PERSONAL INFORMATION

First Name: _______________________ M.I. _____ Last Name: ___________________________ Preferred Name: _________________

Home Phone: ____________________Cell Phone: _____________________ Email: ____

Address: ____

City/State/Zip: ____

Date of Birth: ________________ Age: _______ Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Email

Referred By: ____ Preferred Statement Delivery Method: ☐ Email ☐USPS

EMPLOYER

Company Name: ____ Phone: ___________________________________

Occupation____

Address: ____ City: _________________________ State:___________ Zip:_________

EMERGENCY CONTACT

Name: _______________________________________ Relationship: ________________________ Phone: ______________________

INSURANCE

Please provide insurance card(s) at time of visit if using insurance.

Type of Insurance: ☐ Private Insurance ☐ Auto Insurance ☐ Workers Comp. ☐ Other_____________________________

Primary Insurance Carrier: ____ Phone: _________________________________

ID/Policy#: _____________________________ Group #: ___________________________ Claim#: ______________________________

Name of Policy Holder: ____ Relationship to Patient: __________________________

Policy Holder's Birthdate: ______/_____/______ Employer: __________________________

Is patient covered by another insurance? ☐ Yes ☐ No

Secondary Insurance Carrier: ____ ID/Policy #: ___________________________________

Group #:________________________ Name of Policy Holder: ______________________ Relationship to Patient: ________________

Patient Name: ___________________________________ **Date:** ____________

REASON FOR VISIT

Describe what brings you in today:

____

____

____

How long have you had this condition?___________________ Has this happened before?_______________________________________

Is it getting worse? ☐ Yes ☐ No ☐ Unknown Are your symptoms: ☐ Constant ☐ Intermittent

Onset: ☐ Gradual ☐ Sudden ☐ Other _________________

Do your symptoms bother you while: ☐ Sitting ☐ Standing ☐Exercise ☐ Work ☐ Sleep ☐ Other (please specify)

____

____

What seemed to be the initial cause?____

Have you seen a chiropractor before? ☐ Yes ☐ No If yes, how long ago? ____

For what reason? ____

Are you under the care of a physician? ☐ Yes ☐ No If yes, for what reason? ____

Date of last physical exam: ___________________________ Where: ____

Please mark areas of pain:

Using the scale below, please rate your level of pain today from zero (no pain) to ten (worst possible pain):

1 2 3 4 5 6 7 8 9 10

Using the body chart to the right, indicate the region(s) of your complaint using the following symbols:

A - Aching

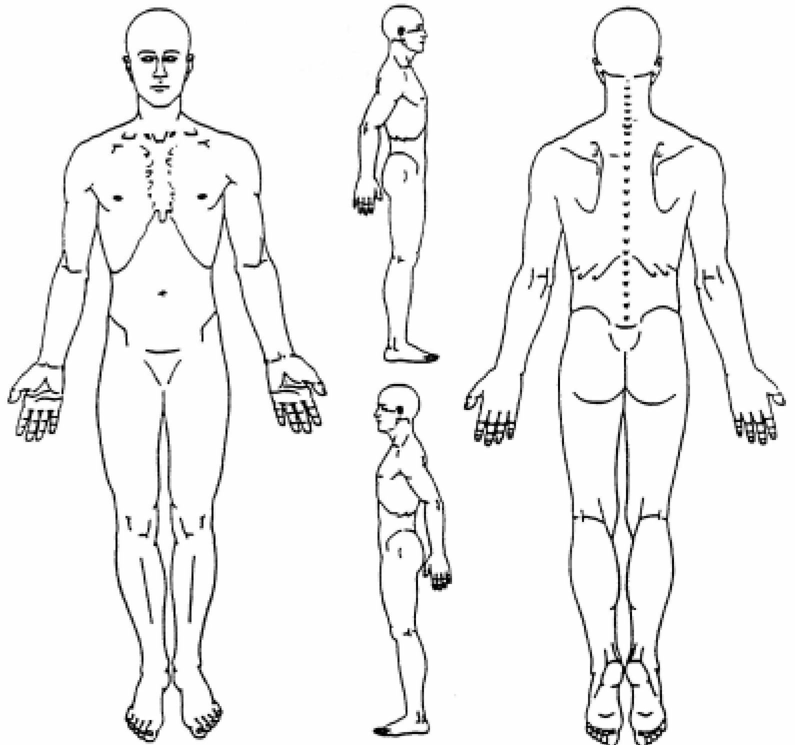
B - Burning

N - Numbness/tingling

S - Stabbing/sharp

T - Tightness

O - Other



Patient Name: ___________________________________ Date: ____________

O F C
Muscle/Joint
rthritis
ursitis
Foot trou le
ernia
o ac ain,
Nec ain, sti ness
ain et een shoulders
ciatica
inal curvature
ollen oints

General
ller ies
Chills
i iness
Faintin
Fever
Fati ue
Fever
eadache
Mi raine
oss o slee
oss o ei ht

es iratory
Chest ain
Chronic cou h
i iculty reathin

O F C
Eye, Ear, Nose and Throat
sth a
Colds
ea ness
Earache
Ear noise
Enlar ed lands
ay ever
oarseness
Far si hted
Near si hted
Nose leeds
inus in ection
ore throat

Gastrointestinal
i icult di estion
loated a do en
Nausea
ain over sto ach
o itin

Cardiovascular
ardenin o arteries
i h lood ressure
o lood ressure
oor circulation
a id heart eat
lo heart eat
ellin o an les

O F C
Skin
Bruise easily
Hives or allergy
Rash
Varicose veins

Pain or Numbness in:
Shoulders
Arms
Elbows
Hands
Hips
Legs
Knees
Feet

Women Only
Congested breasts
Cramps or backache
Menopause

Are you pregnant? es No

If yes, how many months?______

How many children do you have?

____

Check any of the following conditions you currently have or have had:
Past/Present
h s
en t s
rter s er s s
Can er
a etes
e a
e a
h se a
e s
t
eart sease
eas es
t e s er s s
s
Pa e a er
P e r s
Pne n a
P
he at e er
ar et e er
h n es
tr e
er s s
h n

TRAUMA Broken Bones, Sprains, Strains, Major Trauma/Injury - List and Date: ____
____

SURGERIES and/or HOSPITALIZATIONS - List and Date: ____
____

Have you had an X-ray or CT scan or MRI of your spine in the past 5 years? ☐ Yes ☐ No
List current prescription medications or vitamins:

____
____

List any known allergies:

____

SOCIAL HISTORY

Do you exercise? ☐ Yes ☐ No **Times per week?** **Intensity?** ☐ Light ☐ Moderate ☐ Strenuous Type?:
Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former smoker ☐ Never been a smoker **If "Yes"**, how often do you smoke: ☐ Current every day smoker ☐ Current sometimes smoker **Circle level below ↓:** **If "Yes"**, what is your level of interest in quitting smoking? (0 = NO interest, 10=very interested) **0 1 2 3 4 5 6 7 8 9 10**
Do you drink alcohol? ☐ Yes ☐ No **How many drinks per week?** **For how many years?**
Do you drink caffeine? ☐ Yes ☐ No **How many drinks per day?** **What type?** ☐ Coffee ☐ Tea ☐ Soft Drinks ☐ Energy Drinks
Do you take pain killers? ☐ Yes ☐ No **How often?** ☐Daily ☐ Weekly ☐ Monthly ☐ Rarely **What type?** ☐ Aspirin ☐ Ibuprofen ☐ Tylenol ☐ Other____________________________
What do your work duties include? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Other:
Please describe your overall health right now? ☐ Excellent ☐ Very Good ☐ Good ☐Fair ☐ Poor
What is your current stress level? ☐ Mild ☐ Moderate ☐ High

Patient Name: ___________________________________ **Date:** ____________

PATIENT AGREEMENT - ASSIGNMENT AND RELEASE

I authorize the release of any information including diagnosis and the records of any treatment rendered to me, or my child during the period of such care to third party payers and/or other health practioners. I authorize and request my insurance company to pay directly all medical benefits otherwise payable for services. I understand that I that I am financially responsible for all charges whether or not paid by insurance, and I have read and understand the financial policy of this office. I authorize the use of this signature on all my insurance submissions and to obtain other medical records and radiographic/CT/MRI images and their corresponding reports.

Signature of Insured: ____ _____ Date: ______________________________

FINANCIAL POLICY

I certify that I, and/or my dependents, have insurance with the named insurance company(s) on page one and assign directly to Evergreen Family Chiropractic all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co-pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the insurance company(s) on page one and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

Patient Signature: ____ Date:______________________________

☐Private Pay/Cash: By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Name of person responsible for this account:

Patient Signature: ____ Date:______________________________

CONSENT TO TREAT

To Evergreen Family Chiropractic Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, heat application, manual traction, therapeutic exercise, cupping, application of tape, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injuries, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with the spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurological impairment, injures to the spinal discs, and fractures. Serious complications are estimated to be in the range of .5 - 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information of side effects, complications and effectiveness of spinal adjustments is available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warrant for specific cure or result.

I have read the copy of Evergreen Family Chiropractic Patient Privacy Policy.

Patient Signature: ____ Date: ____