**Confidential Patient Health Record** ***Today’s Date*:\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_**

*Whom may we thank for referring you?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Personal Information***

Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_ /\_\_\_\_/\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_ Sex: Male / Female SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single Married Widowed Divorced Separated

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Apt # \_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ ext \_\_\_\_\_\_ Work Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ ext \_\_\_\_\_\_

Cell Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ ext \_\_\_\_\_\_ Fax #: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ ext \_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouses Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact

Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: Spouse Relative Friend Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

***Employment Information***

Business Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation/Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Description \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### SECTION 1 MAIN COMPLAINT/HEALTH CONDITION QUESTIONS

**Main Complaint or 1st Problem area (Where is it located?)**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is your problem the result of ANY type of work related or car accident?** Yes or No  **If YES, date of work injury or car accident?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please describe the onset (how did it this complaint happen?)\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When did this problem begin (DATE THIS BEGAN)?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What have you done since the onset?** Nothing Urgent Care Rest Ice Heat OTC medications RX medications Primary Care Doctor Massage Chiropractic or Physical therapy

**Describe the frequency (Choose one**): □ Constant □Frequent □ Intermittent

**How would you describe the pain (check all that apply):**  □Aching □Burning □Deep □Dull □Pulling □Sharp □Stiff □Shooting □Stabbing □Tight □Numbness □Tingling □Weakness □Other\_\_\_\_\_\_\_\_\_\_

**Does it radiate to any other locations?** Yes or No If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are headaches present?** Yes or No Describe: Tension Sinus Migraine Cluster

**On a scale of 0 to 10 (10 being the worst pain and 0 being no pain) rate your above complaints by circling the number:**

**1st complaint only:** 0 1 2 3 4 5 6 7 8 9 10

**What makes your symptoms BETTER?** Nothing Rest Ice Heat OTC medications RX medications Massage Chiropractic or Physical therapy

**What makes your symptoms WORSE?** Sitting sleeping driving standing walking lifting running any movement

**Have you experienced this condition or any other similar conditions in the PAST?** Yes or No

**If yes, when was the last time**? \_\_\_\_\_\_\_**What treatment did you receive**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By whom**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any RECENT X-Rays, labs or diagnostic testing? Yes or No If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### ACTIVITIES OF DAILY LIVING – PLEASE CHOOSE NO MORE THAN 2 and DESCRIBE HOW LONG YOU CAN PERFORM BEFORE THE SYMPTOMS START

□Sleeping: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□Driving: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□Lifting: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□Standing: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□Sitting: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□OTHER\_\_\_\_\_\_\_\_\_\_ How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

**Do you have a SECOND complaint or health condition which you are now consulting us with? YES or NO, if yes please continue with section 2 if NO skip to REVIEW OF SYSTEMS.**

##### SECTION 2 SECOND COMPLAINT/HEALTH CONDITION QUESTIONS

**2nd Complaint area (Where is it located?)**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is your problem the result of ANY type of work related or car accident?** Yes or No  **If YES, date of work injury or car accident?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please describe the onset (how did it this complaint happen?)\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When did this problem begin (DATE THIS BEGAN)?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What have you done since the onset?** Nothing Urgent Care Rest Ice Heat OTC medications RX medications Primary Care Doctor Massage Chiropractic or Physical therapy

**Describe the frequency (Choose one**): □ Constant □Frequent □ Intermittent

**How would you describe the pain (check all that apply):** □Aching □Burning □Deep □Dull □Pulling □Sharp □Stiff □Shooting □Stabbing □Tight □Numbness □Tingling □Weakness □Other\_\_\_\_\_\_\_\_\_\_

**Does it radiate to any other locations?** Yes or No If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are headaches present?** Yes or No Describe: Tension Sinus Migraine Cluster

**On a scale of 0 to 10 (10 being the worst pain and 0 being no pain) rate your above complaints by circling the number:**

**2nd complaint Pain levels:** 0 1 2 3 4 5 6 7 8 9 10

**What makes your symptoms feel BETTER?** Rest Ice Heat OTC medications RX medications Massage Chiropractic or Physical therapy

**What makes your symptoms feel WORSE?** Sitting sleeping driving standing walking lifting running

**Have you experienced this condition or any other similar conditions in the PAST?** Yes or No

**If yes, when was the last time**? \_\_\_\_\_\_\_**What treatment did you receive**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By whom**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any RECENT xrays, labs or diagnostic testing? Yes or No If yes, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

##### ACTIVITIES OF DAILY LIVING – PLEASE CHOOSE NO MORE THAN 2 and DESCRIBE HOW LONG YOU CAN PERFORM BEFORE THE SYMPTOMS START

□Sleeping: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□Driving: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□Lifting: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□Standing: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□Sitting: How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

□OTHER\_\_\_\_\_\_\_\_\_\_ How long before problem starts? \_\_\_\_\_\_\_\_\_\_\_

##### 3. REVIEW of SYSTEMS: Below is a list of symptoms that may seem unrelated to the purpose of your appointment. These questions must be answered carefully as the problems can affect your overall course of care.

***Musculoskeletal:*  🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **🞎 osteoarthritis** | **🞎 degenerative disc** | **🞎 osteoporosis** | **🞎 joint replacement** | |
| **🞎 osteopenia** | **🞎 Rheumatoid arthr** | **🞎 degenerative disc disease** | |  |

***Neurologic System:* 🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **🞎 dizziness** | **🞎 limb weakness** | **🞎 numbness** | **🞎 slurred speech** | **🞎 tremor** |
| **🞎 facial weakness** | **🞎 loss of consciousness** | **🞎 seizures** | **🞎 anxiety/depression** | **🞎 loss of balance** |
| **🞎 headache** | **🞎 loss of memory** | **🞎 sleep disturbance** | **🞎 strokes** |  |

***Ears, Nose and Throat:* 🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **🞎 bleeding** | **🞎 ear drainage** | **🞎 hearing loss** | **🞎 nosebleeds** | **sore throat** |
| **🞎 dentures** | **🞎 ear pain** | **🞎 history of head injury** | **🞎 postnasal drip** | **tinnitus**  **(ringing in ears)** |
| **🞎 difficulty**  **swallowing** | **🞎 fainting** | **🞎 hoarseness** | **🞎 rhinorrhea**  **(runny nose)** | **TMJ problems** |
| **🞎 discharge** | **🞎 frequent sore throats** | **🞎 loss of sense of smell** | **🞎 sinus infections** |  |
| **🞎 dizziness** | **🞎 headaches/migraine** | **🞎 nasal congestion** | **🞎 snoring** |  |

*Cardiovascular:* 🞎 I DENY having any of the symptoms or problems listed below now or in the past.

|  |  |  |
| --- | --- | --- |
| **🞎 angina (chest pain or discomfort)** | **🞎 high blood pressure** | **🞎 shortness of breath**  **with exertion or exercise** |
| **🞎 chest pain** | **🞎 low blood pressure** | **🞎 swelling of legs** |
| **🞎 claudication (leg pain/ache)** | **🞎 orthopnea (difficulty breathing lying down)** | **🞎 ulcers** |
| **🞎 heart murmur** | **🞎 palpitations** | **🞎 varicose veins** |
| **🞎 heart problems** | **🞎 Pacemaker or Defibrillator** |  |

*Respiration:* 🞎 I DENY having any of the symptoms or problems listed below.

|  |  |  |
| --- | --- | --- |
| **🞎 asthma** | **🞎 coughing up blood** | **🞎 sputum production** |
| **🞎 cough** | **🞎 shortness of breath** | **🞎 wheezing** |
|  |  |  |

***Gastrointestinal:*  🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |
| --- | --- | --- | --- |
| **🞎 constipation** | **🞎 abdominal pain** | **🞎 indigestion/reflux** | **🞎 abnormal stool \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  |  |  |  |
| **🞎 diarrhea** | **🞎 bloating** | **🞎 nausea** | **🞎 abnormal vomiting** |
|  |  |  |  |

***Eyes/Vision:* 🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |
| --- | --- | --- | --- |
| **🞎 blindness** | **🞎 change in vision** | **🞎 field cuts** | **🞎 photophobia** |
| **🞎 blurred vision** | **🞎 double vision** | **🞎 glaucoma** | **🞎 tearing** |
| **🞎 cataracts** | **🞎 eye pain** | **🞎 itching** | **🞎 wear glasses/contacts** |

***Endocrine:* 🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |
| --- | --- | --- | --- |
| **🞎 cold intolerance** | **🞎 excessive hunger** | **🞎 goiter** | **🞎 unusual hair growth** |
| **🞎 diabetes** | **🞎 excessive thirst** | **🞎 hair loss** | **🞎 voice changes** |
| **🞎 excessive appetite** | **🞎 abnormal frequency of urination** | **🞎 heat intolerance** |  |

***Skin:* 🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |
| --- | --- | --- | --- |
| **🞎 changes in nail texture** | **🞎 hair loss** | **🞎 itching** | **🞎 skin lesions / ulcers** |
| **🞎 changes in skin color** | **🞎 hives** | **🞎 paresthesias** | **🞎 varicosities** |
| **🞎 hair growth** | **🞎 history of skin disorders** | **🞎 rash** |  |

***Allergy:* 🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |
| --- | --- | --- | --- |
| **🞎 anaphalaxis** | **🞎 itching** | **🞎 environmental** | **🞎 animals** |
| **🞎 food intolerance** | **🞎 nasal congestion** | **🞎 rash** |  |

***Hematologic:* 🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |
| --- | --- | --- | --- |
| **🞎 anemia** | **🞎 blood clotting** | **🞎 bruising easily** | **🞎 lymph node swelling** |
| **🞎 bleeding** | **🞎 blood transfusion** | **🞎 fatigue** |  |

***Constitutional:*  🞎 I DENY having any of the symptoms or problems listed below now or in the past.**

|  |  |  |  |
| --- | --- | --- | --- |
| **🞎 chills** | **🞎 fatigue** | **🞎 night sweats** | **🞎 weight loss** |
| **🞎 daytime drowsiness** | **🞎 fever** | **🞎 weight gain** |  |

**4. PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.**

***Current Medication (s):*  List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Medication** | | **Dosage** | **For What Condition?** | | | **How long have**  **you been taking this?** | |
|  | |  |  | | |  | |
|  | |  |  | | |  | |
|  | |  |  | | |  | |
|  | |  |  | | |  | |
|  | |  |  | | |  | |
|  |  | | |  |  | |

***Current Illness(es):* LIST all health conditions. CIRCLE all CURRENT conditions.**

|  |  |  |  |
| --- | --- | --- | --- |
| **🞎 ADD/ADHD** | **🞎 cystic kidney disease** | **🞎 hypertension** | **🞎 psychiatric problems** |
| **🞎 Alzheimers** | **🞎 depression** | **🞎 influenzal pneumonia** | **🞎 scoliosis** |
| **🞎 anemia** | **🞎 Diabetes (insulin dep)** | **🞎 liver disease** | **🞎 seizures** |
| **🞎 arthritis** | **🞎 Diabetes (non insulin)** | **🞎 lung disease** | **🞎 shingles** |
| **🞎 asthma** | **🞎 eczema** | **🞎 lupus erythema (discoid)** | **🞎 past history of similar symptoms** |
| **🞎 cancer** | **🞎 emphysema** | **🞎 lupus erythema (systemic)** | **🞎 STD’s (unspecified)** |
| **🞎 Cerebral palsy** | **🞎 eye problems** | **🞎 multiple sclerosis** | **🞎 suicide attempt(s)** |
| **🞎 COPD** | **🞎 fibromyalgia** | **🞎 Parkinson’s disease** | **🞎 thyroid problems** |
| **🞎 Crohn’s/colitis** | **🞎 heart disease** | **🞎 unspecified pleural effusion** | **🞎 vertigo** |
| **🞎 CRPS (RSD)** | **🞎 hepatitis** | **🞎 pneumonia** | **🞎 other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **🞎 CVA (stroke)** | **🞎 HIV** | **🞎 psoriasis** |  |

***Surgery (ies):* LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| |  |  |  | | --- | --- | --- | | **Surgery** | **Date** | **Where was it performed?** | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  |
|  |  |  |  |

***Injury (ies):* Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

|  |  |  |
| --- | --- | --- |
| **🞎 back injury** | **🞎 head injury (loss of consciousness)** | **🞎 motor vehicle accident** |
| **🞎 broken bones** | **🞎 head injury (no loss of consciousness)** | **🞎 soft tissue injury (mild)** |
| **🞎 disability (ies)** | **🞎 industrial accident** | **🞎 soft tissue injury (moderate)** |
| **🞎 fall (severe)** | **🞎 joint injury** | **🞎 soft tissue injury (severe)** |
| **🞎 fracture** | **🞎 laceration (severe)** | **🞎 other:** |

***Family History:* Mark all that apply below. List any specific conditions past or present after has/had:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **general family** | **🞎 alive** | **🞎 deceased** | **🞎 normally developed** | **🞎 no significant disease** | **has/had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **father** | **🞎 alive** | **🞎 deceased** | **🞎 normally developed** | **🞎 no significant disease** | **has/had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **mother** | **🞎 alive** | **🞎 deceased** | **🞎 normally developed** | **🞎 no significant disease** | **has/had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **son (s)** | **🞎 alive** | **🞎 deceased** | **🞎 normally developed** | **🞎 no significant disease** | **has/had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **daughter(s)** | **🞎 alive** | **🞎 deceased** | **🞎 normally developed** | **🞎 no significant disease** | **has/had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **brother(s)** | **🞎 alive** | **🞎 deceased** | **🞎 normally developed** | **🞎 no significant disease** | **has/had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **sister(s)** | **🞎 alive** | **🞎 deceased** | **🞎 normally developed** | **🞎 no significant disease** | **has/had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

***Social History***

**Alcohol: 🞎 Never 🞎 Social Consumption only 🞎 Beer 🞎 Liquor 🞎 Wine ; \_\_\_\_\_ oz \_\_\_\_ glasses; 🞎 Day 🞎 Week 🞎 Month**

**Diet (please mark all that apply): 🞎 High Fat 🞎 High Fiber 🞎 High Protein 🞎 High Salt**

**🞎 Low Calorie 🞎 Low Carb 🞎 Low Fiber 🞎 Low Salt 🞎 Low Sugar**

**Tobacco: 🞎 Deny Tobacco Use 🞎 Do not smoke cigars, cigarettes or pipe 🞎 Live with a smoker 🞎 Quit smoking**

**🞎 Smoke; # \_\_\_\_\_\_\_\_ per 🞎 Day 🞎 Week 🞎 Month 🞎 Chew; #\_\_\_\_\_\_\_\_\_cans per 🞎 Day 🞎 Week 🞎 Year**

**Initials: \_\_\_\_\_\_\_\_ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is separate and distinct healing art from medicine and does not proclaim to cure any named disease.**

**Initials:\_\_\_\_\_\_\_\_\_\_ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

**Initials:\_\_\_\_\_\_\_\_\_\_ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Initials:\_\_\_\_\_\_\_\_\_\_ I grant permission to be called to confirm or reschedule an appointment and to be sent emails or health information to me as an extension of my care in this office.**

**Initials:\_\_\_\_\_\_\_\_\_\_ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

**Initials:\_\_\_\_\_\_\_\_\_\_ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

I acknowledge that I have received the Clinic’s Notice of Privacy Practices for protected health information.

### Patient Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_