Confidential Patient Information

Name:_____ Data:_____
Address:_____ City:_____ __State:_____ Zip:_____
Phone (Home):_____ (Work):_____ (Mobile):_____
Email:_____ Referred By:_____
Age:_____ Birth Day:_____ Social Security No:_____ Sex: M / F Marital Status: S / M / W / D
Occupation:_____ Employer:_____
Spouse's Name:_____ Spouse's Work Phone:_____ Number of Children:_____
Emergency Contact:_____ Contact Phone:_____

Height:_____ Weight (current)_____ One Yr. Ago:_____ Adult Max:_____ Age:___ Adult Min:_____ Age:____
Known Allergies:_____
_____
Blood Type:_____ Have You Ever Had A Blood or Plasma Transfusion? Yes / No

---

Date of Last Physical Exam:_____ With Whom:_____ Where:_____
Reported Findings:_____
Surgeries, Hospitalizations, Serious Illnesses(List Year in Brackets):_____
_____
Fractures, Dislocations, Major Dental Work (List Year in Brackets):_____

Conditions You Have Had:

_ AIDS/HIV	_ Depression	_ High Blood Pressure	_ Prostate Problem
_ Alcoholism	_ Diabetes	_ High Cholesterol	_ Prosthesis
_ Allergies	_ Digestive Disorders	_ Hypoglycemia	_ Rheumatic Fever
_ Anemia	_ Dizziness	_ Neck Pain	_ Sinus Troubles
_ Anorexia	_ Epilepsy	_ Nervousness	_ Stroke
_ Arthritis/Joint Pain	_ Fatigue	_ Neuritis	_ Tuberculosis
_ Asthma	_ Gout	_ Numbness	_ Ulcer
_ Backaches	_ Headaches	_ Osteoporosis	_ Urinary Trouble
_ Bleeding Disorders	_ Heart Trouble	_ Pacemaker	_ Venereal Disease
_ Breathing Problems	_ Hepatitis	_ Parasites	_ Weight Loss
_ Bulimia	_ Hernia	_ Pinched Nerve	_ Yeast/ Candida
_ Cancer	_ Herniated Disk	_ Poor Circulation	_ _____

Purpose of Appointment:_____
_____
Other Doctors Seen For This Condition:_____
Have You Ever Been Treated For Any Other Condition in The Past Year? Yes / No (If So, Describe):_____
_____
Medications/Drugs You Are Taking (State Reason in Brackets Following Drug):_____
_____

Insurance Information:
Who is responsible for this account?_____ Relationship To Patient:_____
Insurance Co:_____ Policy #:_____ Group #:_____

Assignment And Release
I, the undersigned certify that I (or my dependent) have insurance coverage with _____
And assign directly to _____ all insurance benefits, if any, otherwise payable that any missed appointment without a 24-hour notice is subject to a $25.00 fee. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

Habits:

Do you Smoke? Y / N What?_____ How Many / Day:_____ Since When?_____
Other Tobacco Products? Y / N What?_____ How Many / Day:_____ Since When?_____
Drink Coffee? Y / N Cups / Day?_____ Drink Caffeinated Tea? Y/ N Cups / Day?_____
Colas / Soft Drinks? Y / N Number / Day?_____ Glasses of Water / Day?_____
Alcoholic Beverages? Y / N Avg. No. / Wk?_____ Mostly What?_____
Do You Eat Red Meat? Y / N Are You A Vegetarian? Y / N If So, For How Long:_____
Are You Dieting Y / N If So, Describe:_____
Do You Eat in Fast Food Restaurants? Y / N If So, How Many Times / Week?_____
List Nutritional Supplements You Take:_____
Bowel Movement Frequency:_____ Difficulty? Y / N Approximate # of Times You Urinate / Day:_____
Do You Sleep Well? Y / N If No, Describe:_____ Average Hours / Night:_____
Do You Have Sufficient Energy For Normal Activities? Y / N If No, Describe:_____
Do You Wear Corrective Lenses? Y / N What Is Your Uncorrected Vision? Right:_____/20 Left:_____/20
Has Your Vision Changed Recently? Y / N Explain:_____
Do You Wear Heel Lifts or Foot Supports? Y / N Explain:_____

XRAY HISTORY: (Include Cat, Mir, Dye Studies, and Dental) When was most recent x-ray/other study?_____

Age	Body Area	Type (normal X-ray, CAT, MRI, ect.)	No. of Studies

	Living	Age or Age of Death	Allergies	Arthritis	Alcoholism	Cancer	Depression	Diabetes	Heart Disease	High blood Pressure	High Cholesterol	Stroke	Other, Description
Father													
Father's Mother													
Father's Father													
Father's Siblings													
Mother													
Mother's Mother													
Mother's Father													
Mother's Siblings													
Your Siblings													
Your Children													

WOMEN ONLY: Menstrual History

Age at Onset:_____ Are your Periods Regular? Y / N Cycle:_____ days(start to finish) Use Birth Control Pill? Y / N
Your Flow Is: Heavy Medium Light Date of Last Period:_____ Are You Pregnant? Y / N How Many Months:_____
Cramping? Y / N PMS? Y / N Other Menstrual / Hormonal Symptoms:_____
Vaginal Infections? Y / N Miscarriage? Y / N

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment r health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient_____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:_____ Initials:_____Reason:_____

Schroeder Center
for Healthy Living

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, massage and diagnostic x-rays, on me (or on the patient named below for whom I am legally responsible) by the doctor or intern, affiliated with Schroeder Center for Healthy Living.

I understand that, in the practice of chiropractic care there are some risks to treatment. I do not expect the doctor to anticipate and be able to explain all the risks and complications. I will rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based on facts then known, are in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above and allow the doctor or intern affiliated with Schroeder Center for Healthy Living to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment in this office.

_____ _____

Patient's name (Please print) Date

_____

Patient or Guardian's signature