DISCOVER CHIROPRACTIC & WELLNESS
CONFIDENTIAL PATIENT INFORMATION

Date _____

Name _____ Social Security ☐☐☐ ☐☐ ☐☐☐☐ Home Phone (___) _____

Work Phone (___) _____

Address _____ Cell Phone (___) _____

City _____ Zip Code _____ Email _____

Age _____ Birth Date _____ M ☐ F ☐ Marital: M ☐ S ☐ W ☐ D ☐ How Many Children? _____

Occupation _____ Employer _____

Address _____ Work Phone _____

Name of Spouse (or Parent if Minor) _____ Work Phone _____

Employer _____ Address _____

Name of Nearest Relative _____ Address _____ Phone _____

Whom may we thank for referring you? _____ Other: Google, etc. _____

Race A ☐ B ☐ W ☐ O ☐ Ethnicity H ☐ NH ☐ Preferred Language _____

Purpose of this appointment/current problem _____

Other doctors seen for this condition _____

Is the condition due to injury or sickness arising out of an auto accident? _____

Date symptoms appeared or accident happened: _____

Do you suffer from:

1. Allergies _____ Please List _____
2. Dizziness _____ 3. Neck Pain _____ 4. Shoulder/Arm Pain _____ 5. Nervousness _____
6. Back Pain _____ 7. Arthritis _____ 8. Hip/Leg Pain _____ 9. Sinus Trouble _____
10. Heart Trouble _____ 11. Headaches _____ 12. Urinary Problems _____ 13. Male/Female Troubles _____
14. Diabetes _____ *On Set Date* _____ 15. Numbness _____ 16. Digestive Disorders _____ 17. Cancer _____

Do you smoke? ☐ NO ☐ YES _____ packs/day Do you have a pacemaker? ☐ YES ☐ NO

Have you been treated for any health condition by a physician in the last year: ☐ YES ☐ NO

Describe _____

Date of last physical examination _____ List surgeries _____

Serious illnesses _____ Medications _____

What vitamins are you taking? _____

If female, are you taking birth control pills? ☐ YES ☐ NO Pregnant? ☐ YES ☐ NO

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION: By signing this form, you are granting consent to Discover Chiropractic & Wellness to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

_____

Patient Signature (or Guardian Signature Authorizing Care) Date

Insurance Company _____ Insured _____ Date of Birth _____ SS# _____

1. What is your major symptom? _____

2. When was the first time you noticed this problem? _____

   How did it occur? _____

   Has it become worse recently? _____ If yes, when and how? _____

3. How frequent is the condition? _____

   How long does it last? _____

4. Have you ever had the same or a similar condition: ☐ Yes ☐ No

   If yes, when and describe: _____

5. Are there any conditions or symptoms you have that may be related to your major symptom?

   _____

6. If pain is involved, is it – sharp, dull, throbbing, stabbing, aching, burning, tingling, shooting?

   (other) _____

7. Is there anything you can do which seems to provide relief? _____

   _____

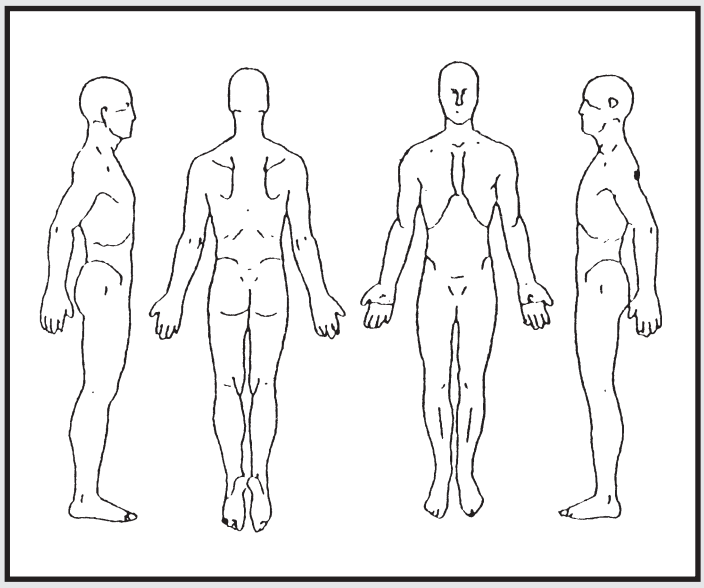
8. What makes the problem worse? _____

9. List accidents, illness, surgeries, or broken bones. _____

   _____

IMPORTANT!

10. **Please Mark Your Symptom Areas**
<u>After you print or come into office mark the symptom areas below</u>



11. **Rate the Severity of Your Condition**