

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

H. Phone \_\_\_\_\_ W. Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address: \_\_\_\_\_

Sex M F Marital Status M S D W Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Referred by: \_\_\_\_\_

Have you ever received Chiropractic Care? Yes No If yes, when? \_\_\_\_\_

Name of most recent Chiropractor: \_\_\_\_\_

**1. Reasons for seeking chiropractic care:**

Primary reason:  
\_\_\_\_\_

Secondary reason:  
\_\_\_\_\_

**2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. Past Health History:**

**A. Previous illnesses you've had in your life:**

\_\_\_\_\_

**B. Previous Injury or Trauma:**

\_\_\_\_\_

Have you ever broken any bones? Which?

\_\_\_\_\_

**C. Allergies:**

\_\_\_\_\_

**D. Medications:**

Medication	Reason for taking
_____	_____
_____	_____

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**E. Surgeries:**

Date	Type of Surgery

**F. Females/ Pregnancies and outcomes:**

Pregnancies/Date of Delivery	Outcome

**4. Family Health History:**

Associated health problems of relatives:  
\_\_\_\_\_  
\_\_\_\_\_

Deaths in immediate family: Cause of parents or siblings death	Age at death

**5. Social and Occupational History:**

**A. Job description:**  
\_\_\_\_\_

**B. Work schedule:**  
\_\_\_\_\_

**C. Recreational activities:**  
\_\_\_\_\_

**D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):**  
\_\_\_\_\_

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to [doctor's name/clinic name] for services performed.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Patient or Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

**HIPAA NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

**Use and Disclosures of Protected Health Information:**

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

**NEW PATIENT HISTORY FORM**

Symptom 1 \_\_\_\_\_

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
  - Did you have this symptom before this motor vehicle collision? Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):      yes      no

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

- If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Symptom 2 \_\_\_\_\_

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
  - Did you have this symptom before this motor vehicle collision? Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

- If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Symptom 3 \_\_\_\_\_

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
  - Did you have this symptom before this motor vehicle collision? Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

- If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Symptom 4 \_\_\_\_\_

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
  - Did you have this symptom before this motor vehicle collision? Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Symptom 5 \_\_\_\_\_

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
  - Did you have this symptom before this motor vehicle collision? Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging,

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Other (please describe): \_\_\_\_\_

- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Symptom 6 \_\_\_\_\_

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
  - Did you have this symptom before this motor vehicle collision? Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

- Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging,  
Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Duties Under Duress Summary**

Complete the following summary as it relates to your living and work duties and how the injury(s) are affecting your performance. List the day to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision. Include those duties/responsibilities which require that you reduce the time you are capable of performing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your performance.

**Work Reason for the difficulty Duration**

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Job Description: \_\_\_\_\_

- |  |                |       |
|--|----------------|-------|
| <input type="checkbox"/> Lifting         | Increased Pain | _____ |
| <input type="checkbox"/> Bending         | Increased Pain | _____ |
| <input type="checkbox"/> Sitting         | Increased Pain | _____ |
| <input type="checkbox"/> Walking         | Increased Pain | _____ |
| <input type="checkbox"/> Computer Duties | Increased Pain | _____ |
| Other: _____                             | Increased Pain | _____ |

**Studies/School Reason for the difficulty Duration**

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- |  |                |       |
|--|----------------|-------|
| <input type="checkbox"/> Lifting         | Increased Pain | _____ |
| <input type="checkbox"/> Bending         | Increased Pain | _____ |
| <input type="checkbox"/> Sitting         | Increased Pain | _____ |
| <input type="checkbox"/> Walking         | Increased Pain | _____ |
| <input type="checkbox"/> Computer Duties | Increased Pain | _____ |
| <input type="checkbox"/> Studying        | Increased Pain | _____ |
| Other: _____                             | Increased Pain | _____ |

**Domestic Duties Reason for the difficulty Duration**

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- |  |                   |       |
|--|-------------------|-------|
| <input type="checkbox"/> Vacuuming           | Increased Pain    | _____ |
| <input type="checkbox"/> Taking Care of Kids | Increased Anxiety | _____ |
| <input type="checkbox"/> Cleaning            | Increased Pain    | _____ |
| <input type="checkbox"/> Preparing Meals     | Increased Pain    | _____ |
| Other: _____                                 | Increased Pain    | _____ |

**Household Duties Reason for the difficulty Duration**

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- |   |                   |       |
|---|-------------------|-------|
| <input type="checkbox"/> Yardwork         | Increased Pain    | _____ |
| <input type="checkbox"/> Transportation   | Increased Anxiety | _____ |
| <input type="checkbox"/> Shopping         | Increased Pain    | _____ |
| <input type="checkbox"/> Taking Out Trash | Increased Pain    | _____ |
| Other: _____                              | Increased Pain    | _____ |



Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Loss of Enjoyment

Domestic Duties	Reason for the difficulty	Duration
<input type="checkbox"/> Vacuuming	Increased Pain	_____
<input type="checkbox"/> Taking Care of Kids	Increased Anxiety	_____
<input type="checkbox"/> Cleaning	Increased Pain	_____
<input type="checkbox"/> Preparing Meals	Increased Pain	_____
Other: _____	Increased Pain	_____

Household Duties	Reason for the difficulty	Duration
<input type="checkbox"/> Yardwork	Increased Pain	_____
<input type="checkbox"/> Transportation	Increased Anxiety	_____
<input type="checkbox"/> Shopping	Increased Pain	_____
<input type="checkbox"/> Taking Out Trash	Increased Pain	_____
Other: _____	Increased Pain	_____

Sports	Reason for the difficulty	Duration
<input type="checkbox"/> Social	_____	_____
<input type="checkbox"/> Competitive	_____	_____
<input type="checkbox"/> Regional	_____	_____
Other:	_____	_____