CHIPLEY CHIROPRACTIC -CONFIDENTIAL PATIENT INFORMATION

Name_____ What do you prefer to be called? _____
(First) (Middle Initial) (Last)

Address_____ City _____ State _____ Zip _____

Best Contact Phone _____ Text Appt Reminder OK? __ Yes / __ No

Date of Birth: _____ Soc Sec #: _____ Email: _____

Employer_____ Occupation _____Work Phone_____

Please Circle One: Married Single Divorced; If Married, Spouse's Name: _____

(Optional) - Please List Any Other Person who can have access to YOUR Health Information:

Name: _____ Relation to You: _____

The Main Reason / Pain that Prompted me to seek treatment today:

_____

When did it start? _____

What makes it worse? _____

Does anything give you relief? _____

What does it feel Like? Ache Sharp Shooting Other: _____
Radiation: _____

Rate your pain from 0 to 10 (0 = No Pain & 10 = Emergency Room Pain): _____

How Frequent is the pain? Circle one: Constant ¾ of the day ½ of the day ¼ or less of the day

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If you have a secondary complaint, please list it below and fill this part out:

_____

When did it start? _____

How did it start? _____

What makes it worse? _____

Does Anything Give you relief? _____

What does it feel Like? Ache Sharp Shooting Other: _____
Radiation: _____

Rate your pain from 0 to 10 (0 = No Pain & 10 = Emergency Room Pain): _____

How Frequent is the pain? Circle one: Constant ¾ of the day ½ of the day ¼ or less of the day

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If you have any additional complaints, please elaborate below:

_____

_____

Family History:

		Back	Heart	Stroke	Cancer	Diabetes	High BP	Arthritis	High Cholesterol	Osteoporosis	Thyroid	Good Health
Mother		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sisters		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brothers		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Children		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Social History:

	Daily	3 X Week	2 X Week	1 X Week	2X Month	1X Month	Never
WORK	☐	☐	☐	☐	☐	☐	☐
Sit at Desk:	☐	☐	☐	☐	☐	☐	☐
Work on Computer:	☐	☐	☐	☐	☐	☐	☐
Work on Phone:	☐	☐	☐	☐	☐	☐	☐
Moderate/Heavy Labor:	☐	☐	☐	☐	☐	☐	☐
Stay At Home:	☐	☐	☐	☐	☐	☐	☐
Deliver Packages:	☐	☐	☐	☐	☐	☐	☐
	Daily	**Occasionally**	**1 X Week**	**Never**	**Quit**		
Habits							
Tobacco/ Smoke	☐	☐	☐	☐	☐		
Alcohol	☐	☐	☐	☐	☐		
Caffeine	☐	☐	☐	☐	☐		
	Daily	**3 X Week**	**1 X Week**	**Never**	**Quit**		
Exercise	☐	☐	☐	☐	☐		

Pre-existing Conditions: Please Check All that Apply to you

	☐ADHD	☐Collagen Vascular Disease	☐Heart Murmur	☐Paralysis
	☐ Alcohol/Drug Addiction	☐Constipation	☐Hemorrhoids	☐Pneumonia
	☐Anemia	☐Depression/Anxiety	☐Hepatitis	☐Polio
	☐Appendicitis	☐Diabetes	☐High Blood Pressure	☐Prostate Problems
	☐Arrhythmia	☐Digestive Disorders	☐High Cholesterol	☐Reflux / Ulcers
	☐Arteriosclerosis	☐Dizziness	☐HIV/AIDS	☐Rheumatic Fever
	☐Arthritis	☐Eating Disorder	☐Joint/ Back Pain	☐Scoliosis
	☐Asthma	☐Emphysema	☐Kidney Infections	☐Seizures/ Epilepsy
	☐Backaches	☐Epilepsy	☐Kidney Stones	☐Sexual Dysfunction
	☐Bleeding Disorder	☐Fatigue	☐Liver Disease/ Problems	☐Sickle Cell
	☐Blood Clots	☐Female Health Changes	☐Lung Disease	☐Sinus Trouble
	☐Blood Transfusions	☐Fibromyalgia	☐Measles	☐Stress / Tension
	☐Blurred Vision	☐Gallbladder Disease	☐Menstrual Cramps	☐Stroke
	☐Bowel Problems	☐Genital Herpes	☐Mental Disorder	☐Suicidal Tendencies
	☐Broken Bones	☐Glaucoma	☐Migraines	☐Thyroid Disease
	☐Cancer	☐Gluten Intolerance	☐Miscarriage	☐Tuberculosis
	☐Carpal Tunnel	☐Goiter	☐Multiple Sclerosis	☐Tumors
	☐Cataracts	☐Gout	☐Neck Pain	☐Ulcers
	☐Chicken Pox	☐Headaches	☐Nervousness	☐Urine discoloration
	☐Cold Sores	☐Hearing Loss	☐Night Sweats	☐Vertigo
	☐Colitis	☐Heart Disease/Attacks	☐Osteoporosis	☐Whooping Cough

Any additional conditions that we should be aware of: _____

_____

_____

Surgical History: Please Note the type of surgery and the Date: (If None then check box here: □)

_____

_____

_____

Any Known Allergies to medications or environmental & date detected (If None then check box here: □)

_____

_____

Current Medications: Please list name, dosage and how often you take it (If None then check box here: □)
(If you have a list we can photo-copy it for you)

_____

_____

_____

Please list all past accidents, slips and falls, sports or work or personal injuries that you've had in the past. Please note the date of injury & if you had treatment for the past injury. (If None then check box here: □)

_____

_____

_____

If you are a Cash Patient (No Insurance), -Skip this section and go to the next page

Insurance Information:

Insured's Name: _____

Relationship to Insured (Check Here □ if it is you): _____

Insured's Date of Birth: _____

ASSIGNEMENT AND RELEASE: (**This must be signed BELOW for Any Patient Using Insurance for payment. *Patients Without Insurance Do Not need to sign***.)

I certify that I, and/or my dependents, have insurance coverage with the above listed insurance company and assign directly to Chipley Chiropractic, PLLC of Beckley, WV all 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 provider's office 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 payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

X_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

Activities of Daily Living: How Does this condition interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐	☐	**Caring for Family**	☐	☐	☐	☐
Rising out of Chair	☐	☐	☐	☐	**Household Chores**	☐	☐	☐	☐
Standing	☐	☐	☐	☐	**Lifting Objects**	☐	☐	☐	☐
Walking	☐	☐	☐	☐	**Reaching Overhead**	☐	☐	☐	☐
Lying Down	☐	☐	☐	☐	**Showering or Bathing**	☐	☐	☐	☐
Bending over	☐	☐	☐	☐	**Dressing Myself**	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐	**Yard work**	☐	☐	☐	☐
Using a Computer	☐	☐	☐	☐	**Getting to Sleep**	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐	**Staying Asleep**	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐	**Concentrating**	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐	**Exercising**	☐	☐	☐	☐

What is the Approximate age of your Pillow? _____

What is the Approximate age of your Mattress? _____

Acknowledgements:
To set clear expectations, improve communications and help you get the best results in the shortest period of time, please read each statement and initial your agreement:

Initials___I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I understand that chiropractic care offered in this practice is based on the best available evidence designed to reduce or correct spinal joint dysfunction. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials___I may request a copy of the privacy policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials___I grant permission to be called or text messaged to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care.

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

Initials___To the best of my ability the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____ _____

Patient (or Guardian's) signature Date (MM/DD/YY)