

# PATIENT HISTORY

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Your Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ Apt # \_\_\_\_\_  
City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (cell) \_\_\_\_\_ (W) \_\_\_\_\_ (H) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ e-mail \_\_\_\_\_  
Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
Have you ever been to another doctor for this problem? Y N Who? \_\_\_\_\_  
Who may we thank for referring you to our office? \_\_\_\_\_

## WHAT BRINGS YOU TO OUR OFFICE?

### FIRST COMPLAINT: \_\_\_\_\_

- Headache  Neck Pain   Mid-Back Pain  Low-Back Pain

Other \_\_\_\_\_

- Date Problem Began \_\_\_\_\_ How Problem Began \_\_\_\_\_
- Did it begin  Gradual  Sudden  Progressive over time
- What makes the symptoms increase? \_\_\_\_\_
- What relieves the symptoms? \_\_\_\_\_
- Type of Pain  Sharp  Dull  Ache  Burn  Throb
- Does the Pain Radiate into your  Arm  Leg  Does not radiate
- Do you experience Numbness or Tingling?  Y  N
- How often do you experience these symptoms?  100%  75%  50%  25%  10%
- **PAIN INTENSITY:** Please circle on the scale describing the intensity of your pain at its worst  
No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain
- Does this interfere with   sleep  work  recreation  sitting  standing   
 driving

### SECOND COMPLAINT: \_\_\_\_\_

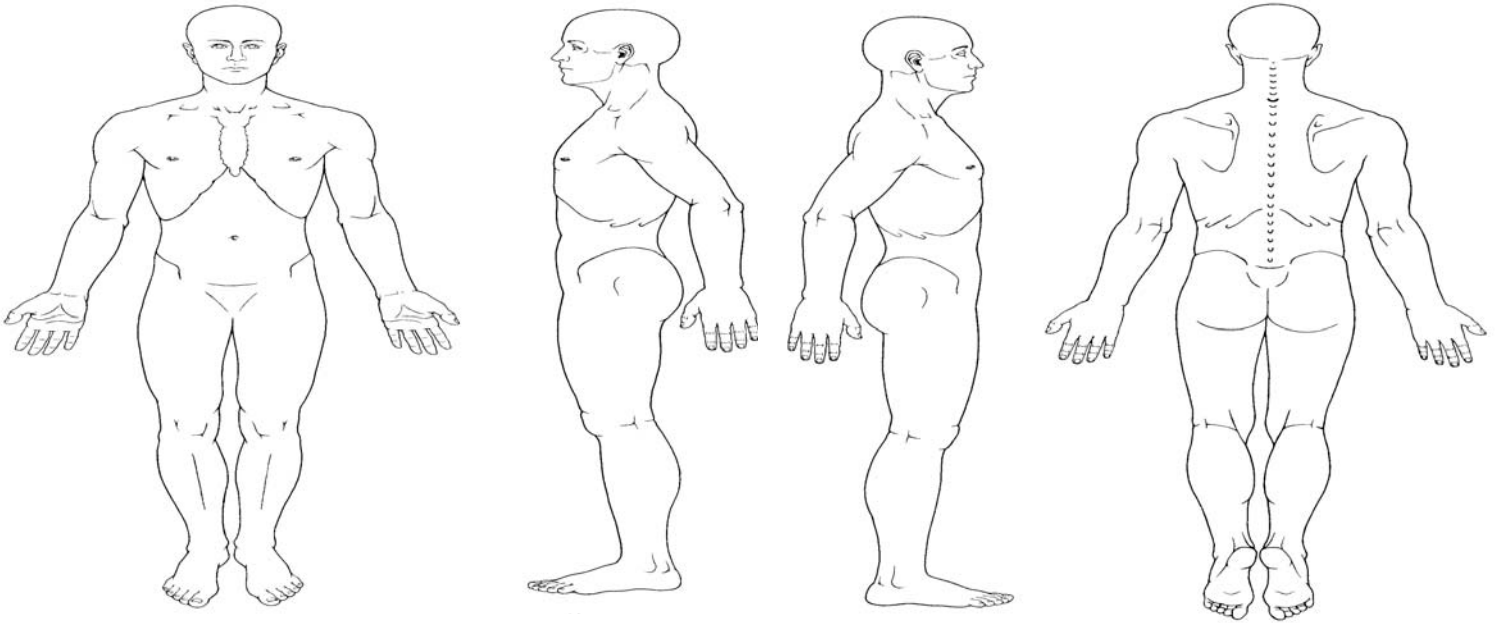
- Headache  Neck Pain   Mid-Back Pain  Low-Back Pain

Other \_\_\_\_\_

- Date Problem Began \_\_\_\_\_ How Problem Began \_\_\_\_\_
- Did it begin  Gradual  Sudden  Progressive over time
- What makes the symptoms increase? \_\_\_\_\_
- What relieves the symptoms? \_\_\_\_\_
- Type of Pain  Sharp  Dull  Ache  Burn  Throb
- Does the Pain Radiate into your  Arm  Leg  Does not radiate
- Do you experience Numbness or Tingling?  Y  N
- How often do you experience these symptoms?  100%  75%  50%  25%  10%

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**PAIN LOCATION**



Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

- PPP**            Where you experience Pain
- NNN**           Where you experience Numbness
- TTT**           Where you experience Tingling
- BBB**           Where you experience Burning
- CCC**           Where you experience Cramping

**Please list all previous treatments for this condition:**  
**Have you had spinal x-rays, MRI, CT Scan?** Yes No **If Yes, When** \_\_\_\_\_  
 Name of Family Doctor \_\_\_\_\_  
 Type of Treatment or Drugs Prescribed \_\_\_\_\_  
 Name of Past Chiropractor \_\_\_\_\_ Date of last visit \_\_\_\_\_

**Please list all past surgeries:**

Type _____	When _____	Doctor _____
Type _____	When _____	Doctor _____
Type _____	When _____	Doctor _____
Type _____	When _____	Doctor _____

**Please list all previous accidents and falls:**

What _____	When _____
What _____	When _____
What _____	When _____

**Please list any medications or vitamins you are currently taking:**

\_\_\_\_\_

\_\_\_\_\_

# PATIENT HISTORY

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

<input type="radio"/> <input type="checkbox"/> History of Recent Infection	<input type="radio"/> <input type="checkbox"/> Prostate Problems
<input type="radio"/> <input type="checkbox"/> Recent Fever	<input type="radio"/> <input type="checkbox"/> Frequent Urination
<input type="radio"/> <input type="checkbox"/> HIV/AIDS	<input type="radio"/> <input type="checkbox"/> Currently Pregnant
<input type="radio"/> <input type="checkbox"/> Diabetes	<input type="radio"/> <input type="checkbox"/> Abnormal weight gain or loss
<input type="radio"/> <input type="checkbox"/> Corticosteroid use	<input type="radio"/> <input type="checkbox"/> Epilepsy/ Seizures
<input type="radio"/> <input type="checkbox"/> Birth Control Pills	<input type="radio"/> <input type="checkbox"/> Visual Disturbances
<input type="radio"/> <input type="checkbox"/> High Blood Pressure	<input type="radio"/> <input type="checkbox"/> Low/ Mid Back Pain
<input type="radio"/> <input type="checkbox"/> Stroke (date) _____	<input type="radio"/> <input type="checkbox"/> Neck Pain
<input type="radio"/> <input type="checkbox"/> Dizziness/ Fainting	<input type="radio"/> <input type="checkbox"/> Arthritis
<input type="radio"/> <input type="checkbox"/> Numbness in Groin/ Buttocks	<input type="radio"/> <input type="checkbox"/> History of Alcohol Use
<input type="radio"/> <input type="checkbox"/> Urinary Retention	<input type="radio"/> <input type="checkbox"/> History of Tobacco Use
<input type="radio"/> <input type="checkbox"/> Aortic Aneurysm	<input type="radio"/> <input type="checkbox"/> Nocturnal Pain (Night Pain)
<input type="radio"/> <input type="checkbox"/> Cancer/Tumor	<input type="radio"/> <input type="checkbox"/> Surgeries _____
<input type="radio"/> <input type="checkbox"/> Osteoporosis	<input type="radio"/> _____
<input type="radio"/> <input type="checkbox"/> Recent Trauma	<input type="radio"/> <input type="checkbox"/> Medications: _____
<input type="radio"/> <input type="checkbox"/> Sinus Problems	<input type="radio"/> _____
<input type="radio"/> <input type="checkbox"/> Asthma	<input type="radio"/> <input type="checkbox"/> Stomach Problems

Family History: (please circle)  Cancer -  Diabetes -  High Blood Pressure -  Cardiovascular Problems

Is this visit due to an accident? Yes  no  auto  work  other \_\_\_\_\_

**Female x-ray authorization PREGNANCY RELEASE**

This is to certify that to the best of my knowledge I am NOT PREGNANT and the doctors and employees have the permission to take perform x-rays. I have been advised that x-rays may be hazardous to an unborn child. Date of last cycle \_\_\_\_\_

I am pregnant and do not want to take any x-rays.

**I am looking for (pick only one)**

Temporary pain relief, NO Correction  Correction of Problem, Optimal Health

What are your concerns if this does not get better? \_\_\_\_\_

Any other concerns? \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Office Policy Regarding Insurance Assignment**

This clinic will try to assist the patient whenever possible. **It must be understood: Regardless of insurance, the patient is ultimately responsible for the entire bill.**

- o Waiting for insurance payment is a courtesy and may be withdrawn at any time.
- o Insurance payment should be made in 30 days. Should payment be delayed, the patient must pay balance in full.
- o Unpaid balances over 90 days past due are subject to a minimum \$3.00 or 1.5% interest charge per month.
- o If the patient discontinues treatment for any reason other than discharge from the doctor the bill is due and payable in full, immediately, regardless of any claims submitted.
- o All deductibles are payable by the patient. Know what yours is annually.
- o The clinic will not enter into dispute with your insurance company over reimbursement. This is the patient's obligation. We will not wait for payment while you dispute your bill.
- o We encourage patients to know the limits of their specific policy.
- o If you do not have insurance all payments are expected at the time of service. Your personal balance may not exceed \$100.00 unless a current payment plan has been authorized. Our payment plans are designed to make care affordable part of your family budget.

**Consent for Treatment:**

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that there may be risk involved in any medical and chiropractic treatment. I understand that I am under the care of the attending physician and it is the responsibility of the staff to carry out the instruction of such physician(s).

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

**Authorization to Pay Doctor/ Clinic**

I hereby authorize and direct payment of any medical expense benefits allowable to the doctor/ clinic named above as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/ clinic. I agree that a photo static copy shall serve as the original. I also understand that if for any reason I do not follow the recommended treatment plan, the doctor will not be held liable.

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

**Authorization to Release Information**

I authorize the doctor and his staff named above to release any information deemed appropriate concerning my physical condition and treatment to any insurance company, attorney, or adjustor in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered. I hereby release him of any consequence thereof. I agree that a photo static copy of this agreement shall serve as the original.

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

**PLEASE CHECK THE ONE THAT APPLIES TO YOU.**

- I am here today for a **FREE CONSULTATION** only.
- I am here today for a **CONSULTATION** with the Doctor. If the Doctor performs an exam and/or an x-ray then I am aware that there is \$**79.00** co-pay due today until we can verify your insurance benefits. If your co-pay is found to be less after verification then you will be given a refund of the difference.
- I have a **HEALTH COUPON**

# PATIENT HISTORY

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## **PATIENT CONSENT FOR USE AND/ OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

I, \_\_\_\_\_, HEREBY STATE THAT BY SIGNING THIS CONSENT, I ACKNOWLEDGE AND AGREE AS FOLLOWS:

1. The Practice’s Privacy Notice (McCracken Chiropractic PC) has been provided to me prior to signing this consent. The privacy notice includes a complete description of the uses and/ or disclosures of my protected health information (“PHI”) necessary for the practice to obtain payment from the insurance company and/ or patient for that treatment and to carry out our health care operations. The Practice explained to me the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this consent.
2. The Practice reserves the right to change its Privacy Practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by the Practice:
  - a) A postcard mailed to me
  - b) Telephoning my home/work and leaving a message on my answering machine or with the individual answering the phone.
  - c) Birthday cards, Christmas cards and statements
4. I understand that I will be receiving treatment/therapy in open rooms where I may be seen by other patients.
5. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
6. I understand that I have the right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the practice agrees to a requested restriction, then the restriction is binding on the Practice.
7. I understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
8. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
9. I understand that if I agree to a video testimonial that it may be used to help educate others.
10. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I understand that if for any reason I do not follow the recommended treatment plan, the doctor will not be liable.

**I understand the Privacy Notice and have been offered a copy of the Privacy Notice for McCracken Chiropractic PC.**

Name \_\_\_\_\_ Signature \_\_\_\_\_  
Witness \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE SIGN AND DATE ALL FORMS ON EACH PAGE**

---