WRIGHT CHIROPRACTIC CENTER

PATIENT INFORMATION **DATE**_____

First Name _____ Middle_____ Last _____

Address _____ City_____ State_____ Zip _____

Primary Phone _____Secondary Phone _____Mobile _____

Home Email _____ Work Email_____

(By providing my email address, I authorize my doctor to contact me via the email)

Contact Method: ___Primary Phone ___Secondary Phone ___Mobile

DOB:_____Age_____ Male_____ Female _____

Marital Status: ___Single ___Married ___Other SSN_____

Employment Status: ___Employed ___FT Student ___PT Student ___Retired ___Self Employed

Occupation _____ Employer _____

Employer's Address _____

Spouse _____ Employer _____

Who is responsible for payment? ___Self ___Spouse ___Other

Primary Insurance Company _____ Insured's Name_____

Insured's DOB _____ How were you referred to our office?_____

Family Medical Doctor _____ Phone_____

When doctors work together it benefits you. May we have permission to update your medical doctor regarding your care?_____

Race: ___White ___Black/African American ___Asian ___Hispanic ___AM Indian ___Other

Multi-racial (check one) ___Yes ___No ___Unknown

Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___I choose not to specify

Preferred Language: ___English ___Spanish ___Other ___I choose not to specify

Answer only if you have email:

Verification Question: (choose only one, then answer that question)

___ What is the name of your favorite pet? ___ In what city were you born? ___What high school did you attend?

Verification Answer to the Chosen question: _____

Must be at least 6 characters

MEDICAL HISTORY OF PRESENT AND PAST ILLNESS

Chief Complaint: Purpose of the appointment:_____

_____

Other doctors seen for this condition _____

Date symptoms/accident happened _____ Is this due to auto___ work___ other _____

Have you had same or similar conditions? ___Yes ___No If yes, when and describe _____

_____

Date of last physical exam _____

Have you had any major illness, injuries. falls, auto accidents or surgeries? Women, please include information about childbirth (include dates)_____

_____

Patient Name _____

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

If yes then describe _____

Women: Are you pregnant? ___ Yes ___ No

Current everyday smoker____ Former Smoker____ Never Smoker____

Current medications, including frequency and dosage if known. If there are no current medications, please check here: ___

1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

7)_____ 8)_____ 9)_____

List any know allergies you have to any medications. If no allergies are known check here ___

Has any doctor diagnosed you with hypertension presently? ___ Yes ___ No. If yes, describe _____

Has any doctor diagnosed you with Diabetes presently? ___ Yes ___ No. If yes, what kind?__ Type I __Type II.

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c >9.0%?___Yes ___No

If yes, other comments regarding Diabetes:_____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 2 years? ___Yes ___No

To be performed by clinic staff:

Height _____ inches Weight_____ pounds BP _____/_____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**:

N = Now P = Previously

___ Headaches
___ Neck Pain
___ Stiff Neck
___ Sleeping Problems
___ Back pains
___ Nervousness
___ Tension
___ Irritability
___ Chest Pains/Tightness
___ Dizziness
___ Shoulder/Neck/Arm Pain
___ Numbness in Fingers
___ Numbness in Toes
___ High Blood Pressure
___ Difficulty Urinating
___ Weakness in Extremities

___ Loss of Balance
___ Fainting
___ Loss of Smell
___ Loss of Taste
___ Unusual Bowel Patterns
___ Feet Cold
___ Hands Cold
___ Arthritis
___ Muscles Spasms
___ Frequent Colds
___ Fever
___ Sinus Problems
___ Diabetes
___ Indigestion Problems
___ Joint Pain/Swelling
___ Menstrual Difficulties

___ Breathing Problems
___ Fatigue
___ Lights Bother Eyes
___ Ears Ring
___ Broken Bones/Fractures
___ Rheumatoid Arthritis
___ Excessive Bleeding
___ Osteoarthritis
___ Pacemaker
___ Stroke
___ Ruptures
___ Eating Disorders
___ Drug Addiction
___ Gall Bladder Problems
___ Ulcers

___ Weight Loss/Gain
___ Depression
___ Loss of Memory
___ Buzzing in Ears
___ Circulation Problems
___ Seizures/Epilepsy
___ Low Blood Pressure
___ Osteoporosis
___ Heart Disease
___ Cancer
___ Coughing Blood
___ Alcoholism
___ HIV Positive
___ Depression

PATIENT INFORMATION

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 and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. 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. Furthermore, when I provide a wireless telephone number or land line number, I am giving you and your representative(s) my prior express consent to call that number.

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. <u>The following person(s) have my permission to receive my personal health information:</u>

_____

Patient's Signature_____ Date:_____

Date: