PATIENT PERSONAL/CONFIDENTIAL DATA

No. _____ Date: _____

Patient: _____ Date of Birth: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Social Security No.: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Employer: _____ Address: _____

Name of Spouse: _____ SS No.: _____ No. of Children: _____

Spouse's Employer: _____ Address: _____

How did you learn of this clinic? _____

Nearest relative not living with you? _____ Phone: _____

Who is responsible for payment? ❑ Self ❑ Spouse ❑ Other _____

PATIENT'S INSURANCE

Name of Company: _____

Address: _____

ID & Group No.: _____

Phone No.: _____

SPOUSE'S INSURANCE

Name of Company: _____

Address: _____

ID & Group No.: _____

Phone No.: _____

Purpose of this appointment and list your complaints: _____

_____

Date of illness: _____ Time: _____ ❑ AM ❑ PM Location: _____

How did accident occur? ❑ Auto ❑ On the job ❑ Other: _____

Please describe the circumstances and what makes the condition(s) better or worse: _____

_____

_____

_____

Other Doctor seen for this condition: _____

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

If Yes, please describe? _____

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 Chiropractic 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 this Chiropractic Office will be credited to my account upon receipt. However, 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 for professional services rendered to me will be immediately due and payable.

Signature Physician: _____ Signature Patient: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he may designate as his 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; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic 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 services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient Signature: _____

Patient's or Guardian's Signature: _____

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ No.: _____

MUSCULO SKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Spasms
- ❑ Broken bones
- ❑ Shoulder pain

GENITO-URINARY SYSTEM

- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast

ARE YOU PREGNANT?
❑ YES ❑ NO

GASTRO-INTESTIONAL SYSTEM

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Difficult swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting Blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscles jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia

HABITS

- ❑ Cigarettes
- ❑ Alcohol Abuse
- ❑ Coffee or Tea
- ❑ Drug Abuse
- ❑ _____

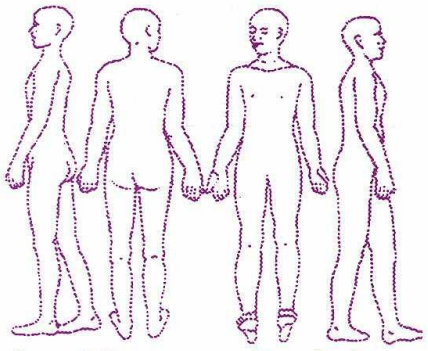
CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficult breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose veins

EYE, EAR, NOSE AND THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficult breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw Pain

SYMPTOM LOCALIZATION



P ___ Pain
N ___ Numb
S ___ Spasm

T ___ Tender
H ___ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

DO NOT WRITE BELOW THIS LINE

_____

_____

_____

_____

Patient Accepted? ❑ Yes ❑ No Doctor's Signature _____

The Office of James W. Campbell, D.C.

Patient Acknowledgement Form
Notice of Privacy Practices

I have been provided with a copy of **The Offices of James W. Campbell, D.C.'s** Notice of Privacy Practices, which describes **The Offices of James W. Campbell, D.C.'s** use and disclosure of my Protected Health Information (PHI)

Patient Name: _____

Patient Signature: _____

Date: _____

PATIENT AUTHORIZATION FOR USE OF EMAIL CORRESPONDENCE

I, _____, hereby authorize Campbell Chiropractic Center to communicate with me via electronic mail to the following email addresses:

_____
_____
_____
_____

PATIENT NAME: _____
SIGNATURE: _____ DATE: _____
If Patient is a Minor PARENT/ GUARDIAN: _____
SIGNATURE: _____ DATE: _____

PATIENT REQUEST FOR ALTERNATE CONTACT METHOD

I hereby request that Campbell Chiropractic Center, it's Staff, Providers, Business Associates, and Agents, do not contact me, or leave any information for me, using the following methods: (Check All That Apply)

Voice Mail/Answering Machine, Home Voice Mail/ Answering Machine, Work Voice Mail, Cell Phone
Voice Mail Answering Machine, Other (Specify: _____)

Home Telephone Work Telephone Cell Telephone Alphanumeric Pager Instant Messaging Service
Home Fax Work Fax
Others (Specify:_____)

In order to provide Campbell Chiropractic Center with reasonable, alternative methods of contacting me, I hereby authorize Campbell Chiropractic Center to contact me via the following method(s):

_____
_____
_____
_____
_____

PATIENT NAME: _____
SIGNATURE: _____ DATE: _____
If Patient is a Minor PARENT/ GUARDIAN: _____
SIGNATURE: _____ DATE: _____