CHIROPRACTIC PATIENT UPDATE

Please complete Parts A & C in all cases. Part B should be completed only if the information has changed since you were last in our office.

Thank You!

PART A

Name: _____ Phone: _____

E-mail address: _____ Fax # _____ Cell Phone _____

Address: _____

Purpose of this appointment: _____

Is this the same problem you were originally under care for? ( ) Yes ( ) No

If yes, are there any additional symptoms? _____

Other doctors seen for this condition: _____

What medications or drugs are you taking? _____

PART B

Occupation: _____ Employer: _____

Employer's address: _____ Work Phone: _____

Spouse: _____ Spouse's Employer: _____

PART C

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. I understand that interest is charged on overdue accounts at the annual rate of (16%).

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. If there is anyone you do not want to receive your medical records, please inform our office.

Date Signed: _____ Signature: _____

Health Insurance Coverage ( ) Yes ( ) No

Company: _____

1. What is your major symptom? _____

2. If this is a recurrence, when was the first time you noticed this problem?_____
   How did it originally occur?_____
   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____
   If yes, when and how? _____

3. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___
   How long does it last? All Day _____ Few Hours _____ Minutes _____

4. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes _____ No _____. If yes, describe _____
   Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____

5. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____
   Burning _____ Stabbing _____ Other _____

6. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____
   _____. If no, what have you tried to do that has not helped? _____
   _____

7. What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____
   Lifting _____ Twisting _____ Other _____

8. Have you had any broken bones? Yes ____ No ____. If yes, please list and give dates _____
   _____

9. List any major accidents you have had other than those that might be mentioned above: _____
   _____

10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes ____ No ____. If yes, please explain _____
    _____

11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes _____ No _____ Uncertain _____

12. Remarks: _____
    _____
    _____

NO SYMPTOMS — EXTREME SYMPTOMS

Please place an “X” on the line above to indicate your level of problem.

Doctor’s Signature _____ Date _____