

PATIENT INFORMATION/HISTORY

If this appointment is due to an automobile accident of any kind, please stop & notify staff.

Today's Date: _____

Name: _____ Birth Date: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Email: _____

Occupation: _____ Employer: _____ OfficePhone: _____

Marital Status: **M S D W** Spouse name: _____ Spouse Employer: _____

Do You Have Any Children? **Yes / No** – How many: _____ Ages: _____

Name of Nearest Relative/Emergency Contact: _____ Relation: _____

Phone: _____ Address: _____

How were you referred to our office? _____ If our patient, their name: _____

Family Medical Doctor (first and last name): _____ Phone: _____

May we share your treatment updates with your medical doctor to support your care? **Yes / No**

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____ Does this condition interfere with daily activities? **Yes / No**

Is this due to: Auto accident ____ Work injury ____ Other _____ (If due to work or auto injury, please stop & see staff)

What aggravates this complaint? **Circle** all that apply: *Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping Physical Activity / Exercise / Movement / Bending forward / Bending backward / Twisting / Reaching / Lifting / Desk work / Sneezing / Coughing Everything / Unknown / Other:* _____

Have you ever had the same or a similar condition? **Yes / No** — If yes, when and describe: _____

Have you been treated by any other physician, **including chiropractor**, for this condition? **Yes / No** – If yes, name of doctor or clinic? _____

MEDICAL HISTORY:

Do you have a history of stroke or hypertension? **Yes / No** Are you taking anticoagulants? **Yes / No** Medical implants/devices? **Yes / No**

In the last year, have you experienced significant weight loss/gain? **Yes / No** — If yes, how much? Lost: _____ Gained: _____

Please list any other major illnesses, injuries, falls, auto accidents, hospitalizations, or surgeries? Women, please list information about childbirth (include dates): _____

Have you been treated for **any** health condition by a physician in the last year? **Yes / No** If yes, describe: _____

Please list medications and/or vitamins are you taking: _____

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SOCIAL HISTORY:

Do you exercise? **Yes / No** If yes, what is the frequency and type of exercise? _____

Smoker: **Current / Past** Alcohol consumption: **Yes / No** – How many per week? _____ Current stress level: **Low / Moderate / High**

What are your hobbies? _____

INSURANCE INFORMATION:

Name of primary insurance company: _____ Secondary insurance: _____

Name of primary insured, if other than patient: _____ Insured date of birth: _____

Primary Insured Employer: _____ Name of responsible party for payment: _____

HIPAA AUTHORIZATION FOR FAMILY/FRIENDS:

I, _____, give permission to Northside Family Chiropractic to disclose and release my protected health information described below to:

Name(s):

Relationship:

Health Information to be disclosed:

My complete health record (including but not limited to diagnoses, prognosis, treatment, and billing, for all conditions

OR

Billing records only (including itemized charges, insurance information, payment history, balances due.)

This health information may be used to enable the person I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons. This authorization shall be effective until I revoke it in writing.

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

Patient/Guardian Printed Name: _____

Patient/Guardian Signature: _____ Date: _____

The patient/guardian 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 will 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. If there is anyone you do not want to receive your medical records, please inform our office. The patient understands that payment is due for all services rendered.

Patient/Guardian Printed Name: _____

Patient/Guardian Signature: _____ Date: _____