ACUTE CHIROPRACTIC

Patient Information Sheet

Name: _____ Date: _____

Address: _____

City: _____ State/Zip: _____

Home Phone: (_____) _____ - _____ Work/Cell Phone: (_____) _____- _____

Social Security Number: _____ Email Address: _____

Birthdate: ____/____/_____ Male: _____ Female: _____
mo day yr

In case of emergency, contact: _____ Phone: (_____) _____-_____

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed Student Status ___ Yes ___ No

Visit Information
What is the reason for your visit today? _____
_____

Primary Insurance Information
Name of Insurance Company: _____ Phone: _____
Address: _____ City: _____ State: _____
Policy Number: _____
Name of Insured: _____ Subscriber Name: _____
Subscriber Soc Sec#:_____ Subscriber Date of Birth: _____
Subscriber Employer Name: _____ Phone: _____

Secondary Insurance Information
Name of Insurance Company: _____ Phone: _____
Address: _____ City: _____ State: _____
Policy Number: _____
Name of Insured: _____ Subscriber Name: _____
Subscriber Soc Sec#:_____ Subscriber Date of Birth: _____
Subscriber Employer Name: _____ Phone: _____

Is your condition due to an accident _____ or illness _____?
If an accident, did it occur at work? _____ Date of accident: _____

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Patient to complete the following sections:

Last Name:	First Name:	MI:	Daytime Phone:
Date:			Evening Phone:

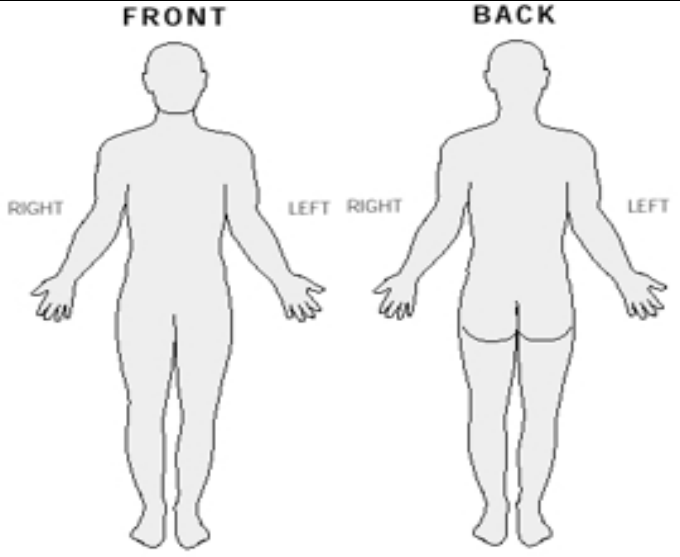
Please list the reasons/condition for your visit in order of importance, most important at the top:	Date you first noticed:	Pain &/or Symptoms Circle the number that best reflects your condition: (0= no effect 10= severe)	Pain &/or Symptoms Circle how much of the time your experience your condition:
A.		0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%
B.		0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%
C.		0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%
D.		0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%

For each condition listed above, please indicate how it happened:

A. ❑ Developed over time ❑ Illness ❑ Injury ❑ Auto accident ❑ Other _____ ❑ I don't know
B. ❑ Developed over time ❑ Illness ❑ Injury ❑ Auto accident ❑ Other _____ ❑ I don't know
C. ❑ Developed over time ❑ Illness ❑ Injury ❑ Auto accident ❑ Other _____ ❑ I don't know
D. ❑ Developed over time ❑ Illness ❑ Injury ❑ Auto accident ❑ Other _____ ❑ I don't know

For each condition listed above, please indicate if it is better or worse with any of the following:

	Heat	Cold	Rest	Activity	Other:_____
A.	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse
B.	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse
C.	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse
D.	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse



Please mark the areas of your discomfort on the figures at right, using the symbol which best describes the feeling: +++ sharp, stabbing; 000 pins & needles; VVV dull, aching; /// numbness

Please indicate if your condition limits any of the following activities:

Activity	How much pain? 0-10, 10 is worst	What motion? Front or back Left or Right
Work _____		
Sleep _____		
Bath/Shower_____		
Getting dressed_____		
Cooking_____		
Cleaning_____		
Laundry_____		
House Work_____		
Landscape_____		
Gardening_____		
Other _____		
Comments:		

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Patient to complete the following sections:	
Patient Last Name: First Name: MI:	Date:

During what time of day do you feel worst? _____
Do you sleep well? Yes ❑ No ❑
What are your normal sleeping hours? _____
Are you currently under the care of a medical doctor or other health care provider for any condition?
Yes ❑ No ❑ Condition: _____
Name of doctor/provider: _____ Phone: _____
Have you ever had an overnight stay in a hospital or surgical procedure of any kind? Yes ❑ No ❑
Date and Description: _____
Date and Description: _____
Do you exercise? Yes ❑ No ❑
Description: _____ Frequency/Minutes per session: _____
Description: _____ Frequency/Minutes per session: _____

Personal History:

Please read through the following list and check any which may apply to you

•Pain in Body•
__Neck pain with difficulty swallowing
__Extreme neck stiffness with pain or electrical shocks in arms or legs when moving neck
__Leg pain that worsens with exercise but is relieved by resting
__Loss of feeling in inner thighs
__Back pain with urinary problems

•Current Conditions•
__Unable to balance properly
__Recent unexplained weight loss
__Recent progressive muscle weakness or shaking
__Blurred or double vision, dizziness, nausea or faintness when neck is in certain position
__Recent major accident such as a fall from a height, whiplash, or a blow to the head
__Memory loss after injury

•Types of Pain•
__Severe pain interrupts sleep
__Constant pain not improved by changing positions or lying down

•Prior diagnosed condition/Medical History•
__Congenital bone or joint disorder
__Rheumatoid arthritis
__Severe degenerative arthritis
__History of compression fracture
__History of heart attack
__History of stroke or aneurysm
__Past history of cancer or currently diagnosed with cancer
__Diabetes with cold, burning, or numb feet
__Gout
__Lupus
__Ankylosing spondylitis
__Immune suppression due to chemotherapy, organ transplant, etc.
__3 or more months use of steroid medications or intravenous drugs (past or recent)

Family History

Please read through the following list and check any which apply to you.

__Autoimmune Disorders __Cancer __Heart Disease __Mental Illness
__Arthritis __Diabetes __Kidney Disease __Seizure Disorder

Comments: _____

_____

_____

_____

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Notice of Privacy Practices

The **Health Insurance Portability and Accountability Act** concerns the security of your personal and medical information. We respect your privacy and rights, so we follow these guidelines as applicable to our practice.

A partial list of **your rights** includes but is not limited to allowing (or prohibiting) health care providers from **revealing information with your permission, as necessary**, to others involved in your health care, such as insurance carriers, physicians, home care aides, and family members, friends, or other health care proxies who share responsibility for your well-being or billing for services rendered.

Information includes but is not limited to medical records, diagnostic reports, treatments, tests and results, billing, and referrals, as well as personal data such as birthdate, etc.

We will coordinate with all parties necessary for prompt, accurate and effective treatment and proper billing. **We will gladly explain** all aspects of your care to you or assigned persons as you wish.

Privacy Policies of Acute Chiropractic Clinic

The **Health Insurance Portability and Accountability Act (HIPAA)** is in effect. HIPAA has certain requirements with which health care providers are required to comply.

We are required to give each patient a notice of Privacy Practices (*see above*) listing was in which we might use your Protected Health Information. Please sign below, thereby stating that you received the notice.

Patient Name: (printed) _____

Patient Signature: _____ **Date:** _____

Release of Information

I certify that the above information is true and correct to the best of my knowledge. I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above other health care professionals to whom I am referred and to the insurance carrier or other entity responsible for payment, utilization and/or quality review for all or a portion of my care and treatments.
Patient Signature: _____ Date**:** _____

Patient's or Authorized Person's Signature

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless arrangements have been made. I further authorize the release of any medical or other information necessary to process insurance claims. This office is committed to protecting your privacy and ensuring the safety of your personal information.

Patient Signature: _____ Date: _____

Insured's or Authorized Patients Signature

I authorize payment of medical benefits to the above named physician or healthcare provider for services described. I also request payment of government benefits to the party who accepts assignment.

Patient Signature: _____ Date: _____