Dr. RJ Crandall
BEATRICE FAMILY CHIROPRACTIC

Medical History Information

First Name:

Last Name: Middle:

☐ Mr. ☐ Miss
☐ Mrs. ☐ Ms.

Marital status (circle one)
Mar / Single / W / D / Sep

Spouse Name:

Email: Birth date: Age: Sex:

Address: City: State:

ZIP Code: Social Security No.: CELL Phone:

Occupation: Employer: Employer phone:

Medical Care Information

Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:

Address: City: State: ZIP Code:

Date of last Visit: / / Date of last exam: / /

Do You Have a Family Chiropractor?: ☐ No ☐ Yes, Name of Chiropractor:

Address: City: State: ZIP Code:

Date of last Visit: / / Date of last exam: / /

Have you had surgeries in the last 5 Years: ☐ Yes ☐ No If yes, Last Surgery Date:

Reason for Surgery:

Present illness /Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	☐
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐

Other:

Family History of illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitus

Other:

Type of Cancer: ☐ Breast ☐ Lung ☐ Other:

Social History:

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous

Misc.:

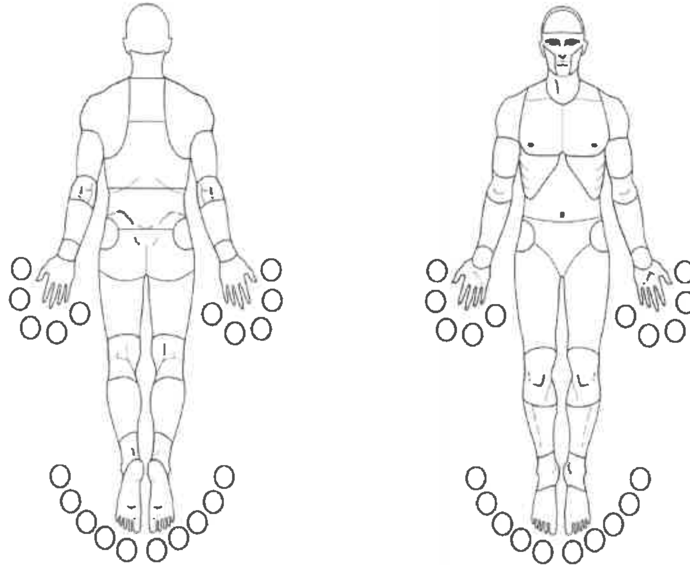
Signature: ______________________ Date: ______________

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

MH-0001

Patient's Name: ______________________ Date: __________

Please mark below where you currently or in the past have had problems (pain):



What is your current pain complaint?	(Complaint #1)______________________ • Left ☐ Right ☐ Both ☐ Center
Rate your pain	• 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
How often is this pain?	• Infrequent < 25% ☐ Occasional 25% to 50% • Frequent 50% to 75% ☐ Constant > 75%
Pain Type: check all that apply	• No Pain ☐ Pain ☐ Numbness ☐ Tingling • Muscle Spasms ☐ Burning

Where else do you experience pain?	(Complaint #2)______________________ ☐ Left ☐ Right ☐ Both ☐ Center
Rate your pain	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
How often is this pain?	• Infrequent < 25% ☐ Occasional 25% to 50% • Frequent 50% to 75% ☐ Constant > 75%
Pain Type: check all that apply	• No Pain ☐ Pain ☐ Numbness ☐ Tingling • Muscle Spasms ☐ Burning

	(Complaint #3)______________________ ☐ Left ☐ Right ☐ Both ☐ Center
Rate your pain	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
How often is this pain?	• Infrequent < 25% ☐ Occasional 25% to 50% • Frequent 50% to 75% ☐ Constant > 75%
Pain Type: check all that apply	• No Pain ☐ Pain ☐ Numbness ☐ Tingling • Muscle Spasms ☐ Burning

AUTHORIZATION AND RELEASE:

I authorize payment of insurance benefits directly to the chiropractor or chiropractor's office (Robert J. Crandall, Jr., D.C. and/or Beatrice Family Chiropractic, P.C.). I authorize the doctor to release all information necessary to communicate with personal physicians and providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:______________________________ Date: ______________

Guardian's Signature:______________________________ Date: ______________

INFORMED CONSENT:

When a patient seeks chiropractic health care and we accept the patient for such care, it's essential to be working towards the same objective. Chiropractic has one goal. It's important that each patient understand that objective and method that will be used to attain it. This will prevent confusion or disappointment. We don't offer to treat or diagnose any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed to others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I,______________________________have read & fully understand the above statements.

Patient's Signature:______________________________ Date: ______________

Guardian's Signature:______________________________ Date: ______________

SEE REVERSE SIDE FOR HIPPA INFORMATION AND APPROVAL SIGNATURE:

**Patient Acknowledgement and Receipt of
Notice of Privacy Practice Pursuant to HIPAA and Consent
For Use of Health Information**

Name ______________________________ Date ______________
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal law.

Dated this __________ day of _________________________, 20____

By ____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By ____
Signature of Parent/Guardian (circle one)