

# WELCOME

Today's Date: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_ (Preferred Name)  Male  Female

Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

How did you hear about us?

Yellow Pages  Sign  Billboard  Paper  Dr. \_\_\_\_\_  Other: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed

Spouse's Name: \_\_\_\_\_

Home phone#: \_\_\_\_\_

Your Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

In event of Emergency Contact: \_\_\_\_\_ Phone#: \_\_\_\_\_

## REASON FOR VISIT

Have you ever been treated by a Chiropractor before?  Yes  No

If so, please explain: \_\_\_\_\_

The reason for this visit is a result of (*Please Circle*): work sports auto trauma chronic

(*Explain what happened*): \_\_\_\_\_

Please describe the pain and its location: \_\_\_\_\_

When did this condition begin? \_\_\_/\_\_\_/\_\_\_

Is this condition getting worse?  Yes  No  Constant  Comes and goes

Is this condition interfering with your (Circle): work sleep daily routine other: \_\_\_\_\_

Have you had this or similar conditions in the past?  Yes  No

If so, please explain: \_\_\_\_\_

Have you been treated by a Medical Physician for this condition?  Yes  No

If so, where? \_\_\_\_\_

Have you been in an auto accident within the last 4 months?  Yes  No

Continued on back

# HEALTH HISTORY

Are you currently taking any of the following medications?:

- Blood Thinners     Pain killers(including aspirin)     Muscle Relaxers  
 Other(s) \_\_\_\_\_

Have you ever had any of the following medical condition(s), please check all that apply:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Heart Attack/Stroke        | <input type="checkbox"/> Lower Back Problems       | <input type="checkbox"/> Artificial Valves |
| <input type="checkbox"/> Frequent Neck Pain         | <input type="checkbox"/> Heart Surgeries/Pacemaker | <input type="checkbox"/> Hepatitis         |
| <input type="checkbox"/> High/Low Blood Pressure    | <input type="checkbox"/> Shingles                  | <input type="checkbox"/> Cancer            |
| <input type="checkbox"/> Severe/Frequent Headaches  | <input type="checkbox"/> Sinus Problems            | <input type="checkbox"/> Chemotherapy      |
| <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Artificial Bones/Joints   | <input type="checkbox"/> Arthritis         |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> HIV +/-AIDS       |

Please list any other serious medical condition(s) you have or ever had?: \_\_\_\_\_

Please list anything that you may be allergic to: \_\_\_\_\_

List previous surgeries/treatments with dates: \_\_\_\_\_

List any **past** serious accidents with dates: \_\_\_\_\_

Do you smoke:     No     Yes / How much: \_\_\_\_\_ How long: \_\_\_\_\_

**FOR WOMEN:** Are you pregnant?     No     Yes/How long?: \_\_\_\_\_

## CONSENT TO TREATMENT & INSURANCE INFO

**AUTHORIZATION & RELEASE:** I authorize payment of insurance benefits directly to the clinic, St. Michael Spinal Rehab Center, Inc. I authorize the clinic to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payments of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating clinician, 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 18%. If my account is placed with a collection agency I understand that I will also be responsible for all legal and/or collection fees necessary for recovery of payment. I understand that I have the right to ask and have questions answered prior to receiving treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician.

The Patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know 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.

**\*Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Guardian's Signature Authorizing care: \_\_\_\_\_ **Date:** \_\_\_\_\_