NEW PATIENT HEALTH HISTORY FORM

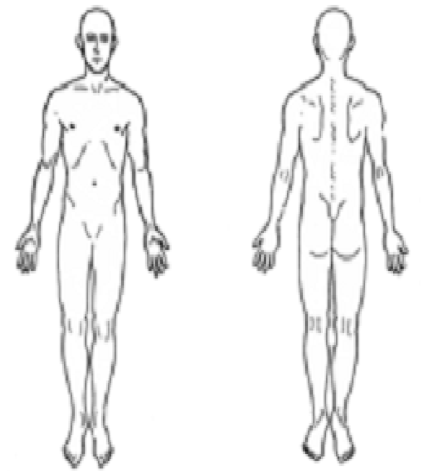
PATIENT DATA

First Name: ___________________ Initial:____ Last Name: ____________________________ Status: ☐ Single ☐ Married
Address: ____ Home Phone: (_____) _______ - __________
City: _____________________________ State: _____ Zip:________________ Cell Phone: (_____) _______ - __________
Birth Date: ___ /___ / ______ Age: ____ Social #: ___________________ Email: ____________________________________
Occupation: _____________________________
Emergency Contact: _________________________________ Phone: (_____) __________________ Relation: ___________________
How did you find our office? ☐ Website ☐ Insurance ☐ Drive By ☐ Referred by: _____________________________________

CURRENT COMPLAINTS

What Brings you in today: ____
When did this start? ____
What is the cause of your pain? ____
IS THIS A: ☐ Auto Accident ☐ Work Injury (Date of onset: __/__/____)
What is your pain level (0-10): _______
Prior Treatment: ☐ Chiropractic ☐ Medical ☐ Physical Therapy
Previous Imaging: ☐ MRI ☐ CT Scan ☐ X-Rays Where:________________
What makes your pain worse? _____________________________________
What reduces your Pain? ____

Mark where you are feeling pain or other symptoms on the diagram:



HEALTH INFORMATION

DO YOU HAVE? ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood pressure ☐ Osteoporosis ☐Stroke ☐ Seizures ☐ Pacemaker
☐ Other medical condition(s): ________________
HAVE YOU HAD A: Hip replacement ☐ R ☐ L Knee replacement ☐ R ☐ L Spinal Surgery: ☐ Lumbar ☐ Cervical
MAJOR SURGERIES in last 5 years: ____
MEDICATIONS: _______________________ _____________________ _________________________ _______________________
_______________________ _____________________ _________________________ _______________________
NUTRITIONAL SUPPLEMENTS: ____
DO YOU SMOKE? ☐ No ☐ Yes **DRINK ALCOHOL?** ☐ No ☐ Yes **DRINK COFFEE?** ☐ No ☐ Yes
ARE YOU PREGNANT? ☐ No ☐ Yes Due Date: ____________ **Number of Children:** ____
DO YOU EXERCISE? ☐ No ☐ Yes (walk, Run: ___ miles/wk, Weights, Cycling, Yoga, Pilates, Swim, Other: ________________)

HEALTH HISTORY

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE LAST 6 MONTHS

☐ Back/neck pain	☐Headaches	☐Lung congestion	☐Weight Loss	☐Diarrhea
☐ Shoulder pain	☐ Dizziness/Vertigo	☐Sore Throat	☐Poor/excessive appetite	☐Constipation
☐ Arm pain	☐ Numbness/tingling	☐Dental problems	☐Nausea/Vomiting	☐Gas/Bloating
☐ Hand pain	☐ Chest Pain	☐ Ankle Swelling	☐Fatigue	☐Black/Bloody stools
☐ Hip pain	☐ Shortness of breath	☐Ear aches	☐Allergies	☐Bladder/Kidney infection
☐ Knee pain	☐ Heart murmur	☐ Depression	☐ Fever	☐Loss of Sleep
☐ Ankle/Foot Pain	☐ Irregular heart beat	☐ fainting	☐ seizures	☐Heart Burn

Signature: ____ Date: _______________

INSURANCE/PAYMENT/CONSENT FORM

PAYMENT / INSURANCE INFORMATION

How will you pay for your treatment? ☐Cash/Credit card ☐ Insurance ☐Medicare ☐Auto ☐Work Comp

Primary Insurance: ________________________________ ID/claim #: ________________________ Group#: ___________

Secondary Ins: ___________________________________ ID#: ______________________________ Group#: ___________

Please read the following statements regarding insurance and collection policies for Restore-U Chiropractic:

1. I understand and agree that my insurance policy is an arrangement between my insurance carrier and myself.
2. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment for all services. Regardless of the results of the services.
3. I understand Copays and outstanding balances are due at the time of service and prior to receiving care.
4. I am responsible to make payments on outstanding balances within 30 days of receipt of a statement, and that late payments will result in the addition of **a late fee of $20 per month** until the balance is brought current. **All accounts over 120 days will be turned over to a collection agency.**
5. I authorize the release of my health and personal information to complete any reports and forms used in collecting from my insurance carrier.

INFORMED CONSENT

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including but not limited to Stroke, Fractures, disc injuries dislocations sprain/strains, bruising and muscle spasm.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise good judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest.

The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

AUTHORIZATION FOR CARE

I hereby request and consent to the performance of Chiropractic treatment including adjustments, recommended therapies and diagnostic x-rays, on me (Or on the patient named below, for whom I am legally responsible), by the doctor of Chiropractic.
I have had the opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and other therapeutic procedures. I understand that results are not guaranteed.

I have read or have had read to me, all the above information. I have had an opportunity to ask questions about its content, and by signing below I agree to and understand fully the insurance and collection policies of Robert Street Chiropractic, the risks related to chiropractic adjustments and I consent to receive chiropractic care or authorize care for the person listed below who I am legally responsible for. I understand this consent form covers the entire course of treatment for the present condition and for any future condition(s) for which treatment is sought.

Patient Name (print): _______________________________ **Signature** ___________________________ **Date**: ___ / ___ / _____

Guardian Name (print): _____________________ Relationship: _____________ **Signature** _______________________________

HIPPA NOTICE

_______ I have received a copy of the HIPPA Notices of privacy practices for Restore-U Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my protected health information Created, received or maintained by this practice.