Welcome to Concise Chiropractic!

Last _____ First _____

Birth Date _____Age _____ Gender: Male_____ Female_____

Address _____

City_____ State_____ Zip _____

Phone (C/H) _____ (W) _____

Email _____

Occupation_____Employer_____

Spouse's Name _____ How many children?_____, ages?_____

What is your preferred method of communication? Email___ Phone___ Text___

Have you had previous Chiropractic care? Yes ___ Never___ , if so when was your last adjustment?

_____ Have you had any imaging (x ray, CT, MRI) _____

Who may we thank for referring you to our office? _____ Referral_____

Internet_____ Signage_____ Event/marketing_____Other_____

Are you Medicare Eligible (65+ or on Medicare Disability) ○ Yes ○ No ○ Not Sure

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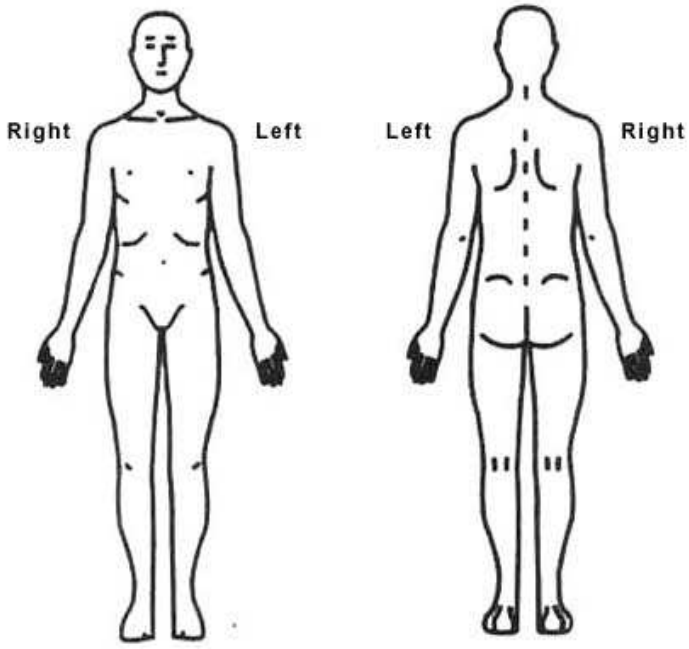
WHAT BRINGS YOU TO OUR OFFICE? Please be as concise and accurate as possible.
Have you had maintenance chiropractic care before?_____
Any Physical Complaints: _____Date when symptom first appeared_____
How Did it begin:_____
Have you had episodes in this area in the past? ○ No ○ Yes, if so when? _____
How often do you experience these symptoms? ○ Constant 100% ○ Frequent 75% ○ Intermittent 50%
○ Occasional 25% ○ Rare10% Have you ever experienced the same or similar symptoms? ○ yes ○ no
When? _____
Have you been to another doctor/provider for this problem? ○ No ○ Yes, if so Who/Where/When?
_____
Type of Pain: ○ Sharp ○ Dull ○ Ache ○ Burn ○ Throb ○ Other _____
Do you have Numbness or Tingling? ○ yes ○ no Where? _____
Does the Pain Radiate into: ○ Arm ○ Hand ○ Leg ○ Foot ○Fingers/Toes ○Other_____
What makes the symptoms increase? _____
What relieves the symptoms? _____
Drugs you now take (Rx or non-prescription):_____
Are you possibly pregnant? ○ No ○ Yes, due date or how many weeks? _____
Are you experiencing any of the following? ○ Double vision ○ Numbness on one side of the face or body
○ Fainting or lightheadedness ○ Dizziness ○ Difficulty Walking ○ Difficulty Speaking ○ Vomiting
○ Headache or neck pain like you have never had before ○ Difficulty swallowing

Have You had any surgeries, if so when? _____
Have you been in a car or work accident? _____
Ever been hospitalized? _____



Please use the figures to the left to illustrate any current areas of discomfort, loss of range of motion or pain. Use the scale below to describe and rate.

Problems with? Rate 1-10	**Feels like? Frequency?**
Headaches/Migraine	
Neck Pain	
Arms/Shoulder	
Upper Back	
Mid Back	
Lower Back	
Hips	
Sciatica	
Legs	
Elbows	
Knees	
Wrists/Hands	

Past History:

○ Headaches/Migraines ○ Neck Pain ○ Shoulder Pain ○ Mid/Upper Back Pain ○ Low Back Pain
○ Hip/Pelvic Pain ○ Sciatica ○ Elbow/Wrist Pain ○ Knee/Ankle Pain ○ Other Serious Injuries
○ Arthritis ○ Herniated Disc ○ Joint Replacements ○ Osteoporosis/Osteopenia ○ Tumors ○ Cancer
○ Stroke ○ Seizures ○ High Blood Pressure ○ Allergies ○ Aids/HIV ○ Diabetes ○ Hepatitis ○ TB
○ Hernia ○ Heart disease ○ Other _____

Patient Acknowledgment and Receipt of Notice of Privacy Practices

Pursuant to HIPAA and Consent for Use of Health Information 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.
Initial_____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I also authorize the doctor to release all information necessary to communicate with personal physicians, other health care providers, and/or payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's Signature (if 18+): _____ Date: _____

Guardian's Signature: _____ Date: _____