

PATIENT INFORMATION			
(Please Print)			
Last Name:		First Name:	
Preferred Name: (if different)		Birthdate:	Sex: M F SSN:
Permanent Address: (street #, city, state, zip)			
Home Phone: [] Preferred		Cell Phone: [] Preferred	
Work Phone:	Email:	Employer Name:	
Are you transferring care from your previous provider? [] Y [] N		Employer Address:	
Primary Care Provider (PCP):		PCP Office/Phone:	
Emergency Contact:		Responsible Party if under 18yrs	
Emergency Contact Phone:		Responsible Party Phone:	
Relationship to Patient:		Relationship:	
GENERAL INFORMATION			
Ethnicity: [] Hispanic/Latino [] Non-Hispanic/Latino [] Other _____	Race: [] Asian [] American Indian/Alaska Native [] Black/African American [] Pacific Islander [] White/Caucasian [] Hispanic [] Other _____	Primary Language: [] English [] Spanish [] Other _____	
OK to leave messages at home? : [] YES [] NO		OK to leave messages on cell? : [] YES [] NO	
OK to leave messages at work? : [] YES [] NO		OK to contact by email? : [] Yes [] NO	
Pharmacy: (Name and Address)		Pharmacy Phone #:	
What is your occupation:		Work Activity: [] Sitting [] Standing [] Light Labor [] Heavy Labor	
How did you hear about our office: [] Newspaper [] Brochure [] Internet [] Friend/Family: Name _____ [] Other _____			

MEDICAL, FAMILY, AND SOCIAL HISTORY

Patient's Full Name:	Date of Birth:	Today's Date:
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Medication Allergies	Medication	Reaction

Current Medications Include vitamins and OTC. (Use back if needed)	Name	Dose (mg, ml...)	Route (oral, topical...)	Frequency (times/day)

Surgical History Please list all surgeries you have had.	Type of Surgery	Date of Surgery

Medical History Have you ever been diagnosed with any of the following:	<input type="checkbox"/> Abnormal Heart Rhythm <input type="checkbox"/> AID/HIV <input type="checkbox"/> Allergies/Hay Fever <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorder/Blood Clot <input type="checkbox"/> Breast Lump <input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Car Accident <input type="checkbox"/> Chicken Pox <input type="checkbox"/> COPD <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Fainting/Dizziness/Vertigo <input type="checkbox"/> Fractures <input type="checkbox"/> Frequent Infections	<input type="checkbox"/> Gallbladder Disease <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter/Thyroid Disease <input type="checkbox"/> Headache/Migraine <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Menstrual Dysfunction <input type="checkbox"/> Measles <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Nervousness/Anxiety <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pacemaker <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Prostate Problem <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Sexually Transmitted Disease <input type="checkbox"/> Sleep Disorder <input type="checkbox"/> Stroke <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Whooping Cough
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Social History	Tobacco Use: [] Yes [] Not currently [] Never	Caffeine: Amount/day _____
	Drug Use: [] Yes [] Never [] Not currently	Exercise: How long/how often _____
	Alcohol Use: [] No [] Yes: Type _____ How Much? _____ How Often? _____	

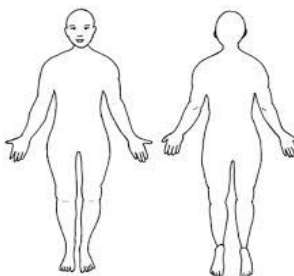
Family History	Father	Mother	Child	Sibling	Grandfather Paternal (P), Maternal (M)	Grandmother Paternal (P), Maternal (M)	Other (Please Specify)
	Heart Disease						
	High Blood Pressure						

Stroke						
Diabetes						
Seizure						
Headaches						
Cancer						
Other (Specify)						

Review of Systems

Patient's Full Name: _____	Date of Birth: _____	Today's Date: _____
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Form Completed By: Patient Parent/Guardian/Other: Name _____ Relation _____

What is your main complaint or reason for visit? _____ When did this start? _____ Are symptoms <input type="checkbox"/> Constant or <input type="checkbox"/> Intermittent? Are symptoms getting Progressively Worse? <input type="checkbox"/> Yes <input type="checkbox"/> No Rate your pain: 1-10 (10 is the worst pain you have ever had): _____	Please mark an X on the diagram at the location of your symptoms. 
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Quality: <input type="checkbox"/> sharp <input type="checkbox"/> dull <input type="checkbox"/> ache <input type="checkbox"/> burning <input type="checkbox"/> tinging <input type="checkbox"/> throbbing	Does your pain radiate? <input type="checkbox"/> YES <input type="checkbox"/> NO
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Are your symptoms related to an injury? <input type="checkbox"/> YES <input type="checkbox"/> NO	Symptoms related to work/auto accident? <input type="checkbox"/> YES <input type="checkbox"/> NO
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Have you used anything to relieve your symptoms? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, what have you tried? _____	Did this help? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Temporarily
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Indicate what activities make symptoms worse: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Bending <input type="checkbox"/> Lying Down	Symptoms interfere with: <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily Routine <input type="checkbox"/> Recreation
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PLEASE MARK THE BELOW SYMPTOMS THAT YOU ARE CURRENTLY EXPERIENCING

<p style="text-align: center;">CONSTITUTIONAL</p> Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Chills/Sweats <input type="checkbox"/> Yes <input type="checkbox"/> No Fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No Weight gain/loss <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Sleeping <input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center;">CHILDREN-BABIES ONLY</p> Decreased Activity <input type="checkbox"/> Yes <input type="checkbox"/> No Inconsolable/Fussy <input type="checkbox"/> Yes <input type="checkbox"/> No Increased Crying <input type="checkbox"/> Yes <input type="checkbox"/> No Drinking/Eating Less <input type="checkbox"/> Yes <input type="checkbox"/> No Pulling at Ears <input type="checkbox"/> Yes <input type="checkbox"/> No Diaper Rash <input type="checkbox"/> Yes <input type="checkbox"/> No Attends Daycare <input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center;">EYES</p> Eye Pain <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to Light <input type="checkbox"/> Yes <input type="checkbox"/> No Redness <input type="checkbox"/> Yes <input type="checkbox"/> No Vision Changes <input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center;">EARS-NOSE-THROAT-MOUTH</p> Sore Throat <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal Congestion <input type="checkbox"/> Yes <input type="checkbox"/> No Runny Nose <input type="checkbox"/> Yes <input type="checkbox"/> No	<p style="text-align: center;">CARDIOVASCULAR</p> Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No Palpitations <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Racing <input type="checkbox"/> Yes <input type="checkbox"/> No Leg Swelling <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Breathing <input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center;">SKIN-HAIR-NAILS</p> Rash <input type="checkbox"/> Yes <input type="checkbox"/> No Skin Redness <input type="checkbox"/> Yes <input type="checkbox"/> No Cold Feet/Hands <input type="checkbox"/> Yes <input type="checkbox"/> No Itching <input type="checkbox"/> Yes <input type="checkbox"/> No Cut, bumps, bruise <input type="checkbox"/> Yes <input type="checkbox"/> No Finger or Toe Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center;">GENITOURINARY/GYN</p> Pain/Pressure/Discomfort with Urination <input type="checkbox"/> Yes <input type="checkbox"/> No Blood in Urine <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Pain <input type="checkbox"/> Yes <input type="checkbox"/> No Vaginal Discharge <input type="checkbox"/> Yes <input type="checkbox"/> No Penile Discharge <input type="checkbox"/> Yes <input type="checkbox"/> No Female Only: Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No Breast Feeding <input type="checkbox"/> Yes <input type="checkbox"/> No	<p style="text-align: center;">GASTROINTESTINAL</p> Abdominal Pain <input type="checkbox"/> Yes <input type="checkbox"/> No Indigestion/Reflux <input type="checkbox"/> Yes <input type="checkbox"/> No Nausea <input type="checkbox"/> Yes <input type="checkbox"/> No Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No Constipation <input type="checkbox"/> Yes <input type="checkbox"/> No Black/Bloody Stool <input type="checkbox"/> Yes <input type="checkbox"/> No Hemorrhoid <input type="checkbox"/> Yes <input type="checkbox"/> No Rectal Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center;">MUSCULOSKELETAL</p> Back Pain <input type="checkbox"/> Yes <input type="checkbox"/> No Neck Pain <input type="checkbox"/> Yes <input type="checkbox"/> No Muscle Ache <input type="checkbox"/> Yes <input type="checkbox"/> No Bone Pain <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Pain <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Swelling <input type="checkbox"/> Yes <input type="checkbox"/> No Extremity Swelling/Pain <input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center;">HEMATOLOGY-ENDOCRINE</p> Easy Bruising <input type="checkbox"/> Yes <input type="checkbox"/> No Prolonged Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No Swollen Glands <input type="checkbox"/> Yes <input type="checkbox"/> No Excessive Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No
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Ear Pain/Ache <input type="checkbox"/> Yes <input type="checkbox"/> No Foreign Body in Nose <input type="checkbox"/> Yes <input type="checkbox"/> No Tooth Pain <input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center;">RESPIRATORY</p> Cough <input type="checkbox"/> Yes <input type="checkbox"/> No *With sputum? <input type="checkbox"/> With Blood? <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No Wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No Pain with cough/breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Method of Birth Control: _____ Last Menstrual Period: _____ <p style="text-align: center;">NEUROLOGICAL</p> Headache <input type="checkbox"/> Yes <input type="checkbox"/> No Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No Loss of Consciousness <input type="checkbox"/> Yes <input type="checkbox"/> No Numbness/Tingling <input type="checkbox"/> Yes <input type="checkbox"/> No Seizure <input type="checkbox"/> Yes <input type="checkbox"/> No Weakness <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Hunger <input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center;">PSYCHOLOGIC</p> Sadness <input type="checkbox"/> Yes <input type="checkbox"/> No Depression <input type="checkbox"/> Yes <input type="checkbox"/> No Anxiety/Nervousness <input type="checkbox"/> Yes <input type="checkbox"/> No Irritability <input type="checkbox"/> Yes <input type="checkbox"/> No Mood Swings <input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center;">OTHER</p> Please Specify: _____
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Patient Consent Form

NOTICE OF PRIVACY POLICY HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) ACKNOWLEDGEMENT

By signing below, you consent to the use of your Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. You consent that Preferred Care Medical Center, LTD. (PCMC) can use and disclose medical information to treat you and to seek payment from third parties for this treatment. You also consent to disclosure of PHI to insurers and providers outside of PCMC, when necessary, so that these insurers and/or providers may treat you, seek payment for that treatment, and so that they can perform their health care operations. You may refuse all or part of this consent. If you refuse the use of your medical information for use of payment from your insurance company, you will be responsible for your bills. This consent will be valid for the entire duration of treatment by PCMC unless you request that consent be revoked.

Initials: _____

FINANCIAL RESPONSIBILITY

By signing below, you agree to pay PCMC accounts on yourself and/or your dependent(s) for the services rendered when they are presented to you. If you have medical insurance on yourself and/or your dependent(s), you authorize those benefits to be paid directly to PCMC. **All co-payments to will be paid to the receptionist prior to your appointment.** My signature states that I understand that I am responsible for any balance that the insurance company does not cover.

Initials: _____

INSURANCE RELEASE OF INFORMATION

By signing below, you authorize PCMC to release any medical information that may be necessary for processing your insurance claim to your insurance company. You further assign any benefits payable on your behalf to PCMC. You are financially responsible for any balance not covered by your insurance carrier.

Initials: _____

PERMISSION TO COMMUNICATE WITH YOUR PRIMARY CARE PHYSICIAN AND/OR ANY OTHER CARE PROVIDERS

My signature below authorizes PCMC to release confidential information in my healthcare records to my primary care provider (PCP) or other healthcare provider. This information includes, but is not limited to, progress notes, history & physical, radiology, lab, medication consultation reports, and ECG. I authorize history of illness and diagnostic/therapeutic information, including any dependency, HIV, AIDS, and/or other communicable diseases.

Initials: _____

Release Private Health Information to:

PCP: _____ Phone: _____ Fax: _____
 Employer: _____ Phone: _____ Fax: _____
 Patient: _____ Phone: _____ Fax: _____
 Guardian: _____ Phone: _____ Fax: _____

CONSENT FOR MEDICAL CARE

Office Use Only: Reviewed by _____ Date _____

Pain/Chiro



By signing below, you grant permission to the physicians, nurse practitioners, and employees of PCMC to do such procedures as may be necessary to diagnose, treat, and care for the needs of medical or mental health conditions, and/or the routine care of yourself or your dependent.

Patient Signature (or person authorized to sign for patient) _____

Relationship to Patient _____ [] self **Date** _____

Authorized Staff Signature _____ **Date** _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether sig\natories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes , dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient/or Guardian: _____

Doctor of Chiropractic Name: _____

Signature of Doctor of Chiropractic: _____

Date: _____