

# Medical History Information

First Name:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		Marital status (circle one) Mar / Single / W / D / Sep Spouse Name:	
Last Name:							
Email:			Birth date:		Age:	Sex:	
Address:			City:		State:		
ZIP Code:		Social Security No.:		Home Phone:			
Occupation:		Employer:			Employer phone:		
<b>Medical Care Information:</b>							
Do You Have a Family Doctor?:		<input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Doctor:					
Address:			City:		State:	ZIP Code:	
Date of last Visit:    /    /			Date of last exam:    /    /				
Do You Have a Family Chiropractor?:		<input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Chiropractor:					
Address:			City:		State:	ZIP Code:	
Date of last Visit:    /    /			Date of last exam:    /    /				
Have you had surgeries in the last 5 Years:		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes; Last Surgery Date:			
Reason for Surgery:							
<b>Present illness / Conditions:</b>							
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Epilepsy		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Tuberculosis		<input type="checkbox"/>	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Ulcer		<input type="checkbox"/>	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Polio		<input type="checkbox"/>	
<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> STD'S		<input type="checkbox"/>	
Other:							
<b>Family History of illness:</b>							
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	<input type="checkbox"/> STD'S			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Ulcer		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Polio	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Scoliosis		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis		<input type="checkbox"/> Diverticulitis	
Other:							
<b>Type of Cancer:</b>		<input type="checkbox"/> Breast		<input type="checkbox"/> Lung		<input type="checkbox"/> Other:	
<b>Social History:</b>							
Alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes		Cigarettes? <input type="checkbox"/> No <input type="checkbox"/> Yes		Caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes		Exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Drinks per week?		Packs per day?		Drinks per day?		Hours per week? (circle one) Light / Moderate / Strenuous	
Misc.:							

Signature: \_\_\_\_\_

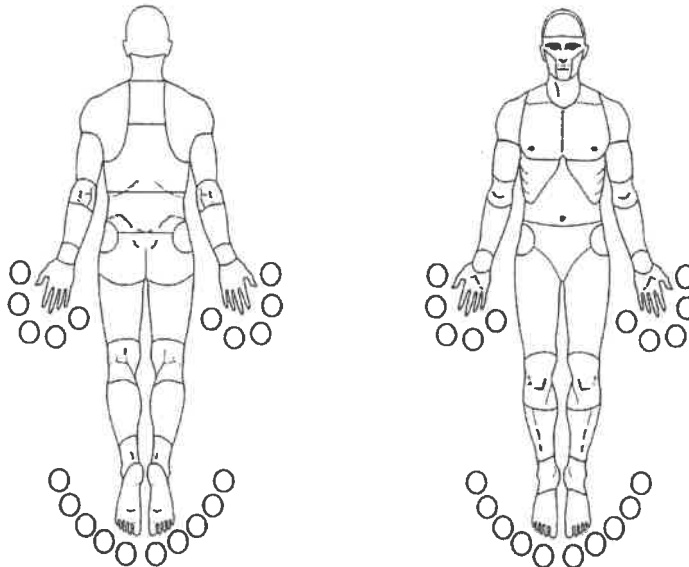
Date: \_\_\_\_\_

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

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

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

Please mark below where you currently or in the past have had problems (pain):



<b>What is your current pain complaint?</b>	(Complaint #1) _____ <ul style="list-style-type: none"> <li>• Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center</li> </ul>
Rate your pain	• 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
How often is this pain?	<ul style="list-style-type: none"> <li>• Infrequent &lt; 25% <input type="checkbox"/> Occasional 25% to 50%</li> <li>• Frequent 50% to 75% <input type="checkbox"/> Constant &gt; 75%</li> </ul>
Pain Type: check all that apply	<ul style="list-style-type: none"> <li>• No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling</li> <li>• Muscle Spasms <input type="checkbox"/> Burning</li> </ul>

<b>Where else do you experience pain?</b>	(Complaint #2) _____ <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center
Rate your pain	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
How often is this pain?	<ul style="list-style-type: none"> <li>• Infrequent &lt; 25% <input type="checkbox"/> Occasional 25% to 50%</li> <li>• Frequent 50% to 75% <input type="checkbox"/> Constant &gt; 75%</li> </ul>
Pain Type: check all that apply	<ul style="list-style-type: none"> <li>• No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling</li> <li>• Muscle Spasms <input type="checkbox"/> Burning</li> </ul>

	(Complaint #3) _____ <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center
Rate your pain	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
How often is this pain?	<ul style="list-style-type: none"> <li>• Infrequent &lt; 25% <input type="checkbox"/> Occasional 25% to 50%</li> <li>• Frequent 50% to 75% <input type="checkbox"/> Constant &gt; 75%</li> </ul>
Pain Type: check all that apply	<ul style="list-style-type: none"> <li>• No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling</li> <li>• Muscle Spasms <input type="checkbox"/> Burning</li> </ul>

**Patient Acknowledgement and Receipt of  
Notice of Privacy Practice Pursuant to HIPAA and Consent  
For Use of Health Information**

Name \_\_\_\_\_  
Print Patient's Name

Date \_\_\_\_\_

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal law.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

By \_\_\_\_\_  
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By \_\_\_\_\_  
Signature of Parent/Guardian (circle one)

## **AUTHORIZATION AND RELEASE:**

I authorize payment of insurance benefits directly to the chiropractor or chiropractor's office (Robert J. Crandall, Jr., D.C. and/or Beatrice Family Chiropractic, P.C.). I authorize the doctor to release all information necessary to communicate with personal physicians and providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of 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 you would like to have more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **INFORMED CONSENT:**

When a patient seeks chiropractic health care and we accept the patient for such care, it's essential to be working towards the same objective. Chiropractic has one goal. It's important that each patient understand that objective and method that will be used to attain it. This will prevent confusion or disappointment. We don't offer to treat or diagnose any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed to others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_ have read & fully understand the above statements.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SEE REVERSE SIDE FOR HIPPA INFORMATION AND APPROVAL SIGNATURE:**