

## Personal Information

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Ph:( ) \_\_\_\_\_ Cell Ph:( ) \_\_\_\_\_  
Work Ph:( ) \_\_\_\_\_ Email: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Sex: M  F   
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Business Ph:( ) \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone:( ) \_\_\_\_\_  
Marital Status: M  S  D  W  Spouse's Name: \_\_\_\_\_ # of Children: \_\_\_\_\_  
How were you referred to our office? \_\_\_\_\_  
Payment for services will be by: Cash  Check  Credit Card  Medicaid  Medicare   
Health Insurance  Workers Compensation  Personal Injury/Auto

## Insurance Information

The following information is necessary to submit claims to your insurance company. As a convenience to you we will submit all of your insurance claims and also verify your Chiropractic benefits. It is important for you to understand that your insurance is a contract between you and your chosen insurance carrier. You should take care to familiarize yourself with your individual benefits. It is also important to understand that most insurance companies offer some Chiropractic benefits but not all. Any charges not covered by your insurance company are your responsibility.

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Employer: \_\_\_\_\_  
Relation to Insured: \_\_\_\_\_

## Reason for Care

Primary Complaint: \_\_\_\_\_ When did it start? \_\_\_\_\_  
How did it begin? Suddenly  Gradually  Has it got better  worse  stayed the same   
Do you know what caused it? \_\_\_\_\_  
Describe the pain: sharp  dull/ache  throbbing  tingling  numbness  other  \_\_\_\_\_  
What makes it better? \_\_\_\_\_  
What makes it worse? \_\_\_\_\_  
What daily activities does it interfere with? \_\_\_\_\_  
Does the pain stay in one spot or spread out? \_\_\_\_\_  
Which side is the pain worse? Left  Right  Middle   
When is it worse? Morning  Noon  Afternoon  Evening   
How severe is the pain on a scale of 1 to 10 at its worst? \_\_\_\_\_ At its best? \_\_\_\_\_  
What percent of the time are you aware of the pain? <25%  25-50%  50-75%  75-100%   
Have you ever had this condition before? Yes  No  If yes, explain \_\_\_\_\_  
Have you tried any medications or self-treatments for this condition? Yes  No   
If yes, explain \_\_\_\_\_ Results: \_\_\_\_\_  
Have you consulted with another health care provider for this complaint? Yes  No   
If yes, whom? \_\_\_\_\_ Results: \_\_\_\_\_  
What imaging procedures were conducted? X-ray  MRI  CT  Other  \_\_\_\_\_  
Additional Complaints: \_\_\_\_\_

## Health History

Have you been seen by a chiropractor before? Yes  No  If yes, whom? \_\_\_\_\_

Reason: \_\_\_\_\_ Date of last adjustment: \_\_\_\_\_

Family Medical Doctor: \_\_\_\_\_ Ph: ( ) \_\_\_\_\_

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

If yes, explain: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

List all supplements / medications you are currently taking: \_\_\_\_\_

List all surgeries you have had: \_\_\_\_\_

List all accidents/major injuries you have had: \_\_\_\_\_

List any known family history of diseases, disorders or major illnesses: \_\_\_\_\_

### Have you ever had problems with any of the following? (Circle all that apply)

#### General Symptoms

Convulsions  
Dizziness  
Fainting  
Headache/Migraine  
Nervousness  
Numbness  
Wheezing  
Sleeping Problems  
Other \_\_\_\_\_

#### Muscles & Joints

Low Back Problems  
Pain between shoulders  
Neck Problems  
Arm Problems  
Swollen Joints  
Painful Joints  
Stiff Joints  
Cramps  
Sore Muscles  
Weak Muscles  
Walking Problems  
Sprains/Strains  
Other \_\_\_\_\_

#### Cardio-Vascular

High Blood Pressure  
Heart Attack  
Pain over Heart  
Pacemaker  
Poor Circulation  
Heart Trouble  
Rapid Heartbeat  
Slow Heartbeat  
Strokes  
Swelling Ankles  
Varicose Veins  
Other \_\_\_\_\_

#### Eye/Ear/Nose/Throat

Earache  
Enlarged Thyroid  
Frequent Colds  
Hay Fever  
Nasal Blockage  
Nose Bleeds  
Pain Behind Eyes  
Poor Vision/Blurry Vision  
Sinusitis  
Sore Throats  
Tonsillitis  
Other \_\_\_\_\_

#### Skin or Allergies

Boils  
Bruising Easily  
Dryness  
Eczema/Rash/Dermatitis  
Hives  
Itching/Sensitive Skin  
Allergy  
Other \_\_\_\_\_

#### Endocrine

Diabetes  
Hyperthyroid/Hypothyroid  
Other \_\_\_\_\_

#### Genito-Urinary

Blood in Urine  
Frequent or Painful Urination  
Kidney Infection  
Prostate Problems  
Loss of Bladder Control  
Other \_\_\_\_\_

#### Bones

Osteopenia/Osteoporosis  
Scoliosis  
Other \_\_\_\_\_

#### Gastro-Intestinal

Belching/Gas  
Colon Problems  
Constipation  
Diarrhea  
Excessive Hunger  
Excessive Thirst  
Gall Bladder Problems  
Hemorrhoids  
Liver Problems  
Nausea  
Abdominal Pain  
Ulcer  
Poor Appetite  
Poor Digestion  
Vomiting Blood  
Black Stool  
Bloody Stool  
Weight Loss/Gain  
Other \_\_\_\_\_

#### Respiratory

Asthma  
Chronic Cough  
Difficulty Breathing  
Spitting Blood/Phlegm  
Other \_\_\_\_\_

#### For Women Only

Hormone Replacement  
Cramps/Backaches  
Excessive Flow  
Hot Flashes  
Irregular Cycle  
Painful Periods  
Other \_\_\_\_\_

Birth Control? Yes  No

Are you Pregnant? Yes  No

Date of Last Period: \_\_\_\_\_

### **Informed Consent For Chiropractic Care**

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime. I understand that if I am accepted as a patient by a physician at Papillion Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request. Initial\_\_\_\_\_

### **Permission To Use Name**

I give you permission to use my name in your patient newsletter and on any office bulletin or other notice boards for purposes of announcing births, birthdays, weddings, graduations or acknowledging my referrals. Initial\_\_\_\_\_

### **HIPPA Patient Consent Form**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a patient rights section describing your patient rights under the law. You have a right to review this notice before signing the consent. The terms of the notice may change, and if this should occur, you may receive a revised copy by contacting the office. You have the right to restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or healthcare operations. You have a right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in relation to you on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- 1) Protected health information may be disclosed or used for treatment, payment, or health care operations.
- 2) The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
- 3) The practice reserves the right to change the notice of privacy practices.
- 4) The patient has the right to request restricted use of their information, but the practice does not have to agree to those restrictions.
- 5) The patient may revoke this consent in writing at any time and all future disclosures will then cease.

Initial\_\_\_\_\_

Printed Name (Patient Name or Representative):\_\_\_\_\_

Signature:\_\_\_\_\_Date:\_\_\_\_\_