Patient Information - Deerpath Chiropractic Clinic

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Mobile Phone _____ Primary Phone _____ Secondary Phone_____

Email_____ Birthdate_____ Gender: Male Female

Marital Status: Single Married Other: _____ Employment: Employed Student Retired Other

Employer_____ Occupation _____

Person to contact in case of emergency _____ Phone _____

How did you hear about our office? _____

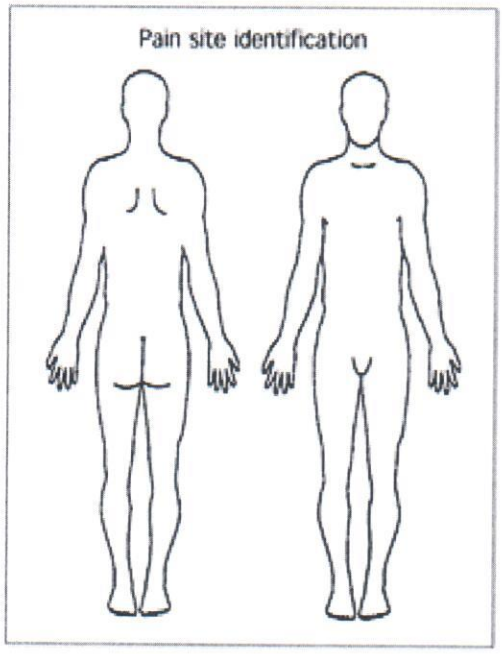
Insurance Information – If insured, please provide your insurance card(s) to be copied.

Insurance Co. _____ Additional Insurance _____

If patient is not the policy holder: Name of Policy Holder _____ Birthdate _____

Relationship to patient _____ Employer _____

Symptoms



Reason for visit: _____

When did this problem start? _____

How did your symptoms start? _____

Are there any activities or movements that are difficult to perform?

_____

Mark each area on the picture indicating where you have pain or other symptoms, and indicate **AREA 1,2…**

Circle your average pain intensity on the scale:

Area 1: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Area 2: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Type of Pain **Area 1** (circle): dull sharp throbbing burning deep aching tingling stabbing cramping numbness radiating stiffness other_____

Area 2: _____

When you have the pain, how frequent is it? **Area 1**: Constantly Frequently Occasionally Intermittently **Area 2**:_____

What treatment/testing have you received for your condition(s)?_____

Health History – please circle all that apply Severe Headaches / Chest Pain / Angina / Kidney Stones / Digestive problems / **Hypertension** / Renal disease / Gout / Stroke / Heart Disease / **Diabetes** / Arthritis / Epilepsy / Arrhythmia / Endocrine Disease / Aids/HIV / Fatigue / Genital-Urinary Problems / Dizziness / Fainting / Anemia / Rheumatic Fever / Scarlet Fever / Prostate Problems / Ulcers / Gallstones / Sexual Dysfunction / Venereal disease / Pancreatitis / Shortness of Breath / Menstrual Dysfunction / Mental Illness / Asthma / Liver Disease / Alcohol or Drug Problems / Bleeding Disorders / Cancer / Fractures / Herniated Disc / High Cholesterol / Osteoporosis / Pacemaker / Parkinson's / Prosthesis / Implants / Rheumatoid / Fibromyalgia / **Smoke Tobacco** / Other(s) _____

Explanation(s) if necessary _____

Please list all surgeries, hospitalizations or significant injuries: _____

(Women) Are you pregnant or could you potentially be pregnant? Yes No Due Date:_____

(Note: Many of the following questions are due to new government requirements)

Race (circle) White / Black/African American / Hispanic / American Indian/Alaskan Native / Asian / Asian Indian / Chinese / Filipino / Japanese / Korean / Vietnamese / Native Hawaiian or other Pacific island / Samoan / Guamanian or Chamorro / Other _____ / I choose not to specify

Verification Question – online access through Microsoft HealthVault (circle one question, then give a 6 letter answer)
What is the name of your favorite pet? In what city were you born? What high school did you attend? What is your mother's maiden name? What was the make of your first car? Verification question answer: _____

Current medications, including dosage: If no medications, check here: ☐ 1. _____
2. _____ 3. _____

List any known medication allergies: If no allergies, check here: ☐ 1. _____
2. _____ 3. _____

Have you been diagnosed with Diabetes? Yes No If yes, Type I or Type II _____
If yes to diabetes, was your blood work for hemoglobin A1c > 9.0%? Yes No Not Sure

To be performed by staff: Height _____ in. Weight _____ lbs. BP _____/_____

Certification and Assignment

I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. This shall remain in effect until revoked by me in writing.

Consent to Care

I hereby authorize Deerpath Chiropractic Clinic, S.C. and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I understand that Illinois law entitles me to receive information concerning my condition and proposed treatment, and to refuse any treatment to the extent permitted by law. With that knowledge and with my consent, I wish to rely on the Practice doctors to make those decisions about my care, based on the facts then known, that they believe are in my best interest.

It is advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those that relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and proposed course of care and treatments by the Practice.

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices. I understand that the Notice describes the uses and disclosures of my protected health information by the Practice and informs me of my rights with respect to my protected health information.

Signature of Patient/Parent/Guardian _____ Date _____