PATIENT RECORD

Name: (first, middle initial, last):_____ **Date:** _____

Address: _____ **City**_____ **State**_____ **Zip**_____

E-Mail Address_____

Date of Birth: _____ **Age:** _____ **Sex:** ☐ **Male** ☐ **Female** **No. of Children**_____

Social Security Number: _____ **Marital Status:** ☐ M ☐ S ☐ W ☐ D

Home Phone: ( ) _____ **Cell Phone: ( )** _____

Work Phone: ( ) _____ **May we call you at work?** ☐ **Yes** ☐ **No**

Employer: _____ **Job Title:** _____

Spouse's Name: _____ **Spouse's Employer:** _____

Contact Person in Case of Emergency: _____ **Phone #:**_____

How did you hear about our office? _____

Primary Insurance Company: _____ **Id#:** _____

Name of Insured: _____ **Name of Employer of Insured:** _____

Secondary or Supplemental Insurance Company: _____ **Id#:** _____

Patient Privacy and Financial Agreement

With my consent, Schroeder Chiropractic, may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Schroeder Chiropractic may call my home or office and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out (TPO) such as appointment reminders, insurance items, and any call pertaining to your clinical care, including laboratory results among others. Schroeder Chiropractic may mail to my home or office any items that assist the practice in carrying out (TPO) such as appointment reminder cards and patient billing statements. I have the right to request that Schroeder Chiropractic restrict how they use or disclose my (PHI) to carry out (TPO). However, Schroeder Chiropractic is not required to agree to my requested restrictions, but if Schroeder Chiropractic does, then they are bound by our agreement. By signing this form, I am consenting to Schroeder Chiropractic to use and to disclose my (PHI) to carry out (TPO). This consent may be revoked in writing except to the extent that Schroeder Chiropractic has already made disclosures in reliance upon my prior consent. If I decline to sign this consent, Schroeder Chiropractic may decline to provide treatment to my self/child/children.

I also understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports or forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the convenience of credit to my account. However, I understand and agree that all services rendered to me are charged directly to me and that I am ultimately responsible for payment of such services.

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

Parent or Guardian's Signature: _____ **Date:** _____

PATIENT HISTORY

Name: _____ **Date:** _____

What is your primary complaint(s) or problem? _____

What is the cause of your complaint? ☐ Auto Accident ☐ Work Injury

☐ Other (Describe) _____

Please briefly describe how and when your problem started? _____

_____

_____

On a scale of 0 to 10, with 0 representing no pain whatsoever and 10 the most severe pain imaginable, circle the appropriate number on the scale below for your primary complaint.

How would you rate your pain <u>right now</u>?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
How would you rate your pain on average in the past 24 hours?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Since your pain started, how would you rate your worst pain level?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Is this your first episode of this complaint? ☐ Yes ☐ No

Your primary complaint is? ☐ Improving ☐ Getting Worse ☐ Staying the Same

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1. Have you ever been diagnosed as having a particular condition or disease, such as diabetes, cancer, fibromyalgia, rheumatoid arthritis, ect.? _____

2. Do you smoke? ☐ No ☐ Yes

3. Are you losing weight without trying? ☐ No ☐ Yes

4. List any diseases or conditions that are common among your family members. _____

_____

5. List all <u>major</u> surgeries and their approximate dates.

_____

_____

6. List all <u>prescription medications</u> that you are currently taking. _____

_____

_____

7. List all the <u>over the counter medications</u> and <u>vitamins/supplements</u> that you are currently taking. _____

_____

<u>Females Only</u>

8. Is there any chance that you are pregnant? ☐ No ☐ Yes _____

9. Have you ever taken birth control pills? ☐ No ☐ Yes **For how long?** _____

10. Who is your Medical Doctor? _____

In the space below, please explain or give additional details regarding any important information about your health history that was not requested above. _____

_____

Patient Consent for Use and Disclosures of Protected Health Information

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With my consent, Schroeder Chiropractic may call my home or office and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out (TPO) such as appointment reminders, insurance items, and any call pertaining to your clinical care, including laboratory results among others.

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_____ _____

Signature of Patient/Parent or Legal Guardian Date

_____

Print Name of Patient/Parent or Legal Guardian