THERIOT FAMILY CHIROPRACTIC CENTER

Account # _ _____

PERSONAL HISTORY **Date: _____**

Name: _____Mailing Address:_____

City/State/Zip:_____

Age: ____ Birth date: _____ Sex: _____ SSN: _____

email address: _____ Phone number: _____

Work number: _____ Employer: _____

Occupation: _____

Married/Separated/Single/Divorced Spouse: _____ Number: _____

Medical Doctor: _____ If needed may we contact your doctor? yes no

In case of emergency contact: _____ Number: _____

The United States Congress requests you answer these 3 questions:

Race: _____ Hispanic yes no Primary Language: _____

Who is responsible for your bill? You Spouse Insurance Other: _____

TYPE OF INSURANCE COVERAGE FOR THIS CONDITION

_____Health insurance _____ Worker's Compensation

_____Medicare _____ Attorney

_____Automobile Insurance _____ Other _____

MEDICATIONS:

_____

_____

_____

Do you have allergies to medications? _____

SURGERIES (Please list and date):

_____

_____

_____

_____

ACCIDENTS AND FALLS (Please describe and date):

_____

_____

_____

REASON FOR CONSULTING THIS OFFICE:

____ I have no problem. I need to maintain my good health with regular chiropractic care.

____ I have a health problem that I need help with.

List Symptoms:	Severity (0-10)	Describe symptom (i.e. Ache, Sharp, Stabbing)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you seen any other doctors for these problems? Who? _____

Have you had any tests or treatment? _____

Have you had any x-rays taken recently? _____

Name: _____ Date: _____

HABITS

☐ Current every day smoker ☐ Occasonal smoker
☐ Former smoker ☐ Never smoker
☐ Drinking Alcohol ____c/day ☐ Coffee ____c/day
☐ Soft Drinks _____c/day ☐ water ____c/day

Exercise: None Moderate Daily

FAMILY HISTORY:	Diabetes	Cancer	Back Pain	Other
Mother	☐	☐	☐	☐ _____
Father	☐	☐	☐	☐ _____
Siblings	☐	☐	☐	☐ _____

PLEASE CHECK IF YOU EVER HAVE OR EVER HAD……

☐ Alcoholism
☐ Asthma
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Fatigue
☐ Heartburn
☐ Heart disease
☐ Hepatitis B
☐ Implants
☐ Insomnia
☐ Mental disorder
☐ Numbness/tingling
☐ Osteoporosis
☐ Pacemaker
☐ Pneumonia
☐ Polio
☐ Allergies
☐ HIV/AIDS
☐ Seizures
☐ Spinal injection
☐ Spinal tap
☐ Stroke
☐ T.I.A.
☐ Tuberculosis
☐ Rheumatoid arthritis
☐ Joint replacement
☐ STDs
☐ Plastic or metal plaltes

PLEASE CHECK ALL THAT APPLY TO YOU:

☐ Neck Problems
☐ Shoulder Problems
☐ Elbow Problems
☐ Wrist Problems
☐ Hand Problems
☐ Headaches
☐ Eye Problems
☐ Sinus Trouble
☐ Ringing in ears
☐ Hay fever
☐ TMJ Problems
☐ Mid Back Pain
☐ Pain between shoulder blades
☐ Abdominal Pain
☐ Digestive problems
☐ Breathing Problems
☐ Nausea
☐ Constipation
☐ Diarrhea
☐ Anxiety Attacks
☐ Gall Bladder Trouble
☐ Colon Problems
☐ Low Back Pain
☐ Hip pain
☐ Sciatica
☐ Groin Pain
☐ Muscle Spasms
☐ Urination Problems
☐ Neuropathy
☐ Bed Wetting
☐ Leg Problems
☐ Knee Problems
☐ Ankle/Foot trouble

FOR WOMEN ONLY

☐ Menstrual Problems ☐ Fertility Problems
☐ Hot flashes Pregnant? Yes No
☐ Irregular Cycle Date of last menstrual cycle _____

THERIOT FAMILY CHIROPRACTIC CENTER
Consent for Chiropractic Services

CONSENT FOR CHIROPRACTIC CARE:

I hereby request and consent to chiropractic treatment including physical examination, diagnostic x-rays (if needed), manipulations, dry needling (as needed), and various physical therapy by the doctors and staff of Theriot Family Chiropractic Center. I shall have the opportunity to discuss the nature, the purpose and the cost of procedures before they are administered. I understand that results can never be guaranteed. I understand that in the practice of chiropractic, as in the practice of medicine, there are some risks which include sprains, disc injuries, dislocations, strokes, and fractures. I do not expect my doctor to be able to anticipate or explain all risks or complications. I wish to rely on the doctor to use judgment during my course of treatment which he/she believe is in my best interest. I have read or have had read to me this consent and may take the opportunity to ask questions whenever I choose. It is my intention that this consent apply to treatment at any time in the future when I decide to take treatment at Theriot Family Chiropractic Center.

_____ _____
Patient or guardian signature Date

CONSENT TO TREATMENT OF A MINOR

I authorize the doctors and staff at Theriot Family Chiropractic Center to administer chiropractic treatment as deemed necessary to:

_____my _____(relationship to patient)

_____ _____
Patient or guardian signature Date

Please note: The parent or guardian must accompany the minor for the first visit.

INSURANCE AUTHORIZATION and RELEASE

Name of primary Insurance Company: _____

Secondary Insurance Company (If applicable): _____

I authorize payment of insurance benefits directly to the chiropractor or TFCC. I authorize the doctor to release all information to communicate with insurance personnel and other healthcare providers in order to secure the payment of benefits and/or the coordination of care. I understand that I am ultimately responsible for all costs of chiropractic treatment, regardless of insurance coverage. I hereby promise to assist collections at this office by completing, signing and mailing insurance forms when necessary.

In so much as I have agreed to allow the use of my patient health information for the purpose of insurance payment and coordination of care, I am still entitled to privacy. I understand my rights of privacy and are detailed in the “HIPAA PRIVACY POLICY” which describes the policy and procedures of this office. This is available for review at the reception desk at any time.
(If you want us to discuss your condition with a family member or friend, we need your written permission to do so.)

_____ _____
Patient or guardian signature Date