CONFIDENTIAL PATIENT INFORMATION

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M/F

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_

Home ph#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Married Single Widow Other Spouse Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ages of Children\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employers Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us?  Family  Friend  Google  Yelp Facebook  Doctor  Therapist  Event

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance:**  HMSA  Kaiser  Medicare  UHA  HMAA  VA Other \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have insurance that covers chiropractic? Yes No Unsure PPO plan HMO plan (requires referral)

Name of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_Group #: \_\_\_\_\_\_\_\_ *Policy Holder’s DOB*: \_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2ndHealthPlan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your condition due to an Auto Accident?  Yes  No Work Related?  Yes  No

Are you employed by the City & County or State?  Yes  No

Have you had Chiropractic before?  Yes  No. If yes, where and when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had Massage Therapy before?  Yes  No. If yes, where and when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Symptoms or Complaints**

|  |  |  |  |
| --- | --- | --- | --- |
| Please list reasons for this visit:1. | Date first noticed | Please circle severity of symptom. 0 = none and 10= Severe0 1 2 3 4 5 6 7 8 9 10 | Please circle how often this symptom is present:0-25% 26-50% 51-75% 76-100% |
| 2. |  | 0 1 2 3 4 5 6 7 8 9 10 | 0-25% 26-50% 51-75% 76-100% |
| 3. |  | 0 1 2 3 4 5 6 7 8 9 10 | 0-25% 26-50% 51-75% 76-100% |

How problem(s) began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Please Mark Areas of Complaints**

Is it getting:  Better  Worse  Staying the same

In the past week, how much has your pain interfered with:

|  |  |
| --- | --- |
| Sleep | 0 = no interference 10 = severely limits 0 1 2 3 4 5 6 7 8 9 10 |
| Work |  0 1 2 3 4 5 6 7 8 9 10 |
| Exercise/Sports |  0 1 2 3 4 5 6 7 8 9 10 |
| Household chores |  0 1 2 3 4 5 6 7 8 9 10 |
| Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  0 1 2 3 4 5 6 7 8 9 10 |

What time of the day do you feel worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What types of exercises do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kinds of therapy have you tried? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Most comfortable sleeping position?  Side  Stomach  Back

Main hobbies and sports? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had spinal X-rays, MRI, CT scan for your area(s) of complaint?  Yes  No

Dates(s) taken:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What areas were taken? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check all of the following that apply to you:**

 Recent Fever

 Diabetes

 High Blood Pressure

 Stroke (date)\_\_\_\_\_\_\_\_\_\_\_

 Corticosteroid Use (cortisone, prednisone, etc.)

 Taking Birth Control Pills

 Dizziness/Fainting

 Numbness in Groin/Buttocks

 Cancer/Tumor (explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Osteoporosis

 Epilepsy/Seizures

 Other Health Problems (explain)\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Prostate Problems

 Menstrual Problems

 Urinary Problems

 Currently Pregnant, # of weeks \_\_\_\_\_\_\_

 Abnormal Weight Gain Loss

 Marked Morning Pain/Stiffness

 Pain Unrelieved by Position or Rest

 Pain at Night

 Visual Disturbances

 Surgeries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**   Cancer  Diabetes  High Blood Pressure

  Heart Problems/Stroke  Rheumatoid Arthritis  Other \_\_\_\_\_\_\_\_\_\_\_

**Current Health Habits:**

Yes No Yes No

  Do you have good posture?

  Did/do you smoke?

  Did/do you drink alcohol?

  Do you eat healthy?

  Do you take supplements?

  Do you exercise regularly?

  Did/do you have occupational stress?

  High level of physical stress?

  High level of mental stress?

Have you been in any accidents? If yes, how many?\_\_\_\_

**What type(s) of service do you desire?**

 Temporary relief of symptoms/pain control

 Elimination of cause of problem, if possible

 Maintenance/regular care to help maintain good health

**Insurance Certification:** I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services received. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that a quote of benefits is NOT a guarantee of payment and benefits are subject to change at any time. I understand that co-payments are to be paid at time of service.**\_\_\_\_\_\_\_\_\_ (INITIAL)**

I understand that my chiropractor or Clinical Services Manager may need to contact my Primary Care Physician if my conditions need to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician, if necessary. **\_\_\_\_\_\_\_\_\_ (INITIAL)**

I have reviewed and agree to the **Insurance Limitations** Forms. **\_\_\_\_\_\_\_\_\_ (INITIAL)**

I have reviewed and agree to the **Open Ceiling and Privacy Information** Forms. **\_\_\_\_\_\_\_\_\_ (INITIAL)**

I have reviewed and agree to the **Arbitration Agreement** Form. **\_\_\_\_\_\_\_\_ (INITIAL)**

For the safety and security of your account, we will be taking your photo. This will help prevent fraudulent activities and help us to identify our patient. Please initial here, allowing us to take your photo. **\_\_\_\_­\_\_\_\_\_\_ (INITIAL)**

I understand that this clinic has a **24 Hour Cancellation Policy** and that I may be charged a $25 fee for any appointments that are either missed or canceled without 24 hours notice. **\_\_\_\_\_\_\_\_\_\_ (INITIAL)**

**Consent for Chiropractic:** I hereby request and consent to chiropractic adjustments and/or other chiropractic procedures by Dr. Tyler Ryan, DC and/or anyone working in this office authorized by him to perform such. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment. The most common risks are temporary aggravation of my condition or soreness. Rarer risks include, but are not limited to, fractures, strokes, dislocations, sprains, burns and aggravation of disc injuries. I do not expect the chiropractor to be able to anticipate and explain all risks and complications. I understand that results are not guaranteed. Further, I wish to rely on the chiropractor to exercise judgment during the course of the procedure which the chiropractor deems are in my best interests at the time, based upon the facts then known. I hereby give my consent for treatment.

**Patient PRINT Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient (or Guardian) Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_