

Chiropractic Healing Center

Date: _____

Phone: _____

Patient: _____
Last Name
First Name
Initial

Street Address: _____

City/State/Zip Code: _____

Sex: M F Age: _____ DOB: _____ Single Married Widowed Separated Divorced

Social Security #: _____ Email: _____

Insured's Name: _____
Last Name
First Name
Initial

Patient Agreement:

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to Chiropractic Healing Center all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. 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 my insurance submissions.

Signature of Insured/Guardian
Date

Present Complaints (Please circle the appropriate ones)

- | | | |
|---|--|--|
| Headache | Feet/Hands Cold | Unbalanced |
| Mental dullness | Depression | Fainting |
| Loss of memory | Rib pain | Blurred vision |
| Dizzy | Nervousness | Irritability |
| Ears ringing/buzzing | Eye strain/pain | Double vision |
| Upper back pain | Shortness of breath | Loss of smell |
| Lower back pain | Fear | Chest pain |
| Midback pain | Confusion | Neck pain |
| Pins and needles in hands
right/left | Pins and needles in arms
right/left | Pins and needles in legs
right/left |

Medical Implants: _____

Medical alerts: _____

Surgical Implants: _____

Pregnancy: **yes** ____ **no** ____

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain
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Patient Name: _____ Date: _____

Medications: (please list all medications and supplements that you currently take)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: (please list all medications that cause allergic reaction)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____	Date _____
_____	_____
_____	_____
_____	_____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

NO MEDICAL PROBLEMS - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> pulmonary embolism | <input type="checkbox"/> respiratory arrest |
| <input type="checkbox"/> COPD | <input type="checkbox"/> pneumonia | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> other: _____ |

Cardiac / Heart and peripheral vascular disease

- | | | |
|---|---|--|
| <input type="checkbox"/> chest pain / angina | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> irregular heartbeat, arrhythmia |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> heart murmur, valve disorder | <input type="checkbox"/> peripheral vascular disease |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> deep vein thrombosis |
| <input type="checkbox"/> other: _____ | <input type="checkbox"/> bleeding problems | |

Neurologic Disorders

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> stroke or TIA | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> cerebral palsy |
| <input type="checkbox"/> peripheral neuropathy | <input type="checkbox"/> MS | <input type="checkbox"/> polio |
| <input type="checkbox"/> other: _____ | | |

Bone & Joint Disorders

- | | | |
|---|--------------------------------|---|
| <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> gout | <input type="checkbox"/> osteomyelitis |
| <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> lupus | <input type="checkbox"/> ankylosing spondylitis |
| <input type="checkbox"/> other: _____ | | |

Patient Name: _____ Date: _____

Gastrointestinal Disorders

- peptic ulcer or stomach ulcer
- acid reflux, GERD
- GI bleed
- other: _____
- diverticulitis
- irritable bowel
- inflammatory bowel disease
- hepatitis - Type _____
- liver disease

Genitourinary Disorders

- urinary tract infection
- bladder problems
- kidney problems
- kidney stones
- dialysis, kidney failure
- other: _____

Metabolic & Other Disorders

- Diabetes x _____ years
- thyroid problems
- sickle cell disease
- high cholesterol or lipids
- skin disorder _____
- psoriasis
- any skin ulcer
- tooth abscess, gingivitis
- depression
- anxiety
- alcohol or drug dependency
- other: _____

Cancer : any type -- please specify

Other medical problems NOT included above (explain)

Family History:

Please indicate with an "X" any significant family medical history or problems.

- asthma
- COPD or Emphysema
- heart attack, myocardial infarction
- irregular heartbeat, arrhythmia
- MS or Parkinson's
- osteoarthritis
- rheumatoid arthritis
- acid reflux, GERD
- liver disease
- kidney problems
- diabetes
- thyroid problems
- Malignant hyperthermia
- tuberculosis
- other lung : _____
- other neuro : _____
- Lupus
- Other bone & joint: _____
- inflammatory bowel disease
- other GI : _____
- sleep apnea
- congestive heart failure
- gout
- bleeding problems
- hepatitis - Type _____
- Peripheral neuropathy
- high cholesterol or lipids
- any skin ulcer

Cancer : any type -- please specify

Other medical problems NOT included above (explain)

Patient Name: _____ Date: _____

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Blue Shield | <input type="checkbox"/> Auto Accident |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Major Medical | <input type="checkbox"/> Union Plan |
| <input type="checkbox"/> Blue Cross | <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Other |

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____

Major Medical or Auto Insurance:

Date of Accident: _____

Insurance Company Name: _____

Adjuster: _____

Address/Phone: _____

Claim #: _____ Policy #: _____ Effective Date: _____

Primary Care Physician:

Name & Address: _____

Phone #: _____

LEGAL INFORMATION:

Attorney Name & Address: _____

Attorney Phone #: _____

*Person to contact in an emergency (Name and Phone #):

Patient Name: _____ Date: _____