CRANE CHIROPRACTIC

1400 16th AVE SW GREAT FALLS, MT
Ph: (406) 590-5900 Fax: (406) 453-5197
Email: cranechiro@bresnan.net

# NEW PATIENT HEALTH HISTORY FORM

*Case #:*_____

**NAME** _____ **DATE** _____ **EMAIL**_____
LAST FIRST MI **USED FOR OFFICE ANNOUNCEMENTS**

**ADDRESS** _____**CITY** _____**STATE** _____**ZIP**_____

**HOME PHONE #** _____ **CELL PHONE #**_____ **WORK PHONE #** _____

**SOCIAL SECURITY #** _____**BIRTH DATE** _____**AGE** _____ **SEX:** M F **MARITAL STATUS:** S M D W

**# OF CHILDREN** _____ **OCCUPATION** _____**EMPLOYER** _____**HOW LONG** _____

**SPOUSE'S NAME** _____**DOB** _____**SOCIAL SECURITY #** _____

**SPOUSE'S OCCUPATION** _____ **EMPLOYER** _____ **WORK #** _____

***EMERGENCY CONTACT*** _____***PHONE #*** _____

***FILL OUT IF PATIENT IS A MINOR***

**FATHER/GUARDIAN NAME** _____ **DOB** _____ **SS#** _____

**EMPLOYER** _____ **PHONE** _____ **ADDRESS** _____

**MOTHER/GUARDIAN NAME** _____ **DOB** _____ **SS#** _____

**EMPLOYER** _____ **PHONE** _____ **ADDRESS** _____

**HOW DID YOU HEAR ABOUT US?** ☐ OFFICE SIGN ☐ PHONEBOOK ☐ PATIENT NAME:_____OTHER:_____

**FAMILY PHYSICIAN:** _____ **PHONE #** _____

**PAST CHIROPRACTIC CARE?:** ☐ N ☐ Y **WHEN** _____**DOCTOR NAME** _____**RESULTS** ☐ **POOR** ☐ **FAIR** ☐ **GOOD**
**MONTH/YEAR**

**MAIN HEALTH COMPLAINTS:**

**1.** _____ **HOW LONG:** _____ **PREVIOUS EPISODES:** ☐ N ☐ Y
DAYS/WEEKS/MONTHS/YEARS

**2.** _____ **HOW LONG:** _____ **PREVIOUS EPISODES:** ☐ N ☐ Y
DAYS/WEEKS/MONTHS/YEARS

**3.** _____ **HOW LONG:** _____ **PREVIOUS EPISODES:** ☐ N ☐ Y
DAYS/WEEKS/MONTHS/YEARS

**CHECK ANY CURRENT SYMPTOMS:**

| | | | |
|---|---|---|---|
| ☐ FEVER | ☐ BACK PAIN | ☐ COLD SWEATS | ☐ LOSS OF MEMORY |
| ☐ FATIGUE | ☐ FEET COLD | ☐ FACE FLUSHED | ☐ STOMACH UPSET |
| ☐ TENSION | ☐ HEADACHE | ☐ NERVOUSNESS | ☐ NUMBNESS IN TOES |
| ☐ FAINTING | ☐ NECK STIFF | ☐ LOSS OF TASTE | ☐ HANDS SEEM HEAVY |
| ☐ DIZZINESS | ☐ CHEST PAIN | ☐ CONSTIPATION | ☐ HEAD SEEMS HEAVY |
| ☐ DIARRHEA | ☐ DEPRESSION | ☐ LOSS OF SMELL | ☐ SLEEPING PROBLEMS |
| ☐ EARS RING | ☐ HANDS COLD | ☐ BUZZING IN EARS | ☐ LIGHTS BOTHER EYES |
| ☐ NECK PAIN | ☐ IRRITABILITY | ☐ LOSS OF BALANCE | ☐ NUMBNESS IN FINGERS |
| ☐ SHORTNESS OF BREATH | | ☐ PINS & NEEDLES IN LEGS | ☐ PINS & NEEDLES IN ARMS |
| ☐ OTHER_____ | | ☐ OTHER_____ | ☐ OTHER _____ |

**HOW DID THESE SYMPTOMS OCCUR?:** _____

**ARE YOUR PRESENT PROBLEMS DUE TO AN INJURY:** ☐ N ☐ Y
☐ **ON THE JOB** ☐ **AUTO ACCIDENT** ☐ **PERSONAL INJURY** **OTHER:** _____

**DO YOU HAVE A PAST HISTORY OF ANY SERIOUS ILLNESSES OR INJURIES?:** ☐ N ☐ Y
**EXPLAIN:**_____

# HEALTH HISTORY (continued)

ARE YOU NOW OR HAVE YOU EVER BEEN DISABLED? (SERVICE OR WORK): ☐ **N** ☐ **Y** WHEN:_____

**DO YOU HAVE ANY MEDICATION ALLERGIES OR OTHER ALLERGIES?:** ☐ N ☐ Y **LIST:** _____

**ARE YOU PRESENTLY TAKING ANY MEDICATIONS?** ☐ N ☐ Y **LIST:**_____

**DO YOU HAVE ANY BODILY IMPLANTS?:** ☐ N ☐ Y **LIST:** _____
(PACE MAKER, BREASTS, JOINTS, SCREWS, PLATES, ETC)

**HAVE YOU EVER HAD X-RAYS TAKEN?:** ☐ N ☐ Y **WHEN?:** _____ **BY WHOM?:** _____
**DO YOU SUFFER FROM ANY CONDITION OTHER THAN THAT WHICH YOU ARE NOW CONSULTING US?:** ☐ N ☐ Y
**LIST:** _____

**HAVE YOU HAD ANY SURGERIES?:** ☐ N ☐ Y **LIST:** _____

***WOMEN:*** **ARE YOU PREGNANT?:** ☐ N ☐ Y **DATE OF LAST MENSTRUAL CYCLE:** _____

**EXERCISE:** ☐ NONE ☐ MODERATE ☐ DAILY **TYPE:** _____

**HABITS:** **TABACCO:** ☐ N ☐ Y **ALCOHOL:** ☐ N ☐ Y **CAFFEINE:** ☐ N ☐ Y **SUBSTANCE ABUSE:** ☐ N ☐ Y

FAMILY HISTORY:

| | DIABETES | HEART/HBP | KIDNEY | CANCER | BACK/NECK | PINCHED NERVE | DISC/JOINT | ARTHRITIS | HEADACHES |
|---|---|---|---|---|---|---|---|---|---|
| MOTHER: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| FATHER: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| BROTHER(S): | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| SISTER(S): | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?: ***CHECK ANY THAT APPLY***

| | | |
|---|---|---|
| ☐ TUBERCULOSIS | ☐ CANCER | ☐ HEART DISEASE |
| ☐ WHOOPING COUGH | ☐ GOITER | ☐ PNEUMONIA |
| ☐ HIV POSITIVE | ☐ DIABETES | ☐ STROKE |
| ☐ POLIO | ☐ ANEMIA | ☐ PLEURISY |
| ☐ CHICKEN POX | ☐ ALCOHOLISM | ☐ APPEDDICITIS |
| ☐ MEASELS | ☐ MENTAL DISORDER | ☐ ECZEMA |
| ☐ MUMPS | ☐ EPILEPSY | ☐ ARTHRITIS |
| ☐ VENEREAL INFECTION | ☐ RHEUMATIC FEVER | ☐ LUMBAGO |

**PAYMENT INFORMATION** We accept cash, checks, money orders, Visa, MasterCard, American Express, Care Credit.

My payment method will be: ☐ Self-Pay ☐ Health Insurance ☐ Medicare ☐ Medicaid ☐ Medicare & Medicaid ☐ Auto Insurance ☐ Personal Injury Insurance ☐ Worker's Compensation

***X-RAYS:*** *Due to state requirements, we must have all original x-ray films in our possession a minimum of seven (7) years. We can provide you with copies, if necessary, at an additional cost.*

**NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (HIPPA)** *Please refer to form on office clipboard.*

**Initials** _____ I acknowledge that I was given the opportunity to read and ask questions regarding the **NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION,** which is effective as of the date signed and will expire six years after that date upon which the record was created.

**CONSENT TO USE HEALTH INFORMATION FOR PAYMENT AND FINANCIAL AGREEMENT**

I authorize Crane Chiropractic Corporation to release any medical information to any insurance company or third-party payer, which may be necessary to process my claim for payment. I understand that regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered. You will be expected to pay co-pays, deductibles, and all self-pay charges the date of service, unless other arrangements are made with the office. All returned check(s) must be paid immediately with a $25.00 cover charge. I also understand and agree to reimburse this office for any and all collection fees, attorney fees, court costs, and filing fees in the event of default to pay the balance.

**X** _____ **DATE** _____
**PATIENT SIGNATURE AUTHORIZING CARE (Guardian, if a minor)**

**CONSENT TO USE HEALTH INFORMATION FOR TREATMENT AND INFORMED CONSENT OF TREATMENT**

**I state that the health history given is correct, to the best of my knowledge. I hereby authorize the doctor to examine and treat mine or my child's condition as he deems appropriate through the use of chiropractic health care, and I give authorization for these procedures to be performed. I agree the doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I hereby authorize Crane Chiropractic Corporation to release to the referring or referred physician, other existing or subsequent healthcare team members, any information including diagnosis and records of treatment, concerning the medical history and care of the patient named above, which may be necessary in mine or my child's treatment.**

**X** _____ **DATE** _____
**PATIENT SIGNATURE AUTHORIZING CARE (Guardian, if a minor)**

Office Personnel Signature: _____