

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Full Name: _____ Social Security#: _____

Address: _____ City: _____ State: _____

Zip: _____ E-mail address: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Male: _____ Female: _____ Marital Status: M S W D

Employer's Name: _____ Occupation: _____

Employer's Address: _____ Office Phone: _____

Contact Preference: Home _____ Work _____ Cell _____ Email _____ Mail _____

Who does patient reside with?: _____

Spouse's Name: _____ How many children do you have? _____

How were you referred to our office? _____

Language: English _____ Spanish _____ Indian _____ Japanese _____ Chinese _____
Korean _____ French _____ German _____ Russian _____ Other _____

Race: White _____ Black or African American _____ Asian _____ American Indian or Alaska Native _____
Native Hawaiian or Other Pacific Islander _____ Decline to Specify _____

Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino _____ Decline to Answer _____
French _____ Unknown _____

Family Medical Doctor: _____

Would you like us to send your family Medical Doctor a copy of today's visit? Yes No

How can we best serve you?

1. _____ Get rid of the symptoms only.
2. _____ Get rid of the symptoms, but then fix the problem so that it doesn't come back.
3. _____ Get rid of the symptoms, fix the problem, and also talk to me about exercise, supplements and nutrition so that I can be as healthy as possible and get the most out of my life.

Thank you for taking the time to complete this form. The more we understand your current health status, the better we will be able to guide you toward your ideal health goals.

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment: _____

How did it originally occur? _____

Is this due to: Auto ___ Work ___ Other _____

Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

Date symptoms appeared or accident happened: _____

How frequent is the condition? Constant _____ Daily _____ Intermittent _____ Night Only _____

Describe the pain: Sharp _____ Dull _____ Numbness _____ Tingling _____ Aching _____

Burning _____ Stabbing _____ Other _____

Is there anything you can do to relieve the problem? Yes ___ No ___

If yes, describe _____

What makes the problem worse? Standing _____ Sitting _____ Lying _____ Bending _____

Lifting _____ Twisting _____ Other _____

Have you ever had the same or a similar condition? Yes No

If yes, when and describe: _____

Have you ever been to a chiropractor?: Yes No

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

Yes _____ No _____ Uncertain _____

PAST MEDICAL HISTORY

Do you have a history of stroke or high blood pressure? _____

Have you ever been diagnosed with diabetes? Type I _____ or Type II _____ If yes, include date & provider seen: _____

Have you been hospitalized or had any surgeries, major illnesses, injuries falls or auto accidents?
Women, please include information about childbirth:

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications, food or environmental?

List type of allergy and reaction: _____

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

General

- Fatigue
- Weakness
- Fever
- Chills
- Weight Change
- Night Sweats

Skin

- Rash
- Redness
- Itching
- Eczema
- Hair Changes
- Nail Changes

Neurologic

- Fainting
- Headache
- Dizziness
- Convulsions

Eyes

- Vision Trouble
- Pain
- Discharge

Ears

- Hearing Trouble
- Ringing
- Pain
- Discharge

Nose

- Pain
- Bleeding
- Absence of Smell

Mouth/Throat

- Absence of Taste
- Abnormal Taste
- Sores
- Bleeding

Heart/Lungs

- Blue Extremities
- Murmur
- Chest Pain
- Palpitations
- Cough
- Wheezing
- Difficulty Breathing
- Swollen Extremities

Breasts

- Lumps in Breast(s)
- Redness/Itching
- Pain
- Dimpling
- Discharge

Stomach/Intestines

- Decreased Appetite
- Increased Appetite
- Abdominal Pain
- Vomiting
- Diarrhea
- Constipation

Reproductive/Urination

- Inability To Hold Urine
- Painful Urination
- Frequent Urination
- Irregular Menstruation
- Painful Menstruation
- Abnormal Vaginal Bleeding
- Impotence
- Sterility

Glandular

- Heat/Cold Intolerance
- Sugar in Urine
- Goiter
- Tremor

Mental

- Anxiety
- Depression
- Memory Loss or Impairment
- Phobias
- Mood Swings

SOCIAL HISTORY:

Do you drink alcoholic beverages? If so, how much per week? _____

Do you smoke? Never Former Smoker Current/Every Day Smoker Current Some Day Smoker

Do you take vitamin supplements? If so, please list: _____

Do you consume caffeine? If so, how much per day: _____

Do you exercise? _____ If yes, what is the frequency and type of exercise? _____

Do you use recreational drugs? _____

FAMILY HISTORY: Parents: Father: living deceased cause of death if deceased: _____ Mother: living deceased cause of death if deceased: _____ Family diseases (check if applicable and indicate whether family member is Father, Mother, Brother, Sister): Cancer Mental Illness Diabetes Asthma Heart Disease Stroke Kidney Disease Lung Disease Arthritis Liver Disease Other _____

AUTHORIZATION:

- A: I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or the party who accepts assignment.
- B: I understand and agree that health and accident 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 any amount authorized to be paid directly to this office will be credited to my account upon receipt. 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. I also understand that if I suspend or terminate my care and treatment, any fees or products or professional services rendered will be immediately due and payable.

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Bratcher Injury & Wellness Center, P.A. or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

Name of Patient (print)

Signature of Patient or Patient Representative

Date