

New Patient Health History Form

In order to provide you the best possible chiropractic wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name _____ Date _____ Email _____
Your email will NOT be shared with any 3d parties, and is used for general office announcements and promotions.

Mailing address

Address _____ City _____ State _____ Zip _____
Telephone (work) _____ (home) _____ Referred By _____
Age _____ Birth date _____ Social Security # _____ Number of children _____
Occupation _____ Employer _____
Marital Status _____ Spouse's name _____ Spouse's Occupation _____
Spouse's employer _____ Spouse's health status _____
Emergency contact _____ Phone _____

Current Complaints

Nature of injury: Automobile* Work Other

Please describe _____

Date of injury _____ Date symptoms appeared _____

Have you ever had same condition? No Yes If yes, when? _____

List other practioners seen for this injury/condition _____

Have you ever been under chiropractic care? No Yes

If yes, please describe _____

Insurance Information

Name of party responsible for payment _____ Phone _____

Do you have health insurance? No Yes Name of company _____

** If an auto accident please provide:*

Insurance company name _____ Contact person _____

Phone _____ Claim # _____

Billing Address

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? No Yes

If yes, please describe _____

Date of last physical exam _____ Is there a chance that you are pregnant? No Yes

Have you had X-rays taken? No Yes If yes, where? _____

What medications are you taking and for what conditions (Please list dosage and amounts, etc). _____

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency).

Have you ever:

	No	Yes	Briefly Explain
Broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been in an auto accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had Sprains/Strains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Habits:

	None	Light	Moderate	Heavy		Yes	No
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you experience pain every day?	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do your symptoms interfere with daily life?	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does pain wake you up at night?	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are your symptoms worse during certain times of the day?	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do changes in weather affect your symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear orthotics?	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you take vitamin supplements?	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What activities aggravate your symptoms?		
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Have you ever suffered from:

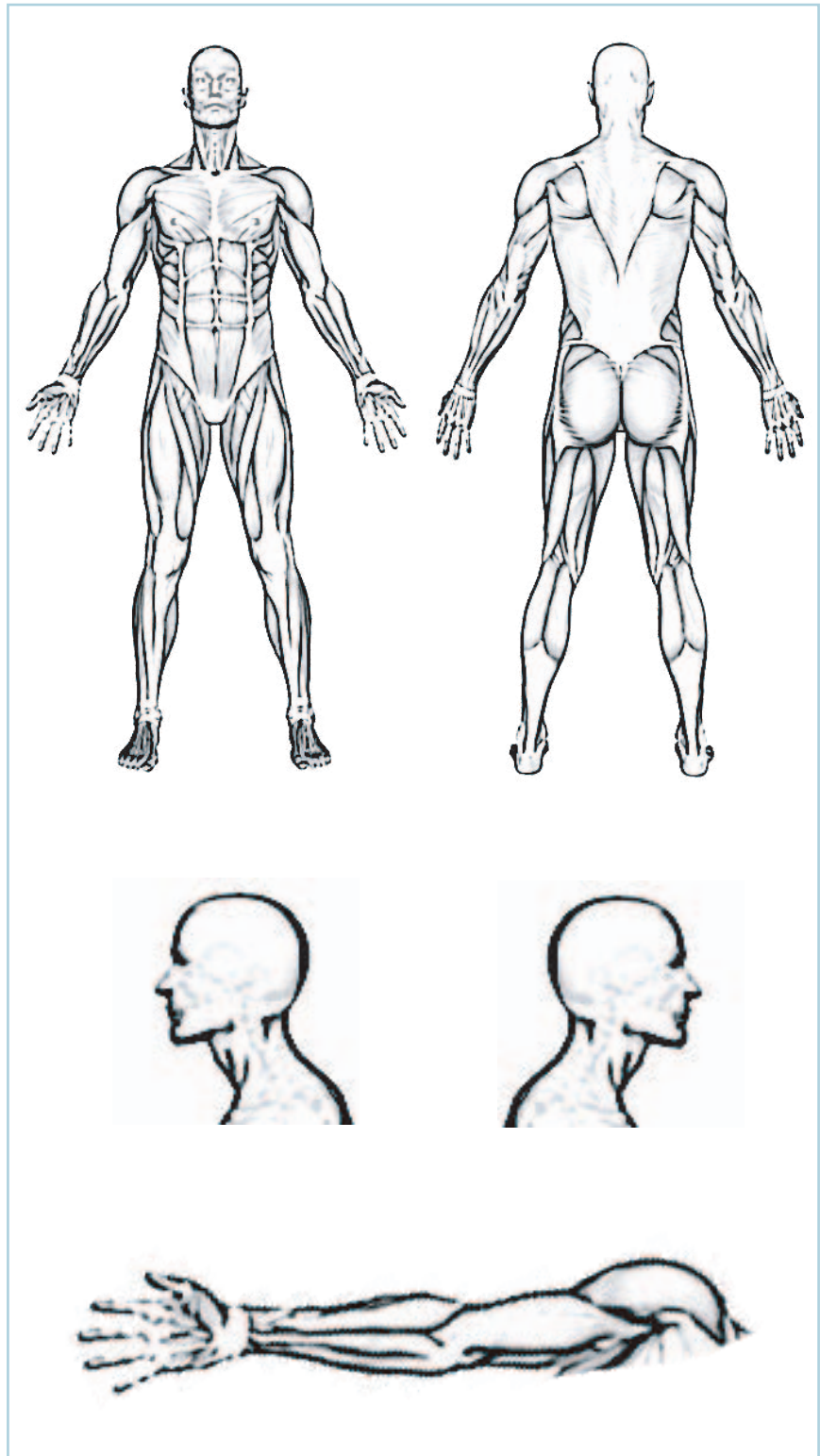
- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain/Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems/insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Current Complaints (Continued)

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
 B=Burning
 N=Numbness

O=Other
 P=Pins & Needles
 S=Stabbing



BAYSIDE CHIROPRACTIC CENTER

1200 Brittan Avenue, San Carlos, CA. 94070

NOTICE OF PRIVACY PRACTICE AND CONSENT FORM

Patients Name: _____

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THESE RIGHTS ARE GIVEN TO YOU UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA). PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Bayside Chiropractic Center, we may use or disclose personal and health related information about you in the following ways:

- ◆ Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- ◆ Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, your employer (if they are or may be responsible for the payment of your bills), or your attorney (if they are or may be responsible for the payment of your bills)
- ◆ Your name, address, phone numbers, and your health care records may be used by this office to contact you by the following means and regarding the following information:

By Mail

(If you would like to receive the following information at an address other than your home address, please advise us in writing)

- ◆ Welcome and Thank You letters to the patients from the Doctor and the Team
- ◆ Discharge and non compliance letters to the patient, from the Doctor and Team
- ◆ Office visit reminder post cards
- ◆ Missed office visit reminder post cards
- ◆ Birthday cards with an offer for a free adjustment
- ◆ Monthly billing statements and reminder letters, if appropriate
- ◆ Newsletters with relevant information and special offers
- ◆ Postcards or flyers regarding special events and / or discounts

By Email

- ◆ Newsletters and notices sent by Bayside Chiropractic Center with relevant health information and special events or offers sent to your email address
- ◆ Information requested by you, the patient, and sent by Bayside Chiropractic Center

By Telephone

- ◆ Reminder calls to your home, office or cell phone from the Doctor or the team where we may leave a message on your answering machine
- ◆ Progress / evaluations calls to your home, office or cell phone from the Doctor or team to inquire about your reaction to treatment and / or your state of health; a message may be left on your answering machine.
- ◆ Inquiry calls may be made to your home, office or cell phone from the Doctor or team regarding billing and accident information, and any other category of information needed to enhance the billing and report process; a message may be left on your answering machine.
- ◆ If you do not wish to be contacted at your work, please advise us in writing

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

