WELCOME

Patient Information (Please Print)

Name_____________________________________ **Date**____ /____/_____ **S/S**______-____-_________

Address______________________________ **City**_______________ **State**______ **Zip**______________

Sex: ____Female ____Male **Birth Date**____/____/____

Home Phone # _______________ **Work Phone #** _______________ **Cell Phone #**_________________

Do you prefer to receive calls at: ___ Home ___ Work ___Either

Is it alright to leave messages?: ___Yes ___No **Preferred Language**: English Other ____________

Are you: ___ Minor ___ Married ___Divorced ___ Widowed ___Single ___ Separated

Your Employer_______________________________________ **Occupation**_____________________

Business Address______________________________ **City**________________ **State**____ **Zip**_________

Spouse's or Parent's Name________________ **Workplace**_______________ **Work Phone #** _________

Spouse's or Parent's SS# ____________________ **Spouse's or Parent's Birth Date** ____/ ____/ _____

Name of Emergency Contact ______________________ **Emergency Contact Phone#** ______________

Is it alright to also email office/website correspondence by e-mail? Yes No

If Yes, Email address ___________________________________

Are there any other person(s) who we may discuss your case with? If so, Please list the their name(s):

____

Race: ___ White ___ Black/African American ___ Hispanic ___ Other ___ I choose not to specify

Multi-Racial: ___ Yes ___ No ___ I choose not to specify

Ethnicity: ___ Hispanic or Latino ___ NOT Hispanic or Latino ___ I choose not to specify

Verification Question: (*Choose **one** by circling the question, then give the answer to that question*)

What city were you born in? What high school did you attend? What is your mother's maiden name?

Answer: ____

How did you hear about our office? Yellow Pages Newspaper Radio Patient Doctor Other

If Doctor, Patient or other (Name)_______________________________

Medicare, Privacy & General

I authorize the release of any medical information necessary to process insurance claims for services rendered at this office. I understand that DeGraw Chiropractic Center Inc. reserves the right to charge for an office visit for appointments broken without 24hr advanced notification. I authorize payment of any medical benefits directly to the DeGraw Chiropractic Center Inc. for services rendered. I understand that I am fully responsible for the balance of my account. A collection fee will be added to my account if this account becomes delinquent and is referred to a collection agency or an attorney for collections. *Interest will be charged for bills over 90 days old at 18% per year.*

DeGraw Chiropractic Center is required to provide you with a copy of our **Notice of Privacy Practices**, which states how we may use and/or disclose for health information. I (patient) acknowledge at I have received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of DeGraw Chiropractic Center. I understand that the Notice describes the uses and disclosures of my protected health information and informs me of my rights with respect to my protected health information.

Signature:____ Date:_________________

Patient History Form

Name: ____ *Date*: __________________

(Patient Checklist)
Health History (Choose only those conditions which are applicable)

Aids/HIV	Alcoholism	Allergies	Anemia	Acid Reflux
Appendicitis	Arthritis	Asthma	Bleeding Disorder	Breast Lump
Bronchitis	Cancer	Constipation	Drug Dependency	Depression
Diabetes	Emphysema	Fatigue/low energy	Fractures	Gout
Heart Disease	Hepatitis	Hernia	Herniated Disc	Herpes
High Cholesterol	Kidney Disease	Liver Disease	Migraines	Multiple Sclerosis
Osteoporosis	Pacemaker	Parkinson's Disease	Pinched Nerve	Pneumonia
Prostate Disease	Psychiatric Care	Rheumatoid Arthritis	Stroke	Suicide Attempt
Thyroid Problems	Tuberculosis	Tumors/Growths	Ulcers	Venereal Disease
High Blood Pressure	Frequent falls	Other Conditions: ________________________________		

Where are your symptoms located **AND** when did your symptoms start:
____

Have you had any recent trauma: ____

What makes it feel better: ____

What makes it feel worse: ____

What does your pain feel like (achy, sharp, numb, radiating, etc): ______________________________

Do the symptoms feel better or worse at any particular time of the day: _______________________

Any family history of any diseases or illnesses (ie. diabetes, stroke, heart disease, arthritis, etc):
____

List any prior surgeries: ____

Recent Unexplained Weight Loss: ________ Are you Pregnant: ________ *(If yes)* how long: ________

Prior Chiropractic Care: _______________________________ Family Doctor: _____________________

Current Medications (include mg. & dosage):

____ None: ____

Allergies to any medication: ____ None: ____

Has any doctor diagnosed you with hypertension presently? ___ Yes ___ No If yes, what kind? _______

Has any doctor diagnosed you with diabetes presently? ___ Yes ___ No If yes, which kind? Type 1 or 2
If yes to Diabetes, was your blood lab work test for Hemoglobin A1c > 9.0%? Yes No Not Sure

Has any doctor diagnosed you with a significant health syndrome presently? ___ Yes ___No ___ Not Sure
If yes, what kind? ____

Do you currently smoke tobacco of any kind? ___ Yes ___ Never been a smoker ___ Former smoker
If yes, How often do you smoke: ___ Current every day smoker ___ Current some days smoker
If yes: What is your level of interest in quitting smoking? **0 1 2 3 4 5 6 7 8 9 10 N/A**

Have you had an x-ray or CT scan or MRI of your **low back** spine in the past 28 days? ___ Yes ___ No

What are you not able to do? ____