PATIENT INFORMATION

Name_____ Age_____ Birthdate_____ ◯ Male ◯ Female
First Middle Initial Last

Mailing Address_____
Street / PO Box City State Zip

Occupation_____ Employer_____Address_____

Cell Phone_____Home Phone_____Work Phone_____

EMAIL ADDRESS _____ **Social Security #**_____

CONTACT PREFERENCE ◯ Email ◯ US Mail ◯ Text ◯ Cell phone

Cell Carrier : ◯ Verizon ◯ Sprint ◯ US Cellular ◯ Other _____

Emergency Contact_____ Phone #_____

MARITAL STATUS ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Separated

Spouse's Name_____ Spouse's Employer_____

Spouse's Birthdate_____ Spouse's Phone #_____

If you have children please list the ages_____

How did you hear about our office? ◯ Friend/Family ◯ Co-Worker ◯ Internet ◯ Other

Name of person that referred you to our office _____

COMPLAINTS/HISTORY

What part bothers you the most?_____

Next most?_____

What caused your pain?_____

When (date) did your pain start?_____

Did your pain start because of a motor vehicle accident? ◯ Yes ◯ No

If yes, does your Insurance know you are here for treatment? ◯ Yes ◯ No

Did your pain start while you were "on the job?" ◯ Yes ◯ No

If yes, does your employer know you are here for treatment? ◯ Yes ◯ No

Who is your Medical Doctor?_____

Has he/she ever treated you for this complaint?_____

Have you ever been treated for back or neck pain?_____

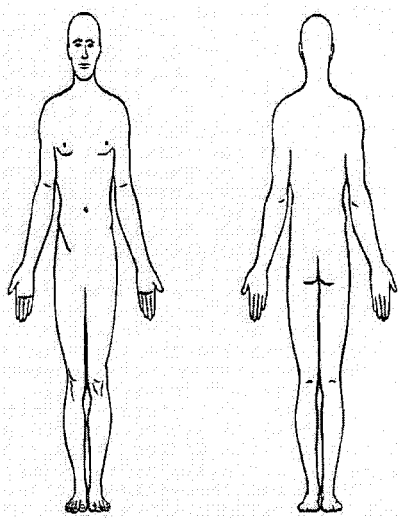
Have you ever seen a chiropractor for care?_____

Have you ever had surgery on your back or neck?_____

History of Cancer or Tumor?_____

Female patients: Are you pregnant now? ◯ Yes ◯ No

Please shade your areas of pain on the figures below.



PATIENT HISTORY

Have you...	Yes	No
Been diagnosed with high blood pressure	◯	◯
If yes, are you currently taking medication for it ?	◯	◯
Been diagnosed with cancer or a tumor?	◯	◯
Been diagnosed with (or currently have) diabetes?	◯	◯

If yes, which type ◯ Type I ◯ Type II

Smoking Status: ◯ Never ◯ Former ◯ Current

Have you been hospitalized in the last 5 years?
◯ Yes ◯ No

If yes, please list the date and reason:

_____

_____

_____

DO YOU HAVE AN ALLERGY TO ANY MEDICATION? ◯ Yes ◯ No

If yes, which medication? _____

Do you have a food allergy? ◯ Yes ◯ No If yes list which food_____

Do you have seasonal allergies? ◯ Yes ◯ No

LIST PRESCRIPTION MEDICATIONS AND DOSE BELOW (OR WE CAN MAKE A COPY OF YOUR LIST)

◯ I am not currently taking any prescriptions

_____ _____

_____ _____

MARK ANY OF THE FOLLOWING YOU ARE CURRENTLY TAKING and list name of product

◯ OTC pain reliever (including tylenol or advil) _____

◯ Vitamins/ Supplements_____

◯ I do not take **ANY** over the counter products

HEALTH HISTORY (Mother) ◯ Living ◯ Deceased **(Father)** ◯ Living ◯ Deceased

Has she been diagnosed with:
◯ Cancer ◯ High Blood Pressure
◯ Diabetes ◯ Stroke

Has he been diagnosed with:
◯ Cancer ◯ High Blood Pressure
◯ Diabetes ◯ Stroke

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Name of Policyholder_____Date of birth_____

Relationship to patient_____

Consent of Professional Services and Release of Information

I herby authorize and release the Doctor and whomever he/she may designate and his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Notice of Privacy Practices (HIPAA)

◯ I have been offered a copy of the Grand Island Chiropractic Center's privacy policy.

Patient Signature_____

Parent or Guardian Signature_____

Date_____