OF INFORMATION: The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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.

The following person(s) have my permission to receive my personal health information:

____

____

Patient's Signature ____ Date ______________________

Guardian's Signature Authorizing Care _____________________________ Date ______________________

COMPLAINTS:

Reasons for seeking Chiropractic care:

Primary reason ____

Secondary reason ____

When did the symptoms begin? ____

How did the symptoms begin? ____

Is this due to ___Auto ___Work ___Other ____

Have you ever had the same or a similar condition? Yes No

If yes, when and describe ____

____

Previous interventions, treatments, modifications, surgeries, or care you sought for your complaints: __________

____

Have you had any major illnesses, injuries, falls, auto accidents, surgeries, childbirth? (include dates) __________

____

____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe ____

Women: Are you pregnant? Yes No

Do you smoke? Yes No If yes, please specify below:

____ Current every day smoker ____ Current some day smoker ____ Former smoker ____ Never smoker

Do you have any medication allergies? Yes No If yes, please list: ____________________________

____

Are you currently prescribed any medications? Yes No If yes, please list below:

Medication ______________________ _____Mg Reason for taking ______________________________

Medication ______________________ _____Mg Reason for taking ______________________________

Medication ______________________ _____Mg Reason for taking ______________________________

Medication ______________________ _____Mg Reason for taking ______________________________

FAMILY HISTORY:

Has anyone in your family had any of the following: If Yes, list relationship to patient.

Cancer __________________________ Diabetes ____________________________________

Heart Trouble ____________________ High Blood Pressure _________________________

Do any family members suffer from the following: Please circle and list the relationship to you.

Neck Problems ___________________________ Disc Problems ___________________________

Back Problems ___________________________ Pinched Nerves __________________________

Headaches ______________________________ Bad Posture _____________________________

Arthritis _________________________________ Scoliosis _______________________________

Osteoporosis _____________________________

REVIEW OF SYSTEMS:

In the past 6 months have you suffered from: Circle all that apply or circle normal

General:	Fatigue	Weakness	Weight Change	Loss of sleep	Normal
Neurological:	Headaches	Seizures	Dizziness	Nervousness	Normal
Eyes:	Vision trouble	Dryness	Redness	Cataract Glaucoma	Normal
Nose:	Pain	Bleeding	Sinus Trouble	Infections	Normal
Mouth/Throat:	Sores	Bleeding	Enlarged Glands	Tonsillitis	Normal
Cardiovascular:	Coughing	Sneezing	Wheezing	Chest Pain	Normal
	Palpitations	Hypertension			
Gastrointestinal:	Diarrhea	Vomiting	Appetite Change	Heartburn	Normal
	Constipation	Gas			
Endocrine:	Goiter	Sugar in Urine	Heat Intolerance	Cold Intolerance	Normal
Psychological:	Anxiety	Depression	Memory Loss	Mood Swings	Normal

Have you ever had any of the following: Circle all that apply

Arthritis	Heart trouble	Pacemaker
Diabetes	Dislocated joints	Hay Fever
Asthma	Bone fracture	Tuberculosis
Epilepsy	High blood pressure	Serious Injury
Allergies	Low blood pressure	Prostrate trouble
Sinus	Rheumatic fever	Kidney trouble
Scoliosis	Spinal disease	Polio
Cancer	Thyroid trouble	HIV
Ulcer	Sexually Transmitted Disease	Aids

"Look well to the spine for the cause of disease." ~ Hippocrates

Thank you for trusting us with your healthcare needs.