

CHIPLEY CHIROPRACTIC -CONFIDENTIAL PATIENT INFORMATION

pg 1/4

Name _____ What do you prefer to be called? _____
(First) (Middle Initial) (Last)

Address _____ City _____ State _____ Zip _____

Best Contact Phone _____ Text Appt Reminder OK? Yes / No

Date of Birth: _____ Soc Sec #: _____ Email: _____

Employer _____ Occupation _____ Work Phone _____

Please Circle One: Married Single Divorced; If Married, Spouse's Name: _____

(Optional) - Please List Any Other Person who can have access to YOUR Health Information:

Name: _____ Relation to You: _____

The Main Reason / Pain that Prompted me to seek treatment today:

When did it start? _____

What makes it worse? _____

Does anything give you relief? _____

What does it feel Like? Ache Sharp Shooting Other: _____
Radiation: _____

Rate your pain from 0 to 10 (0 = No Pain & 10 = Emergency Room Pain): _____

How Frequent is the pain? Circle one: Constant $\frac{1}{4}$ of the day $\frac{1}{2}$ of the day $\frac{1}{4}$ or less of the day

If you have a secondary complaint, please list it below and fill this part out:

When did it start? _____

How did it start? _____

What makes it worse? _____

Does Anything Give you relief? _____

What does it feel Like? Ache Sharp Shooting Other: _____
Radiation: _____

Rate your pain from 0 to 10 (0 = No Pain & 10 = Emergency Room Pain): _____

How Frequent is the pain? Circle one: Constant $\frac{1}{4}$ of the day $\frac{1}{2}$ of the day $\frac{1}{4}$ or less of the day

If you have any additional complaints, please elaborate below:

Family History:

	Back	Heart	Stroke	Cancer	Diabetes	High BP	Arthritis	High Cholesterol	Osteoporosis	Thyroid	Good Health
Mother	<input type="checkbox"/>										
Father	<input type="checkbox"/>										
Sisters	<input type="checkbox"/>										
Brothers	<input type="checkbox"/>										
Children	<input type="checkbox"/>										

Social History:

	Daily	3 X Week	2 X Week	1 X Week	2X Month	1X Month	Never
WORK	<input type="checkbox"/>						
Sit at Desk:	<input type="checkbox"/>						
Work on Computer:	<input type="checkbox"/>						
Work on Phone:	<input type="checkbox"/>						
Moderate/Heavy Labor:	<input type="checkbox"/>						
Stay At Home:	<input type="checkbox"/>						
Deliver Packages:	<input type="checkbox"/>						
	Daily	Occasionally	1 X Week	Never	Quit		
Habits							
Tobacco/ Smoke	<input type="checkbox"/>						
Alcohol	<input type="checkbox"/>						
Caffeine	<input type="checkbox"/>						
	Daily	3 X Week	1 X Week	Never	Quit		
Exercise	<input type="checkbox"/>						

Pre-existing Conditions: Please Check All that Apply to you

<input type="checkbox"/> ADHD	<input type="checkbox"/> Collagen Vascular Disease	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Alcohol/Drug Addiction	<input type="checkbox"/> Constipation	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Polio
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Digestive Disorders	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Reflux / Ulcers
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Dizziness	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Joint/ Back Pain	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Kidney Infections	<input type="checkbox"/> Seizures/ Epilepsy
<input type="checkbox"/> Backaches	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Sexual Dysfunction
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Liver Disease/ Problems	<input type="checkbox"/> Sickle Cell
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Female Health Changes	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Measles	<input type="checkbox"/> Stress / Tension
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bowel Problems	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Mental Disorder	<input type="checkbox"/> Suicidal Tendencies
<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraines	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gluten Intolerance	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Carpal Tunnel	<input type="checkbox"/> Goiter	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tumors
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Gout	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Headaches	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Urine discoloration
<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Colitis	<input type="checkbox"/> Heart Disease/Attacks	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Whooping Cough

Any additional conditions that we should be aware of: _____

Surgical History: Please Note the type of surgery and the Date: (If None then check box here:

pg 3/4

Any Known Allergies to medications or environmental & date detected (If None then check box here:

Current Medications: Please list name, dosage and how often you take it (If None then check box here:
(If you have a list we can photo-copy it for you)

Please list all past accidents, slips and falls, sports or work or personal injuries that you've had in the past.
Please note the date of injury & if you had treatment for the past injury. (If None then check box here:

**If you are a Cash Patient (No Insurance),
-Skip this section and go to the next page**

Insurance Information:

Insured's Name: _____

Relationship to Insured (Check Here if it is you): _____

Insured's Date of Birth: _____

ASSIGNMENT AND RELEASE: (This must be signed BELOW for Any Patient Using Insurance for payment. Patients Without Insurance Do Not need to sign.)

I certify that I, and/or my dependents, have insurance coverage with the above listed insurance company and assign directly to Chipley Chiropractic, PLLC of Beckley, WV all 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 insurance. I authorize the use of my signature on all insurance submissions.

The above named provider's office may use my health care 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 payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

X

Signature of Patient, Parent, Guardian or Personal Representative

Date

Activities of Daily Living: How Does this condition interfere with your life and ability to function?

pg 4/4

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caring for Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising out of Chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Household Chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lifting Objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reaching Overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Showering or Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dressing Myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yard work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using a Computer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Getting to Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in/out of car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Staying Asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking over shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What is the Approximate age of your Pillow? _____

What is the Approximate age of your Mattress? _____

Acknowledgements:

To set clear expectations, improve communications and help you get the best results in the shortest period of time, please read each statement and initial your agreement:

Initials ___ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I understand that chiropractic care offered in this practice is based on the best available evidence designed to reduce or correct spinal joint dysfunction. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials ___ I may request a copy of the privacy policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials ___ I grant permission to be called or text messaged to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care.

Initials ___ I acknowledge that any insurance I have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials ___ To the best of my ability the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Patient (or Guardian's) signature _____

Date (MM/DD/YY) _____