armouth
hiropractic

Confidential Patient Information

Today's Date: _____

Please Print in Black Ink

Name: Last_____ First _____ MI____ Date of Birth ___/___/_____
Address_____ City_____ State_____ Zip_____
Home Phone (_____)_____ Work (_____)_____ Cell (_____)_____
Email_____
SS # _____-_____-_____ Marital Status: ____Married _____Single _____Other_____
Occupation: _____ Employed by _____
Emergency Contact: _____ Phone: (____) _____Relationship to Patient: _____

Race (Circle): Decline to Disclose American Indian Alaska Native Black/African American Asian Native Hawaiian/Pacific Islander White/Caucasian Unknown Other_____

Ethnicity (Circle): Decline to Disclose Latino/Hispanic Mexican/Mexican-American/Chicano Cuban Puerto Rican Unknown Other: _____

Preferred Language: _____

Do you smoke (Check one)? _____Current Every Day Smoker _____Current Someday Smoker _____Former Smoker _____Heavy Tobacco Smoker _____Light Tobacco Smoker _____Never Smoked _____Current Status Unknown _____Unknown if Ever Smoked

How many cigarettes per day? ____ What date did you start? _____ What date did you stop? _____

How did you hear about Yarmouth Chiropractic? _____
Have you received Chiropractic care before? _____ If so, where?_____

Is the reason for this appointment the result of an injury while on the job or an auto accident? _____
Have you ever had a similar condition before? _____ If so, when?_____
Describe_____

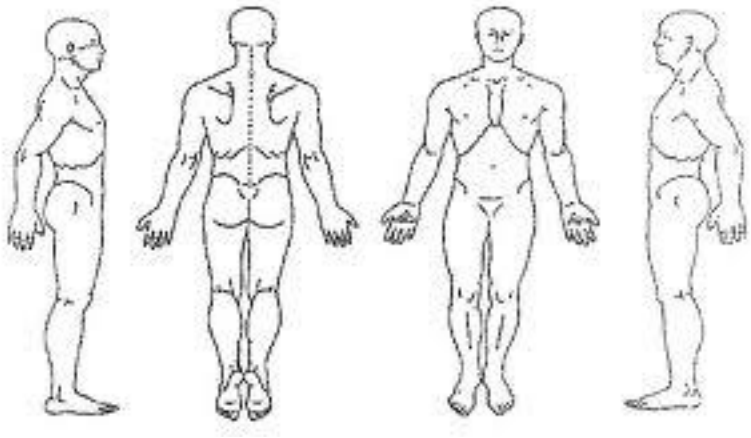
Have you ever suffered from: (circle all that apply)

Dizziness Tuberculosis Asthma Sinus Trouble Diabetes Numbness
Backaches Arthritis Neuritis Anemia Anxiety Cancer Heart Trouble
Headaches Digestive Disorders Rheumatic Fever

Female, are you pregnant? ___Yes ___No Date of last physical exam:_____

List any surgeries and dates of surgeries:_____
_____
List any other illnesses and date of diagnosis:_____
_____

Please mark areas of pain or numbness on the figures below:



What conditions are you most interested in correcting (in the order of importance):
1. _____
2. _____
3. _____
4. _____

When did the complaint/episode begin? _____
What seemed to cause this complaint? _____

How often do you experience your symptoms? ____Constantly (75%-100% of the time) ____Frequently (51%-76% of the time) ____Occasionally (26%-50% of the time) ____Intermittently (0%-25% of the time)

Average pain intensity: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)
What seems to aggravate your condition?_____

Is it getting progressively worse? ____Yes ____No ____Constant ____Comes and Goes
Is this condition interfering with: ____Work ____Sleep ____Daily routine ____Other:
_____

Do you take vitamins or minerals? _____ If so, what?_____
_____
_____
If not, do you think you may need vitamins or minerals? _____ Would you be interested in a nutrition evaluation? _____
Are you taking any medications? _____If so, what?_____
_____

Do you have any allergies? If so, what are they?_____
_____

Are you wearing any of the following: _____Heel lifts _____Sole lifts ____ _Inner soles _____Arch supports
Any additional information?_____
_____
_____

CANCELLATION & NO-SHOW POLICY
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
1. If an appointment is not cancelled at least 24 hours in advance you will be charged a forty-five dollar ($45) fee; this will not be covered by your insurance company.
2. We understand that delays can happen however we must try to keep the other patients on time. If a patient is 10 minutes past their scheduled time we may have to reschedule the appointment. !!!!

_____ _____ ____/____/____
Print Name Patient Signature Patient/Guardian Today's Date

PAYMENT IS EXPECTED AT THE TIME OF THE VISIT.
Are you insured? ____Yes ____No Insurance Company _____
Name of person responsible for payment_____

To the best of my knowledge the above information is accurate. I authorize the performance of chiropractic services for myself or my minor child as designated above and give my consent to any advisable and necessary laboratory, x-ray and treatment procedures to be administered by the attending chiropractor or by her assistants for diagnostic purposes and other chiropractic treatments.
Please initial the following:
___I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself; not this office.
___I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid to this office directly will be credited to my account upon receipt.
___I understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment.
___I understand that if I terminate my care, any fees for professional services rendered to me will be immediately due and payable.

PATIENT SIGNATURE_____DATE___/___/_____
GUARDIAN/SPOUSE (If applicable) Signature authorizing care _____DATE___/___/_____