# New Patient Health History Form

Please print. All information is CONFIDENTIAL.

Name (First, MI, Last): _____ Today's date: _____

Address: _____ City:_____State:____Zip:_____

Phone (Cell):_____ (H):_____ (W):_____

Soc. Sec. #:_____ Date of birth:____/____/____ Age:_____ ☐ Male ☐ Female

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Number of children:_____

Occupation: _____ Employer: _____

Work address: _____ City:_____State:____Zip:_____

Name of spouse: _____ Spouse's employer: _____

Name of Family Physician: Dr._____ Phone: _____

Have you ever been treated by a chiropractor? ☐ Yes ☐ No Name of Chiropractor: _____

Date of last visit: _____ Purpose:_____

How did you hear about our office?_____

Do you have health insurance? ☐ Yes ☐ No Insurance company name:_____

Insured's name:_____ Insured's Soc. Sec. #: _____

Policy #:_____ Group #:_____ Insured's birth date: _____

## HEALTH HISTORY

Have you ever had any surgery? ☐ Yes ☐ No If yes, please describe below and give approximate date:

_____

Have you ever fractured a bone or had a severe sprain to a joint? ☐ Yes ☐ No

If yes, please describe below and give approximate date:

_____

Are you currently taking any medication? ☐ Yes ☐ No If yes, please list below:

_____

Have you ever been involved in an auto accident or other injury that required medical care? ☐ Yes ☐ No

If yes, please describe below and give approximate date:

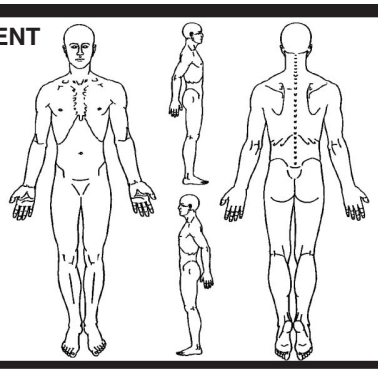
_____

Have you been seen by a medical doctor for any reason in the past year? ☐ Yes ☐ No

If yes, for what reason? _____

**OFFICE USE**

**SPECIAL MANAGEMENT**



**Straughn Chiropractic Offices** ***Subjective Complaint Form***

| HM | HA | UPMC | AET | CIG | MED | Sec B | Fre B | Adv | FFS | WC/AA | 99203 | 99213 | CMT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

**1. Name:** _____ **Date:** _____

**2. Main complaint:** _____

**3. Type of Problem:** ☐New Problem ☐Return of the Same Problem ☐Always Same Problem, Worse Now

**4. Caused by:** *(choose one)* ☐lifting ☐bending ☐reaching ☐over exertion ☐repetitive motion ☐slip/fall ☐slept wrong ☐unknown ☐gradual worsening ☐no injury

Describe the onset/injury: _____

**5. Quality of Pain:** *(check all that apply to you)* ☐sore ☐stiff ☐ache ☐tight ☐sharp ☐stab ☐shoot ☐catch ☐burn ☐throb ☐numb ☐tingle ☐asleep ☐other:_____

**6. Severity:**

| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **With Activity** | no pain | | mild pain | | moderate pain | | | severe pain | | | extreme pain |
| **At Rest** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**7. When did this start?** Started or worsened: (approximately)_____

**8. Have you had similar problems?** Last episode/Last occurred:_____ ☐ No similar problem in past

**9. Timing:** *(check all that apply to you)*

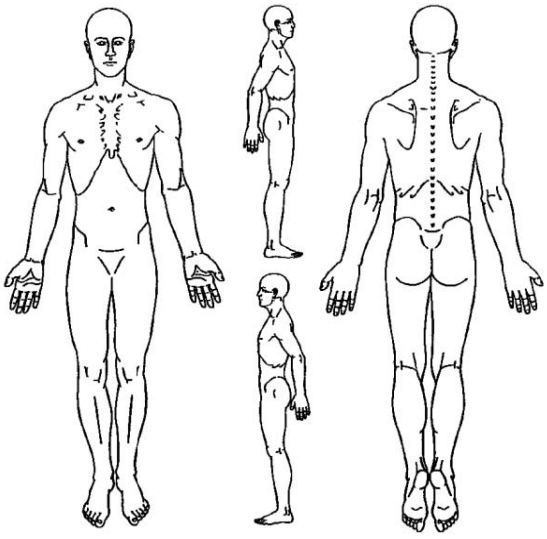
| | | | | | | |
|---|---|---|---|---|---|---|
| **Worse:** | ☐morning | ☐daytime | ☐night time | ☐with activity | ☐with inactivity | ☐same all day |
| **Better:** | ☐nothing helps | ☐moving | ☐stretching | ☐applying heat | ☐applying cold | ☐resting |
| | ☐Otc meds | ☐Rx meds | ☐lying down | ☐sitting | ☐standing | ☐walking |

**10. Other Symptoms:**

| | | | | | |
|---|---|---|---|---|---|
| ☐headaches | ☐tingling/numb | ☐joint stiffness | ☐muscles spasm | ☐muscle knots | ☐chronic fatigue |
| ☐sleep problems | ☐hard to walk | ☐hard to breathe | ☐cold hands/feet | ☐dizziness | ☐swelling |
| ☐nausea/vomiting | ☐heartburn | ☐blurred vision | ☐depression | ☐anxiety/panic | ☐mood swings |

| **11. Difficulty with ADL's** (Activities of daily living) | **Mild Pain** But can do | **Moderate Pain** Limits ability | **Severe Pain** Unable to do |
|---|---|---|---|
| Sleeping | ☐ | ☐ | ☐ |
| Bending Over | ☐ | ☐ | ☐ |
| Prolonged Sitting | ☐ | ☐ | ☐ |
| Prolonged Standing | ☐ | ☐ | ☐ |
| Prolonged Walking | ☐ | ☐ | ☐ |
| Getting Up From Sitting | ☐ | ☐ | ☐ |
| Climbing Stairs | ☐ | ☐ | ☐ |
| Driving | ☐ | ☐ | ☐ |
| Extended Computer Use | ☐ | ☐ | ☐ |
| Household Chores | ☐ | ☐ | ☐ |
| Yard Work | ☐ | ☐ | ☐ |
| Getting Dressed | ☐ | ☐ | ☐ |
| Lifting/Straining | ☐ | ☐ | ☐ |
| Turning/Moving Head | ☐ | ☐ | ☐ |
| Rolling Over/Twisting | ☐ | ☐ | ☐ |
| Reaching Up/Out | ☐ | ☐ | ☐ |
| Using Arms | ☐ | ☐ | ☐ |
| Exercise | ☐ | ☐ | ☐ |
| Job, Occupational Work | ☐ | ☐ | ☐ |
| Other: | ☐ | ☐ | ☐ |

**Shade the Areas of Symptoms**



R L L R

# PATIENT INFORMATION

## HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE ANY MEDICAL HEALTH PROBLEMS?

| | | | |
|---|---|---|---|
| ☐ Arthritis | ☐ High Blood Pressure | ☐ Stroke | ☐ Epilepsy/Seizure |
| ☐ Heart Attack | ☐ Kidney Disorder | ☐ Hernia | ☐ Thyroid Condition |
| ☐ Digestive Disorders | ☐ Sinus Condition | ☐ Glaucoma | ☐ Fibromyalgia |
| ☐ Asthma | ☐ Cancer | ☐ Hypoglycemia | ☐ HIV/Aids |
| ☐ Polio | ☐ Circulation Problems | ☐ Emphysema | ☐ Lyme Disease |
| ☐ Heart Condition | ☐ Prostate Problem | ☐ Female Disorder | ☐ Carpal Tunnel |
| ☐ Bowel Disorder | ☐ Ear Condition | ☐ TMJ Problem | ☐ Chronic Fatigue |
| ☐ Foot Problems | ☐ Diabetes | ☐ Anemia | ☐ No Health Problems |

☐ Allergies _____

☐ Other _____

## DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING DISEASES?

| | | | | | |
|---|---|---|---|---|---|
| ☐ **Cancer** | ☐ Grandparents | ☐ Father | ☐ Mother | ☐ Siblings | ☐ Children |
| ☐ **Diabetes** | ☐ Grandparents | ☐ Father | ☐ Mother | ☐ Siblings | ☐ Children |
| ☐ **Heart Disease** | ☐ Grandparents | ☐ Father | ☐ Mother | ☐ Siblings | ☐ Children |
| ☐ **High Blood Pressure** | ☐ Grandparents | ☐ Father | ☐ Mother | ☐ Siblings | ☐ Children |
| ☐ **Stroke** | ☐ Grandparents | ☐ Father | ☐ Mother | ☐ Siblings | ☐ Children |
| ☐ **Arthritis** | ☐ Grandparents | ☐ Father | ☐ Mother | ☐ Siblings | ☐ Children |
| ☐ **Back/Neck Problems** | ☐ Grandparents | ☐ Father | ☐ Mother | ☐ Siblings | ☐ Children |

## SOCIAL HISTORY

1. Do you eat what you think is a well balanced diet? ☐ Yes ☐ No
2. Do you exercise regularly? ☐ Yes ☐ No
3. Do you sleep 6-8 hours per night? ☐ Yes ☐ No
4. Do you take daily vitamins? ☐ Yes ☐ No
5. Do you drink 6-8 glasses of water per day? ☐ Yes ☐ No
6. Do you drink more than a couple cups of coffee each day? ☐ Yes ☐ No
7. Do you drink more than a couple glasses of soda each day? ☐ Yes ☐ No
8. Do you drink alcoholic beverages? ☐ Yes ☐ No ☐ Socially only ☐ Daily
9. Do you smoke or use tobacco products? ☐ Yes ☐ No ☐ Packs/cans per day?____
10. Do you have a stressful home or work environment? ☐ Yes ☐ No
11. Are you overweight? ☐ Yes ☐ No
12. What are your hobbies?_____

## FEMALES ONLY

To the best of your knowledge are you pregnant? ☐ Yes ☐ No If yes, Due date:_____

What was the date of your last menstrual cycle? _____

**Printed Name:**_____ **I.D.#**_____

## Consent for Use or Disclosure of Health Information

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are many circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to health care providers if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. This includes potentially updating your primary care physician with your care in this office.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.
- We may need to use your name, address, phone number, email address and/or your clinical records to contact you to provide appointment reminders, treatment follow-up calls, treatment alternatives, health related information that may be of interest to you, or to discuss billing issues.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change our privacy practices, we will notify you in writing when you come in for treatment or by mail.

### Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restriction in the use of disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

### Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have been offered to receive a copy of this authorization.

_____ _____/_____/ _____ _____

Patient's Signature Date Witness

## Consent for Chiropractic Care and Terms of Acceptance

I, the undersigned hereby authorize Straughn Chiropractic doctors and assistants to perform and/or order diagnostic tests, including but not limited to radiographs (x-rays), and to administer chiropractic care as is necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand that I am choosing to be seen by a chiropractor and that the chiropractor's objective is different than the medical doctor's objective. Therefore, I may choose to seek medical care while at the same time receiving chiropractic care. The chiropractor's objective is the correction (reduction) of Vertebral Subluxations (spinal misalignments) to enhance nerve system function and therefore, my overall health.

I understand and agree the health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to Straughn Chiropractic will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

_____ _____/_____/ _____ _____

Patient's Signature Date Witness

## Authorization to Release Chiropractic Information

I authorize Straughn Chiropractic to release any information pertinent to my care in order to receive reimbursement for the cost of services rendered to me. This authorization includes insurance companies, collectors, attorneys, etc. This authorization shall remain valid as long as there is a balance owed on my account. I certify that all insurance information given to Straughn Chiropractic is correct and complete.

_____ _____/_____/ _____ _____

Patient's Signature Date Witness