Patient Name: _____

File # (*Office Use Only*): _____

Date: _____

Patient Information

Name_____ Address_____

DOB _____ SSN_____ City, State, Zip _____

Home Phone_____ Cell Phone_____

Male☐ Female☐ / Single ☐ Married☐ Divorced☐ Email Address _____

Name of Spouse (or Parent if under 18) _____ # of Children _____

How did you hear about our office? _____

Employer_____ Occupation_____

Address_____ Work Phone_____

City, State, Zip_____

Name of family physician_____ Location (city) _____

Have you ever had Chiropractic care before? _____ If yes, doctor name _____

Date of last visit _____ How many visits this year? _____

If you are experiencing any pain (neck pain, mid back pain, low back pain, etc.), health problems, symptoms, and/or complaints, please list in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____

Has this problem been getting worse or staying the same? _____

	Yes	No
Currently or in the past have you ever experienced any of these complaints while working?.....	☐	☐
If yes, please explain_____		
Are there any activities or incidents outside of work that may have caused these complaints?.....	☐	☐
If yes, please explain_____		
Have you at any time in the past ever suffered a work injury?.....	☐	☐
If yes, what is the date of injury? _____		
Do you have an attorney representing you for this work injury?.....	☐	☐
If yes, who is your attorney? _____		
Have you been involved in an auto accident in the last 12 months?.....	☐	☐
If yes, what is the date of the auto accident? _____		
Have you ever had any surgeries of hospitalizations?.....	☐	☐
If yes, please list _____		

Please list any current or past injuries and illnesses not listed above _____

Please check all medications (over the counter and/or prescribed) you are currently taking:

☐ Aspirin/Tylenol ☐ Pain Killers ☐ Muscle Relaxers ☐ Insulin ☐ Birth Control Pills

☐ Sleeping Pills ☐ Anti-Depressants ☐ Others _____

Please list FAMILY HISTORY of illness/disease: _____

_____

_____

Patient Name: _____

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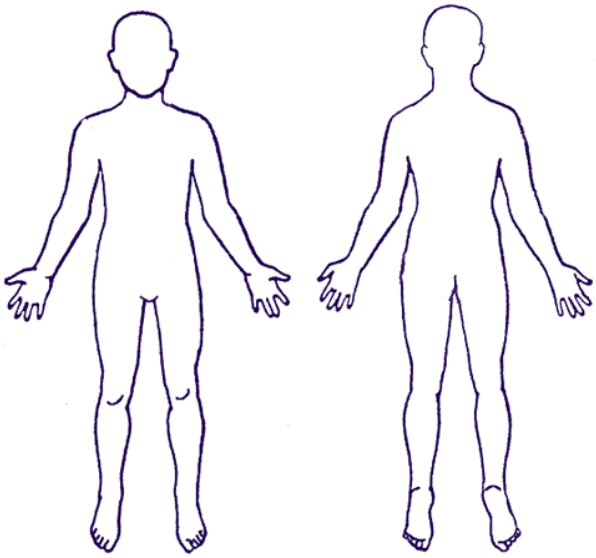
Date: _____

If you are experiencing any health problems:

- Please mark the exact location of your pain on the diagram below.
- Describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking, etc.

COMPLETE THESE DIAGRAMS



Front Back

Please indicate your pain levels (1 = lowest, 10= highest):

On Average:	1	2	3	4	5	6	7	8	9	10
At Its Worst:	1	2	3	4	5	6	7	8	9	10

Patient Name: _____

File # (*Office Use Only*): _____

Date: _____

Consent to Treatment

I wish to receive examinations and treatment at Elite Chiropractic. The diagnoses and methods of treatment have been explained to me.

I understand that individuals respond differently to treatment and there are no guarantees of the result of any treatment. I understand the examination and treatment involves certain risks and those risks have been explained or provided to me.

I therefore authorize examination and treatment to be performed by the staff at Elite Chiropractic.

Patient Name _____

If the patient is unable to consent for the following reason(s):

☐ Under 18 years of age ☐ Other: _____

Parent/Guardian Name _____

Patient/Guardian Signature _____ **Date** _____

HIPAA
Consent for Purposes of Treatment, Payment & Healthcare Operations

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me, and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have rights prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor.

Patient/Guardian Signature _____ **Date** _____