Patient Health History

Today's Date / / **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Middle Name**_____

Last Name _____ **Nick Name** _____**Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____**Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Social Security Number _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Continued …

Verification Question *(choose only one question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the question: (Answer must be 6+ characters)_____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications: including dosage, times per day taken, quantity of bottle, and form of med (tablet, capsule, liquid.)
If there are no current medications, check here: ❑

1) _____ **5)** _____

2) _____ **6)** _____

3) _____ **7)** _____

4) _____ **8)** _____

List any known allergies you have had to any medications. Include your reaction to the medication.
If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: (all health issues) _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____

MOTOR VEHICLE ACCIDENT HISTORY

PATIENT NAME:			DATE:
ADDRESS:		CITY:	STATE/ZIP CODE:
HOME PHONE NUMBER:		CELL PHONE NUMBER:	
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	AGE:	GENDER:
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT PHONE NUMBER:	
EMPLOYER NAME:		EMPLOYER ADDRESS:	

ACCIDENT INFORMATION

DATE OF ACCIDENT:	TIME OF ACCIDENT:	WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT? ❑ DRIVER ❑ PASSENGER ❑ FRONT SEAT ❑ BACK SEAT	
NUMBER OF PEOPLE IN THE CAR:	NAMES OF PEOPLE IN THE CAR WITH YOU:		
WHAT DIRECTION WAS YOUR CAR HEADED? ❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST		ON WHAT STEET WERE YOU HEADED?	
WHAT DIRECTION WAS THE OTHER CAR HEADED? ❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST		WERE YOU STRUCK FROM: ❑ BEHIND ❑ FRONT ❑ LEFT SIDE ❑ RIGHT SIDE	
WERE YOU KNOCKED UNCONSCIOUS? ❑ YES ❑ NO		DID YOU HIT YOUR HEAD? ❑ YES ❑ NO	
WHERE WERE YOU TAKEN AFTER THE ACCIDENT?			BY AMBULANCE: ❑ YES ❑ NO
WERE THE POLICE ON THE SCENE? ❑ YES ❑ NO	WAS A REPORT FILED? ❑ YES ❑ NO	DO YOU HAVE A COPY? ❑ YES ❑ NO	
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS INJURY/ACCIDENT? ❑ YES ❑ NO		SINCE THE INJURY, ARE YOUR SYMPTOMS: ❑ IMPROVING ❑ GETTING WORSE ❑ GETTING BETTER	
HAVE YOU LOST TIME FROM WORK? ❑ YES ❑ NO		DATE YOU LEFT WORK:	DATE YOU RETURNED TO WORK?
HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST? ❑ YES ❑ NO		IF YES, PLEASE DESCRIBE:	
DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE? ❑ YES ❑ NO		IF YES, PLEASE DESCRIBE:	
DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? ❑ YES ❑ NO		IF YES, PLEASE DESCRIBE:	

INSURANCE INFORMATION

INSURANCE COMPANY NAME:	INSURANCE COMPANY PHONE:
ADJUSTER NAME:	ADJUSTER PHONE:
POLICY NUMBER:	CLAIM NUMBER:

Best Chiropractic:
A Creating Wellness Center

1610 Maxwell Dr., Ste. 100
Hudson, WI 54016

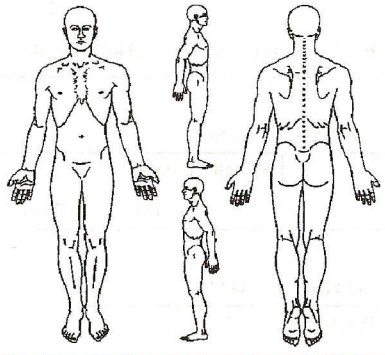
SYMPTOMS

INSTRUCTIONS: *Check (✓) any/all symptoms noted after the accident.*

- ❑ HEADACHE
- ❑ NECK PAIN
- ❑ NECK STIFFNESS
- ❑ SLEEPING PROBLEMS
- ❑ BACK PAIN
- ❑ NERVOUSNESS
- ❑ TENSION
- ❑ IRRITABILITY
- ❑ CHEST PAIN
- ❑ DIARRHEA
- ❑ CONSTIPATION
- ❑ FEVER
- ❑ DIZZINESS
- ❑ HEAD SEEMS HEAVY
- ❑ PINS & NEEDLES IN ARMS
- ❑ PINS & NEEDLES IN LEGS
- ❑ NUMBNESS IN FINGERS
- ❑ NUMBNESS IN TOES
- ❑ SHORTNESS OF BREATH
- ❑ FATIGUE
- ❑ DEPRESSION
- ❑ FEET FEEL COLD
- ❑ HANDS FEEL COLD
- ❑ COLD SWEATS
- ❑ LIGHT BOTHERS EYES
- ❑ LOSS OF MEMORY
- ❑ EARS RING
- ❑ FACE FLUSHED
- ❑ BUZZING IN EARS
- ❑ LOSS OF BALANCE
- ❑ FAINTING
- ❑ LOSS OF SMELL
- ❑ LOSS OF TASTE
- ❑ UPSET STOMACH
- ❑ OTHER: _____
- ❑ OTHER: _____

INTRUCTIONS: *Please mark the area and type of pain on the drawings using the codes listed below:*

N=Numbness P=Pain A=Ache T=Tingling S=Stiffness/Soreness



COMMENTS:

PLEASE PROVIDE ANY OTHER PERTINENT INFORMATION YOU THINK WE SHOULD KNOW:

DOCTOR ONLY

DOCTOR COMMENTS:

LUMBAR ROM	CERVICAL ROM
90 FLEXION	65 FLEXION
30 EXTENTION	50 EXTENSION
20 R L FLEX	45 R L FLEX
20 L L FLEX	45 L L FLEX
30 R ROTATION	80 R ROTATION
30 L ROTATION	80 L ROTATION

SIGNATURE

PATIENT SIGNATURE:

DATE:

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Ownership of X-ray Films: *It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

❑ PATIENT ❑ SPOUSE ❑ PARENT ❑ WORKERS COMP ❑ AUTO INSURANCE ❑ MEDICARE ❑ HEALTH INSURANCE

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

SIGNATURE:	DATE:
WITNESS SIGNATURE:	DATE:

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (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 with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

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