

Confidential Patient Health Record

Today's Date: _____

Patient Number: _____

Please fill in all information on the front and back of this form.

How did you **FIRST** hear about us? _____

Personal Information

Last: _____ First: _____ Middle: _____

Birth Date: ____/____/____ Age: _____ Gender: Male / Female Social Security #: _____ - _____ - _____

Driver's License #: _____ State: _____

Marital Status: Single Married Widowed Divorced Separated

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ ext _____ Work Phone: (____) _____ - _____ ext _____

Cell Phone: (____) _____ - _____ ext _____ Fax #: (____) _____ - _____ ext _____

Email Address: _____ Spouse's Name: _____

Emergency Contact

Name: _____ First: _____ Middle: _____

Relationship: Spouse Relative Friend Other _____

Home Phone: (____) _____ - _____ ext _____ Cell Phone: (____) _____ - _____

Employment Information

Business Name: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____ Country: _____ County: _____

Phone: (____) _____ - _____ Fax #: (____) _____ - _____

Employer's Email Address: _____

Occupation/Job Title: _____ Job Description _____

Insurance Information:

Who Is Responsible For Your Bill? **YOU and...** (Mark appropriate box (s)) Myself **ONLY**

Spouse Worker's Comp Auto Insurance Medicare Medicaid Other (be specific): _____

Personal Health Insurance Carrier: _____ Health ID Card #: _____

Policy Holder's Name: _____ Group #: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employment: _____

Policy Holder's Social Security #: _____ - _____ - _____ Phone number: _____

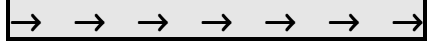
Primary Care Physician: _____

Current Health Condition

Unwanted Condition (Why you are here today?): _____

Use the letters BELOW to indicate the TYPE & LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing

When did this Condition BEGIN? ____/____/____

Has it ever occurred before? Yes No. When? _____

Is the Condition: Auto Related Job Related Home Injury

Slip or Fall Lifting Slept Wrong Unknown Cause Other

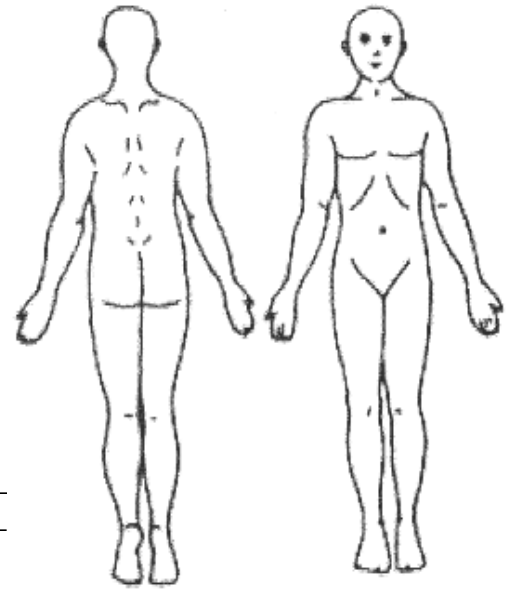
Explain: _____

Date of Accident: _____ Time of Accident: _____ am /pm

Condition/Pain STARTED on what Date: _____

Have you seen other doctors for THIS CONDITION?

If yes, Who? (Name): _____



Type of Treatment: _____ Were you satisfied with the results of your treatment? Yes No

Explain: _____

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

Do you SUFFER with ANY OTHER Condition than that which you are now consulting us? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic 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 Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered 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 or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: _____ Patient's Signature: _____ Date: _____

Consent to treat a Minor: _____ Date: _____

Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ Date: _____

Patient's Signature: _____ Date: _____