PATIENT INFORMATION

Name____ Age________ Birthdate___________ ◯ Male ◯ Female

First Middle Initial Last

Mailing Address____

Street / PO Box City State Zip

Occupation________________________ Employer______________________Address__________________________

Cell Phone______________________Home Phone______________________Work Phone_______________________

EMAIL ADDRESS _____________________________________ **Social Security #**___________________________

CONTACT PREFERENCE ◯ Email ◯ US Mail ◯ Text ◯ Cell phone

Cell Carrier : ◯ Verizon ◯ Sprint ◯ US Cellular ◯ Other _______________________

Emergency Contact______________________________ Phone #_____________________________

MARITAL STATUS ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Separated

Spouse's Name____________________________ Spouse's Employer_________________________________

Spouse's Birthdate____________________________ Spouse's Phone #_________________________________

If you have children please list the ages____

Who referred you to our office?____

COMPLAINTS/HISTORY

What part bothers you the most?____

Next most?____

What caused your pain?____

When (date) did your pain start?_______________________________________

Did your pain start because of a motor vehicle accident? ◯ Yes ◯ No

If yes, does your Insurance know you are here for treatment? ◯ Yes ◯ No

Did your pain start while you were "on the job?" ◯ Yes ◯ No

If yes, does your employer know you are here for treatment? ◯ Yes ◯ No

Who is your Medical Doctor?____

Has he/she ever treated you for this complaint?________________________________

Have you ever been treated for back or neck pain?______________________________

Have you ever seen a chiropractor for care?___________________________________

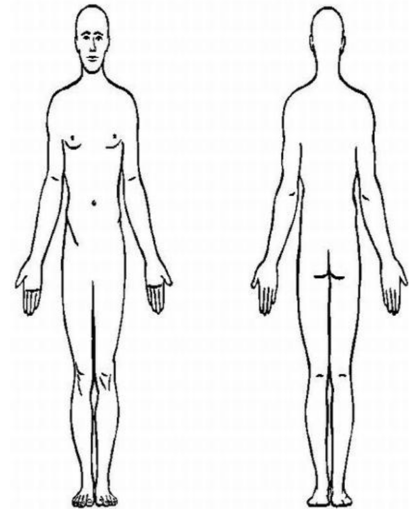
Have you ever had surgery on your back or neck?_______________________________

History of Cancer or Tumor?____

Female patients: Are you pregnant now?_______________________________

Date of your last period?_________________________________

Please shade your areas of pain on the figures below.



PATIENT HISTORY

Have you…	Yes	No
Been diagnosed with high blood pressure	◯	◯
If yes, are you currently taking medication for it ?	◯	◯
Been diagnosed with cancer or a tumor?	◯	◯
Been diagnosed with (or currently have) diabetes?	◯	◯

If yes, which type ◯ Type I ◯ Type II Date & Result of last A1C ___________________________

Been hospitalized in the last 5 years? ◯ Yes ◯ No

If yes, please list date and reason for hospitalization____

Please list any major surgeries you have had____

CURRENT PHARMACY ________________________________

LIST YOUR CURRENT PRESCRIPTION MEDICATIONS

____ ____

____ ____

◯ I am not currently taking any prescriptions

MARK ANY OF THE FOLLOWING YOU ARE CURRENTLY TAKING and list name of product

◯ OTC pain reliever (including tylenol or advil) ____

◯ Vitamins ____

◯ Supplements, Herbs, or Minerals____

◯ Other____

◯ I do not take **ANY** over the counter products

DO YOU HAVE AN ALLERGY TO ANY MEDICATION? ◯ Yes ◯ No

If yes, which Medication? ____________________________

DO YOU HAVE A FOOD ALLERGY? ◯ Yes ◯ No If yes list which food____________________________

DO YOU HAVE SEASONAL ALLERGIES? ◯ Yes ◯ No

PRIMARY LANGUAGE:

◯ English ◯ Spanish ◯ Other______________________

RACE:

◯ White (Caucasian) ◯ American Indian or Alaska Native ◯ Asian

◯ Black or African American ◯ Native Hawaiian Or Pacific Islander ◯ Decline

ETHNICITY: (Social group/cultural traditions)

◯ Not Hispanic/Latino ◯ Hispanic/Latino ◯ Other ◯ Decline

SMOKING STATUS:

◯ Never ◯ Light Tobacco Smoker ◯ Yes I have taken a prescription medication to help me stop smoking. (ie. Chantix)

◯ Former Smoker ◯ Heavy Tobacco Smoker

HEALTH HISTORY (Mother) ◯ Living ◯ Deceased

Has she been diagnosed with:

◯ Cancer ◯ Heart Disease ◯ High Blood Pressure ◯ No Major Illness

◯ Diabetes ◯ Kidney Disease ◯ Stroke

HEALTH HISTORY (Father) ◯ Living ◯ Deceased

Has he been diagnosed with:

◯ Cancer ◯ Heart Disease ◯ High Blood Pressure ◯ No Major Illness

◯ Diabetes ◯ Kidney Disease ◯ Stroke

Insurance Information & Signatures for payment and care

I have supplied the office with a copy of my current insurance card ◯ Yes ◯ No

Name of Policyholder on the current card____

Policy holder's Date of birth____

Policy holder's Relationship to patient____________________________________

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Consent of Professional Services and Release of Information

I herby authorize and release the Doctor and whomever he/she may designate and his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Notice of Privacy Practices (HIPAA)

◯ I have been offered a copy of the Grand Island Chiropractic Center's privacy policy.

Patient Signature____

Parent or Guardian Signature____

Today's Date_____________________