

PAST MEDICAL HISTORY

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

<input type="checkbox"/> Broken or Fractured Bones	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Circulatory Problems
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Pace Maker
<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Strokes	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> A Congenital Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Excessive bleeding	<input type="checkbox"/> Ruptures
<input type="checkbox"/> Depression	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Ulcers

SOCIAL HISTORY

- Do you drink alcoholic beverages: _____ If so, how much per week: _____ Do you smoke _____
- If so, how many packs per day: _____ Do you consume caffeine: _____ If so, how much per day: _____
- Do you exercise: _____ If yes, what is the frequency and type of exercise: _____
- What percentage of time during the day (at home or at your job away from home) do you spend: _____
- Lifting _____ Sitting _____ Bending _____ Working at a computer _____

FAMILY HISTORY

FAMILY DISEASES (Check if applicable and indicate whether family member is Father, Mother, Sister or Brother):

<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Asthma	<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Liver Disease

Other: _____

Please check any and all insurance coverage that may be applicable in this case:

<input type="checkbox"/> Major Medical	<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/> Auto Accident
<input type="checkbox"/> Medical Savings Account & Flex Plans		<input type="checkbox"/> Other		

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all cost of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Financial Agreement Example

I understand I am responsible for all services rendered. I hereby agree that in the event of default in payment of any amount due, and if this account is placed in the hands of a collection agency or attorney, I will pay an additional charge equal to the cost of collection agency fee, and attorney's fee and court cost incurred and permitted by laws covering these transactions.

Date _____