Patient Health History

What Brings You To Our Office?

If you have NO symptoms/complaints and are here for Wellness, please indicate using NONE.

List of Problems/Concerns: (most important first)

1._____ 2. _____

Frequency of MAIN problem	Better	Relieving Factors	
☐ Constant	☐ in the morning	☐ sitting	☐ heat
☐ Frequent	☐ by mid-day	☐ standing	☐ ice
☐ Intermittent	☐ by evening	☐ lying down	☐ massage
☐ Occasional	☐ at night	☐ movement	☐ medication
	☐ doesn't change	☐ stretching	

Quality of Pain	Worse	Aggravating Factors	
☐ dull ache	☐ in the morning	☐ sitting	☐ coughing
☐ sharp	☐ by mid-day	☐ driving	☐ rest
☐ burning	☐ by evening	☐ standing	☐ movement
☐ stiffness	☐ at night	☐ bending	☐ exercise
☐ numb/tingling	☐ doesn't change	☐ lifting	☐ stress
☐ radiating		☐ walking	☐ fatigue
		☐ sleeping	☐ household chores
		☐ work activities	

Have you seen other doctors for this problem? ☐No ☐Yes

If yes, what treatment was received and did it help?_____

No Complaints or Problems? Start Here:

Have you seen a chiropractor before?	When? _____	Do you wear orthotics or arch support?
☐ Yes		☐ Yes
☐ No		☐ No

How would you rate your mattress?	Sleeping position	How many hours do you sleep onaverage?
☐ Great	☐ Side	☐ 6-8 hours
☐ OK	☐ Back	☐ 4-5 hours
☐ Need a better one	☐ Stomach	☐ 2-3 hours
	☐ Change positions	

Caffeine Used	Exercise	Alcohol	Feel Stressed
☐ Often	☐ Often	☐ Often	☐ Often
☐ Occasionally	☐ Occasionally	☐ Occasionally	☐ Occasionally
☐ Never	☐ Never	☐ Never	☐ Never

Average daily water intake:_____oz.

Vitamins/Supplements:

1. _____ 3. _____

2. _____ 4. _____

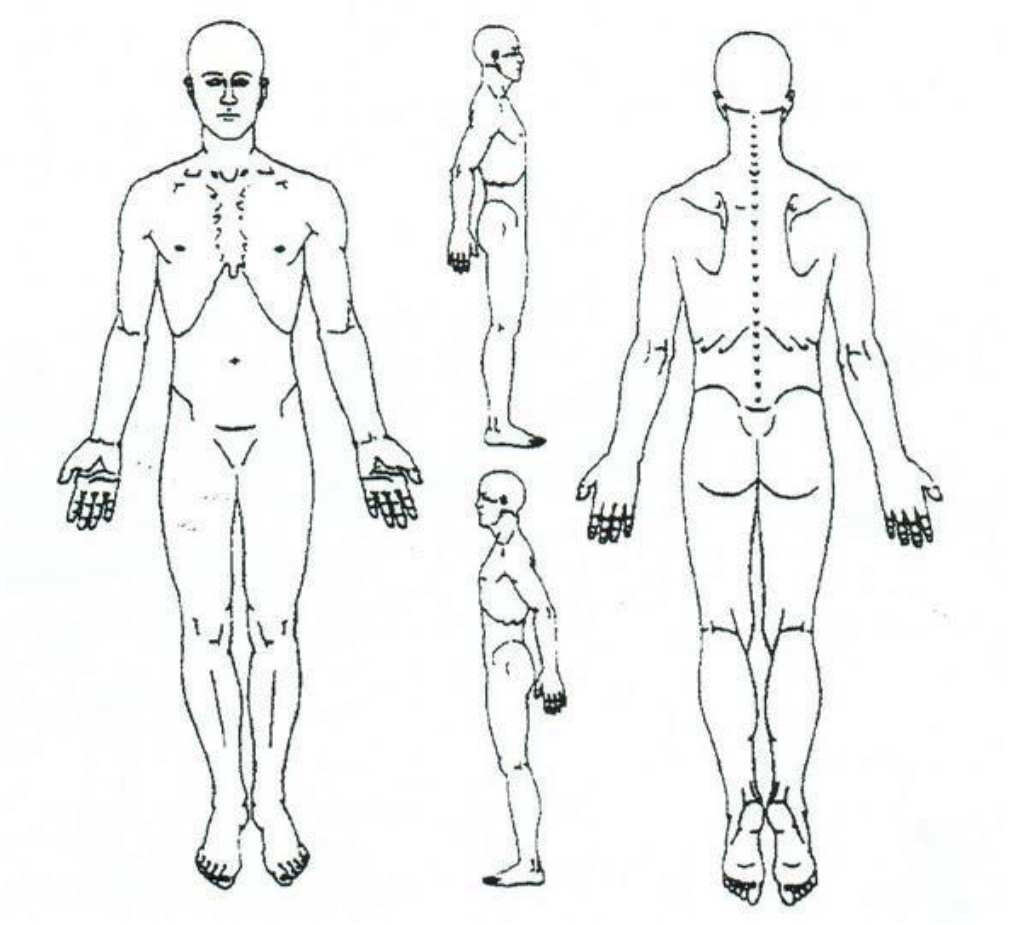
Patient Health History

Please mark areas on the picture below that correspond to the areas of your body where you feel thedescribed sensations. Mark areas of radiation. Include all affected areas.

Use appropriate symbols:

Numbness - - - - - **Pins & Needles ooooo** **Burning xxxxx**

Aching ***** **Stabbing /////**



VISUAL ANALOG PAIN SEVERITY SCALE

Please place a mark on the line that corresponds to your ***current*** pain.

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORSE PAIN EVER

Please place a mark on the line that corresponds to your ***average*** pain

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORSE PAIN EVER

Patient Signature:_____ **Date:**_____

Shapiro Family Chiropractic Center
112 Saundersville Road, Ste. C312
Hendersonville, TN 37075

Patient Health History

Informed Consent

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, in rare cases, complications such as sprain/strain injuries, irritation of adisc condition, and although rare minor fractures, and possible stroke have been associated with chiropractic adjustments.

Patient Signature_____ Date _____

X-Ray Consent

By my signature below I am acknowledging that the doctor and/or a member of the staff has discussedwith me the hazardous effects of ionization to an unborn child, and I have conveyed my understandingof the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination if the doctor has deemed necessary in my case.

Patient Signature_____ Date _____

Office Financial Policy

All services rendered are the responsibility of the patient and said patient is ultimately responsible for all payment on services regardless of whether or not this office accepts insurance assignment. Our officewill prequalify your insurance coverage. We will give you the best estimate of your coverage for the recommended services. This is **not a guarantee of benefits.** Should you discontinue care for any reason, other than discharge by the doctor, any and all balances will become due and payable. If you areon a predetermined payment plan, that plan will continue to be in effect until your balance is zero. Any expenses incurred by this office (collections, court fees, etc.) in the effort to obtain payment on unpaid accounts past 90 days will be added to your balance.

Patient Signature_____ Date _____

Notice of Privacy Practices

The undersigned acknowledges receipt of a copy of the current Notice of Privacy Practices for thishealth care facility. It describes your rights to the limited use of protected health information, including your demographic information.

You have the right to request a restriction or disclosure on the use of your PHI (Protected HealthInformation). This office may or may not agree to your request.

This office utilizes open or common areas for treatment; however, private areas are available upon request. You may refuse to sign this acknowledgement and authorization and revoke this consent touse PHI. This must be done in writing.

I authorize contact from this office to confirm my appointments, treatment, and billing informationby means:

- ☐ Cell phone
- ☐ Home phone
- ☐ Text message
- ☐ Email
- ☐ All of the above

Patient Signature_____ Date _____

Witness

Shapiro Family Chiropractic Center

112 Saundersville Rd. Ste. C312, Hendersonville, TN 37075
Phone (615) 822-5522 Fax (615) 822-7655

Patient Information

(Please Print)

Name_____ **Date**_____ **Soc. Sec.**_____-_____-_____
First MI Last

Address_____ **City**_____ **State**_____ **Zip**_____

Sex: ☐**Female** ☐**Male** **Driver's License #** _____**Birth Date**_____
Home phone #_____ **Work phone #**_____ **Cell Phone: #**_____

Are you: ☐**Minor** ☐**Married** ☐**Divorced** ☐**Widowed** ☐**Single** ☐**Separated**

Your employer_____ **Occupation**_____

Business Address_____ **City**_____ **State**_____ **Zip**_____

Spouse's or parent's name_____ **Workplace**_____ **Work phone #**_____

Email Address: _____

Whom may we thank for referring you to us?_____

Person to contact in case of emergency_____ **Phone #**_____

Responsible Party

Name of person responsible for this account?_____

Relationship to patient_____ **Phone #**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Insurance Information

Name of insured_____ **Relationship to patient**_____

Birth date_____ **Social Security #**_____

Please mark with C for current problem or P for past problem.

__ Headaches	__ Fainting	__ Pins and Needles in legs	__ Neck Pain
__ Pins and Needles in arms	__ Loss of Smell	__ Loss of Balance	__ Back Pain
__ Dizziness	__ Buzzing in Ears	__ Ringing in Ears	__ Nervousness
__ Numbness in fingers	__ Numbness in toes	__ Stomach upset	__ Loss of taste
__ Fatigue	__ Depression	__ Irritability	__ Tension
__ Sleeping problems	__ Neck Stiff	__ Cold hands	__ Cold Feet
__ Diarrhea	__ Constipation	__ Hot Flashes	__ Fever
__ Cold sweats	__ Lights bother eyes	__ Problem urinating	__ Heartburn
__ Mood swings	__ Menstrual pain	__ Menstrual irregularity	__ Ulcers

List any medications you are taking _____
_____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

All fees are payable when services are received unless special arrangements are made in advance.

Patient/Guardian Signature_____ **Date** _____

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Family History:

Please check any diseases or disorders for the following family members:

Mother: __ High Blood Pressure __ Heart Disease __ Mental Disorders __ Diabetes __ Cancer __Alzheimer's __ Alcoholism ___ Currently Living _____ Deceased, Date of death:

Father: __ High Blood Pressure __ Heart Disease __ Mental Disorders __ Diabetes __ Cancer __Alzheimer's __ Alcoholism ___ Currently Living _____ Deceased, Date of death:

Siblings: __ High Blood Pressure __ Heart Disease __ Mental Disorders __ Diabetes __ Cancer __Alzheimer's __ Alcoholism___ Currently Living _____ Deceased, Date of death:

Maternal Grandmother: __ High Blood Pressure __ Heart Disease __ Mental Disorders __ Diabetes __ Cancer __Alzheimer's __ Alcoholism ___ Currently Living _____ Deceased Date of death

Maternal Grandfather: __ High Blood Pressure __ Heart Disease __ Mental Disorders __ Diabetes __ Cancer __Alzheimer's __ Alcoholism___ Currently Living _____ Deceased, Date of death:

Paternal Grandmother: __ High Blood Pressure __ Heart Disease __ Mental Disorders __ Diabetes __ Cancer __Alzheimer's __ Alcoholism___ Currently Living _____ Deceased Date of death

Paternal Grandfather: __ High Blood Pressure __ Heart Disease __ Mental Disorders __ Diabetes __ Cancer __Alzheimer's __ Alcoholism ___ Currently Living _____ Deceased, Date of death:

Patient Name: _____

Reviewed by:

Doctor's Signature :_____Date: _____