

Patient Information

Welcome! Please allow our staff to photocopy your driver's license and all available insurance cards. PLEASE PRINT.

Name: _____ Nickname: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Home/Cell Phone: _____

Age: _____ Birth Date: _____ Occupation: _____

Employer: _____ Office Phone: _____

Employer's Address: _____ Spouse: _____

Spouse Occupation: _____ Spouse Employer: _____

How many children? _____ Names and Ages of Children: _____

Emergency Contact: _____ Emergency Contact Relationship: _____ Phone: _____

How were you referred to our office?

Google Facebook Physician Insurance Referred by: _____ Other _____

Primary Care Provider and office: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Yes No

Please check all insurance coverage that may be applicable in this case:

Major Medical Worker's Compensation Medicaid Medicare Auto Accident Other _____

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

Primary Cardholder: _____ Date of Birth of Primary Cardholder: _____

Address of Primary Cardholder (If different than above): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors 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 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 a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

OFFICE USE ONLY: Height: _____ Weight: _____ Blood Pressure: _____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: _____

Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto Work Other _____

Have you ever had the same or a similar condition? Yes No If yes, when and describe: _____

Days lost from work: _____ Date of last physical examination: _____

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents, or surgeries? Women, please include information about childbirth (include dates): _____

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

If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? Yes No

If yes, describe: _____

Do you have any allergies of any kind? Yes No

If yes, describe: _____

Do you have a congenital condition? Yes No If YES, Describe _____

Women: Are you pregnant? _____ First day of last menstrual period? _____

Have you ever received chiropractic care? Yes No

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:

OFTEN= "O" SOMETIMES= "S" NEVER= "N"

Vigorous Exercise		Family Pressures	
Moderate Exercise		Financial Pressures	
Alcohol Use		Mental Stresses	
Drug Use		Other _____	
Caffeine Use		Other _____	
High Stress Activity			

PATIENT NAME _____

Date of Birth _____

Informed Consent Chiropractic Care

In coming to Premier Chiropractic & Wellness, you give the doctor permission and authority to care for you, the patient, in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. Premier Chiropractic & Wellness, of course, will not give any treatment or health care if they are aware that such care may be contra-indicated.

Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the doctor. Premier Chiropractic & Wellness provides specialized, non-duplicating health care service. Our doctors are licensed in chiropractic and are available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient at Premier Chiropractic & Wellness, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Initial _____

Photo/Announcement Release:

I, Patient Name (please print) _____, give Premier Chiropractic & Wellness permission to use my name and picture in its patient newsletter and on any office bulletin or other notice boards for purposes of announcing births, birthdays, weddings, graduations or acknowledging my referrals.

Initial _____

Email/Text Appointment Reminders

We try to utilize the most advanced and convenient way to remind you of your appointments. We offer email or text reminders with 24 hour prior notice. Please provide us with your cell phone and carrier to provide text alerts or email address to provide email alerts, or both. You may also opt out of this service by checking below.

Cell Phone Number: _____

Email Address: _____ Opt out here: _____

I acknowledge that the above information is true and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

PATIENT NAME (Print) _____ Date of Birth _____

Patient Quality of Life Survey

Company Information: _____

Name: _____ Date: _____

Please take several minutes to answer these questions so we can help you get better.
(Please check all that apply)

01 How have you taken care of your health in the past?

- | | |
|--|---|
| <input type="checkbox"/> Medications | <input type="checkbox"/> Nutrition/Diet |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Holistic Care |
| <input type="checkbox"/> Routine Medical | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Chiropractic |
| <input type="checkbox"/> Other (please specify): _____ | |

02 How did the previous method(s) work out for you?

- | | |
|--|---|
| <input type="checkbox"/> Bad Results | <input type="checkbox"/> Did Not Get Worse |
| <input type="checkbox"/> Some Results | <input type="checkbox"/> Did Not Work Very Long |
| <input type="checkbox"/> Great Results | <input type="checkbox"/> Still Trying |
| <input type="checkbox"/> Nothing Changed | <input type="checkbox"/> Confused |

03 How have others been affected by your health condition?

- | | |
|--|---|
| <input type="checkbox"/> No One Is Affected | <input type="checkbox"/> They Tell Me To Do Something |
| <input type="checkbox"/> Haven't Noticed Any Problem | <input type="checkbox"/> People Avoid Me |

04 What are you afraid this might be (or beginning) to affect (or will affect)?

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> Job | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Kids | <input type="checkbox"/> Time |
| <input type="checkbox"/> Future Ability | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Freedom |
| <input type="checkbox"/> Self-Esteem | |

05 Are there health conditions you are afraid this might turn into?

- | | |
|---|--|
| <input type="checkbox"/> Family Health Problems | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Need Surgery |
| <input type="checkbox"/> Arthritis | |

06 How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

07 What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.). Give 3 examples:

1. _____

2. _____

3. _____

08 What are you most concerned with regarding your problem?

09 Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.

10 What would be different/better without this problem? Please be specific.

11 What do you desire most to get from working with us?

12 What would that mean to you?
