Please fill out our history forms *completely* and *accurately* to the best of your ability so that we can quickly get you on the road to health.

Date: _____ Social Security #_____

Name: _____
Last First M.I

Permanent Address_____

E-mail (Doctors will communicate with you via email) _____

Cell Phone: _____ Home Phone: _____

Preferred method of communication: (Check one) Email___ Text___ + Carrier Name _____ App. Reminders? Y N

Sex: _____Male _____ Female Age: _____ Birthdate: _____

___Married ____Separated ____Widowed ____Divorced ____Single ____Partnered for ___Yrs ____Minor

Preferred Language: _____ Ethnicity (Circle): Hispanic or Latino / Not Hispanic or Latino/ Decline

Race (Circle): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) /
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Patient Employer/School _____

Address: _____

Phone: _____ Occupation: _____

Spouse's Name: _____ SS#_____ - _____ - _____ Phone: _____

Birthdate: _____ Spouse's Employer: _____

Emergency Contact: _____ Relationship: _____ Phone_____

**ACCIDENT INFORMATION**: Is condition due to an accident? Yes____ No____ Date of Accident _____
Type of Accident: Auto ____ Work ____ Home____ Other ____

***INSURANCE INFORMATION:***

*Even if you are here through a non-referral source such as an external workshop, we are happy to verify your insurance coverage. We will **NEVER** bill your insurance without your permission. It means we will verify your benefits and have that information prepared for you. Thank you for providing.*

Who is responsible for this account? _____ Relationship to patient: _____

Insurance Co: _____ ID#_____

Subscriber Name _____ Birthdate: _____

**ASSIGNMENT AND RELEASE:** I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Drs. Jacob Young and/or Jessica Young all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company/(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____

Please print name of above signature Relationship to Patient

## *X-Ray Consent*

I hereby give my consent to Black & Gold Chiropractic and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant.
I have read and understood all the above information.

_____ _____

Patient Signature Date

## *Notice of Privacy Practices Acknowledgement*

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request in writing, that you restrict how my private information is used to disclose, to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

Patient Signature Date

## Financial Responsibility

**Patient Name**_____

Dear Patient,
Black & Gold Chiropractic & Wellness provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. In the event that we are billing your insurance company and a check is mailed to you, you MUST bring the check into the office within 7 days so that we may properly credit your account.
I have read and understood all the above information.

_____ _____
Patient Signature Date

## Consent to Release & Disclosure of PHI (Protected Health Information)

I hereby give my consent to Black & Gold Chiropractic and its representatives to share my health record with the following individuals only at my request:

Name: _____ Phone: _____

Relationship to patient: _____ Email: _____

Name: _____ Phone: _____

Relationship to patient: _____ Email: _____

Name: _____ Phone: _____

Relationship to patient: _____ Email: _____

_____ _____
Patient Signature Date

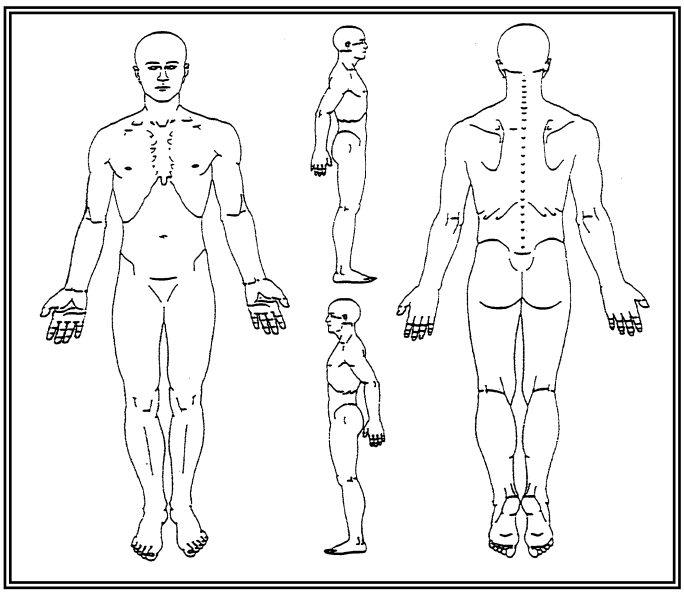
**We appreciate you choosing our office. Is there anyone we can thank for referring you?** _____

**Please indicate the main reason you are seeing us today:** _____

_____

**If you are seeing us for a pain related issue, USE THE SYMBOLS to show the type of pain you feel in each location.**

| XXXXXXXXX | / / / / / / / / / / | o o o o o o o o o o | s s s s s | - - - - - - - - |
|---|---|---|---|---|
| **DULL/ACHY** | **SHARP/STABBING** | **NUMBNESS/TINGLING** | **STIFF/TIGHT** | **BURNING** |



**Using the pain scale below, CIRCLE the pain level you experience when your problem is at its very worst:**

**0** = **No Pain**. No Discomfort
**1** = **Minimal Discomfort**. Minor stiffness or tightness.
**2** = **Discomfort**. Stiff, tight, sore. Muscle fatigue.
**3** = **Minimal Pain**. More than just sore. Uncomfortable.
**4** = **Mild Pain**. Noticeable pain but tolerable.
**5** = **Moderate Pain**. Aggravating. Still allows movement.
**6** = **Strong Pain**. Quite aggravating. Movement slightly limited.
**7** = **Very Strong Pain**. Very aggravating. Movement definitely limited.
**8** = **Very, Very Strong Pain**. Extremely aggravating. Movement very limited.
**9** = **Severe Pain**. Brings tears. Almost impossible to move.
**10** = **Excruciating Pain**. Agony. Unbearable. Cannot move. ER.

**Is there any radiating pain into the arms or legs?** _____ **Is there any numbness or tingling?** _____

**How often do you experience your problem? (Please indicate for each of the body location if applicable)**

Constant (75 – 100% of the time) _____

Frequent (50 – 75% of the time) _____

Occasional (25 – 50% of the time) _____

Intermittent (0 – 25% of the time) _____

**List any MD's or Chiropractors you've already seen for this problem:** _____
_____

**What tests have you already had for this problem?** □X-rays □MRI □C.T. Scan □Myelogram □EMG/NCV
□None □Other _____

**What makes your problem <u>worse</u>?** □Sitting □Standing □Changing Position □Walking □Bending □Lifting □Twisting
□Reaching □Driving □Sleeping □Sneeze/Cough □Computer Work □Telephone □Going From Sit to Stand
□Other_____

## PAST MEDICAL HISTORY

**Please list any significant conditions that you've been diagnosed with or been treated for over the course of your life:** _____

_____

**Please list any surgeries you have had over the course of your life:** _____

_____

## MEDICATIONS & ALLERGIES

**Are you allergic to any medications?** □Yes □No **If yes, please list:** _____

**List any medications, herbs or supplements you are taking and the reason for their use:**

_____
_____

## FAMILY HISTORY

**Mother:** □Living □Deceased List any medical problems: _____

**Father:** □Living □Deceased List any medical problems: _____

**List any problems common in your family:** □Cancer □Diabetes □Heart disease □High blood pressure □Stroke □Arthritis
□Scoliosis □Thyroid disease □Osteoporosis _____

## SOCIAL HISTORY

**Marital status:** □Married □Single □Divorced □Common Law □Engaged □Widowed

**Do you have any children?** □Yes □No If yes, how many? _____

**Do you drink alcohol?** □Yes □No If yes, how much & how often? _____

**Do you smoke?** □Yes □No If yes, how much, how often & how long? _____

**Are you currently employed?** □Yes □No If yes, what is your occupation? _____

**Who is your current employer?** _____ **How long have you been at this job?** _____

**What do you do most of the day in your job postures, positions and repetitive movements:** _____-
_____

**I am looking for the following type of care:**
□ Acute symptom relief (short-term care)
□ Corrective Care (symptom relief + spinal correction
□ Doctor to determine best care recommendations

## REVIEW OF SYSTEMS

Please use the criteria below to list each symptom on this page according to your health status:
C= Current Issue P= Past Issue

| | | | | |
|---|---|---|---|---|
| **___Headaches** | **___Ear Infections** | **___Sinus Issues** | **___Kidney Problems** | **___Sexual Dysfunction** |
| **___Migraines** | **___Hear Loss** | **___Frequent Colds** | **___Bladder Problems** | **___Sleep Problems** |
| **___Jaw/TMJ Pain** | **___Ringing in the Ears** | **___Thyroid Issues** | **___Menstrual Problems** | **___Tight/Sore Muscles** |
| **___Neck Pain** | **___Dizziness** | **___Asthma** | **___Prostate Problems** | **___Sports Injury** |
| **___Shoulder Pain** | **___Loss of Energy** | **___Chest Pain** | **___Infertility** | **___Sciatica** |
| **___Arm Pain** | **___Nervousness** | **___Heart Problems** | **___Fibromyalgia** | **___Arthritis/Joint Pain** |
| **___Upper Back Pain** | **___Double/Blurry Vis.** | **___Nausea** | **___Epilepsy/Convuls.** | **___GERD/Gastric Ref.** |
| **___Mid Back Pain** | **___Anxiety** | **___Ulcers** | **___Tremors** | **___Difficulty Breathing** |
| **___Low Back Pain** | **___ADD/ADHD** | **___Digestive Issues** | **___Disc Problems** | **___Stomach Problems** |
| **___Hip/Leg Pain** | **___Loss of Balance** | **___Diarrhea** | **___Scoliosis** | **___High/Low Blood Pr.** |
| **___Knee Pain** | **___Depression** | **___Constipation** | **___Poor Posture** | **___Heart Attack** |
| **___Foot Pain** | **___Allergies** | **___Bed Wetting** | **___Skin Problems** | **___Stroke** |
| **___Cancer** | **___Spinal Surgery** | **___Diabetes** | **___Arthritis** | **___Seizures** |
| **___Spinal/Bone Fracture** | | **___Other:_____** | | |
| **___Pregnant:** | **Due Date:_____** | | | |