INITIAL HEALTH STATUS

Patient Name: ________________________ **Date of Birth:** ______________ **Sex:** Male / Female

Address: ______________________________ **City:** ________________ **ZIP:** _________

Phone: ________________________ **Email:** ________________________________

Occupation: ________________________ **Employer:** __________________________

Health Insurance Company: ______________ **Subscriber ID #:** ______________ **Group #:** _________

Family History: ☐ Cancer ☐ Diabetes ☐ Heart Problems / Stroke ☐ High Blood Pressure ☐ Rheumatoid Arthritis

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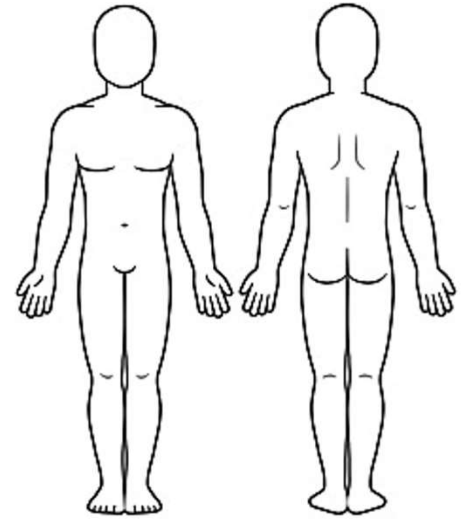
Reason for your visit: ☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Low back pain ☐ Other: ______________

Is your pain: ☐ Work-related ☐ Auto-related ☐ N/A

Please indicate the location of your pain.



How long have you been having symptoms? ________________

What is your pain level today? 1 2 3 4 5 6 7 8 9 10

What percentage of the day are your symptoms present?

☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

In the past week, how much has your pain interfered with your daily activities (sleeping, working, household chores, etc.?)

☐ No interference ☐ Some interference ☐ Unable to carry on activities

Have you had x-rays, MRI, or CT of your area(s) of pain? ☐ YES ☐ NO

If YES, what area(s) were taken? ___________________________

Date(s) taken: ___________________________________

Please check all of the following that apply to you:

- ☐ Alcohol/Drug Dependence
- ☐ Diabetes
- ☐ Recent Fever
- ☐ High Blood Pressure
- ☐ Stroke (Date): ______________________
- ☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
- ☐ Taking Birth Control Pills
- ☐ Dizziness/Fainting
- ☐ Numbness in Groin/Buttocks
- ☐ Cancer/Tumor (Explain): ______________
- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Urinary Problems
- ☐ Currently Pregnant / # Weeks: _________
- ☐ Abnormal Weight Gain
- ☐ Abnormal Weight Loss
- ☐ Morning Pain/Stiffness
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Osteoporosis
- ☐ Epilepsy / Seizures
- ☐ Visual Disturbances
- ☐ Surgeries: ______________________
- ☐ Tobacco Use (Type): ______________
- ☐ Medications: ______________________
- ☐ Other Health Problems (List): __________

I certify to the best of my knowledge; the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefits through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature: ______________________________ **Date:** ____________________

Informed Consent & Medical Information Release form (HIPAA Release Form)

Name: ____ **Date of Birth:** ________________

Chiropractic Care – Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropracticthere are some risks to treatment.

The most common side-effects are of short duration and include local discomfort in the area of treatment, pain, and headache. Most adverse events associated with spinal manipulation are benign and self-limiting. The incidence of severe complications (including but not limited tostroke) following chiropractic care and manipulation is extremely low. The best evidence suggests that chiropractic care is a useful therapy for subjects with neck or low-back pain for which the risks of serious adverse events should be considered negligible (JMPT, 2008 Jul-Aug;31(6):461-4).

Release of Information:

- ☐ **I DO NOT** authorize the release of information, including the diagnosis, records, examination(s) and treatment rendered to me at this office, as well as claims information.

- ☐ **I DO** authorize the release of information, including the diagnosis, records, examination(s) and treatment rendered to me at this office, as well as claims information.

  - Spouse: ____
  - Child(ren): ____
  - Other: ____

If you need to reach me, please call me at the following number: ______________________________

If you are unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call

The best time to reach me is: ☐ In the morning ☐ In the afternoon ☐ In the evening ☐ No preference

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This ***Release of Information*** will remain in effect until terminated by me in writing.

Patient Signature: __________________________________ **Date:** ________________________

Witness: ____ **Date:** ________________________