PATIENT INFORMATION

General Information

First Name _____
Called Name _____
Middle Initial _____
Last Name _____

Address _____
City _____
State _____
Zip Code _____

Cell Phone _____
Other Phone _____
Email Address _____

Birthdate _____
Sex Male Female
Marital Status Single Married Other _____

Appt Reminder None Phone Call Text E-mail
Referred By _____

Have you ever been to a Chiropractor? Yes No
If yes, which clinic _____
If yes, when was your last appointment? _____
Did you have x-rays there? Yes No Did you have a good experience? Yes No

For Office Use Only

Account Number _____
Diagnosis Codes _____
Charges _____

Insured's Information

Patient is the: Same/Self Spouse Child Other
Please present your insurance card.

Employer Information

Employer Name: _____
Work Status: Employed – full time / part time
Student – full time / part time

Condition Information

Related to Auto Accident? Yes No
Related to Personal Injury? Yes No
Related to Employment? Yes No

Pain Information

Where do you hurt? _____When did it start?_____
How did it happen?_____
What makes it feel better?_____ Worse?_____
Frequency of pain: Constant-100% of time Frequent-75% of time
Intermittant-50% of time Occasional-25% of time
What type of pain is it? Achy Sharp Dull Burning Shooting Throbbing Numb Tingling Other

List symptoms individually:	Choose the severity level associated with each:
_____	❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Severe
_____	❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Severe
_____	❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Severe
_____	❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Severe

Treatment Information

List any tests, studies or medications received for this condition:

❑X-ray/MRI: _____

❑Medications: _____

Where you admitted to the hospital due to this condition: ❑Yes ❑No

If yes, what hospital? _____Transported by? ❑Ambulance ❑Police ❑Other:_____

Date Admitted: _____ Date Released: _____ Length of Stay: _____

List the hospital procedures received:

Health Information

HABITS

□Current Everyday Smoker □Current Some Day Smoker

□Former Smoker □Never Smoker

□Alcohol Bottles or Cans/Day: _____ □Coffee Cups/Day: _____

□Soft Drink Bottles or Cans/Day: _____ □Water Cups/Day: _____

EXERCISE

□Sedentary

□Moderate

□Daily

□Athlete

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	□	□	□	□
Father	□	□	□	□
Sibling(s)	□	□	□	□

MEDICATION

Are you taking any medications (prescription or over-the-counter)? □Yes □No

Medication: _____ Medication: _____

Began: _____ Frequency: _____ Began: _____ Frequency: _____

SURGERY

Have you ever had any spinal surgeries? □Yes □No (If yes, please enter the type and date of surgery.)

Date: _____ Date: _____

Type of Surgery: _____ Type of Surgery: _____

SYMPTOMS

GENERAL
- ❑ Allergic to: _____
- ❑ Convulsions/Epilepsy
- ❑ Headache
- ❑ Dizziness
- ❑ Fainting
- ❑ Numbness or pain extremities

MUSCLES & JOINTS
- ❑ Backaches
- ❑ Spinal curvature
- ❑ Stiff neck
- ❑ Pain between shoulders
- ❑ Painful tail bone
- ❑ Foot trouble

CARDIOVASCULAR
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Rapid heart rate
- ❑ Slow heart rate
- ❑ Heart trouble
- ❑ Chest pain

Patient's/Guardian's Signature: _____ **Date:** _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

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

INFORMED CONSENT

I understand the nature and purpose of chiropractic care, the possible consequences of the care, and the risks of the care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each, and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

AUTHORIZATION FOR CHIROPRACTIC CARE

I have read the provided paragraphs, and I understand the information provided and all questions which I have asked have been answered to my satisfaction.

HAVING THIS KNOWLEDGE, I KNOWINGLY ACCEPT HIPPA PRIVACY & AUTHORIZE: DR. DAVID D. WOLF TO PROVIDE CHIROPRACTIC CARE AND TREATMENT.

Today's Date _____

Print Patient's Name _____

_____ OR _____

Patient's Signature | Parent or Guardian's Signature