



PATIENT CONTACT INFORMATION

PATIENT NAME FIRST MIDDLE LAST SUFFIX TODAY'S DATE

ADDRESS CITY STATE ZIP CODE

() () HOME CELL EMAIL ADDRESS

Please indicate how you would like to receive appointment confirmations by checking the box(s) below:

Email Home Cell - Who is your cell phone carrier?(Ex: Verizon, T-Mobile, etc.)

Who may we Thank for Referring you to our office?

PATIENT INFORMATION FORM

Gender: Male Female Marital Status: Single Married Widow Separated Divorced

BIRTHDATE (MM/DD/YYYY) AGE PATIENT SOCIAL SECURITY NUMBER DRIVER'S LICENSE NUMBER

Employment Status: Employed Unemployed Full-time Student Part-time Student

EMERGENCY CONTACT
NAME: FIRST LAST
()
RELATIONSHIP PHONE

INSURANCE INFORMATION
NAME OF PRIMARY INSURANCE
NAME OF SECONDARY INSURANCE (IF ANY)

ADDITIONAL CONTACTS-EMPLOYER INFORMATION

EMPLOYER NAME OCCUPATION

ADDRESS PHONE

SPOUSE INFORMATION

SPOUSE NAME: FIRST LAST () CELL PHONE

EMPLOYER NAME OCCUPATION () WORK PHONE

HISTORY OF PRESENT ILLNESS

CHIEF COMPLAINT: Purpose of this appointment (Briefly describe):

Condition is due to: Work injury Illness Auto Accident Gradually Appeared Other

How did your pain begin? No Apparent Reason Bending Lifting Fall Auto Accident

Other, describe:

Have you had the same or similar condition? No Yes Have you seen another Doctor for it?

If so, about how long ago? Date symptoms appeared or accident happened?

PAST MEDICAL HISTORY

1. Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Broken or Fractured Bones | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Strokes | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Ruptures | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> A Congenital Disease | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ulcers | | | |

2. Do you have a history of stroke or hypertension? YES NO If Yes, Explain: _____

3. List any major illnesses, injuries, falls, auto accidents or surgeries? (Women, please include information about childbirth-including dates.):

4. Have you been treated for any health condition by a physician in the last year? YES NO If Yes, Describe: _____

5. What Medications or Drugs are you taking? _____

6. Do you have allergies to any medications? YES NO If Yes, Describe: _____

7. Do you have allergies of any kind? YES NO If Yes, Describe: _____

8. Please list any other health problems you have, no matter how insignificant they may be: _____

SOCIAL HISTORY

10. Do you drink alcoholic beverages? _____ If so, how much per week? _____

11. Do you use tobacco products? _____ Do you smoke? _____ If so, how many packs per day? _____

12. Do you take vitamin supplements? _____ If so, please list: _____

13. Do you consume caffeine? _____ If so, how much per day? _____

14. Do you exercise? _____ If yes, what is the frequency and type of exercise? _____

15. What are your hobbies? _____

16. What percentage of time during the day (at home or at your job away from home) do you spend:

Lifting _____% Sitting _____% Bending _____% Working at the computer _____%

FAMILY HISTORY

FATHER (Check one):

MOTHER (Check one):

Living _____ Deceased _____ Still Living/Current Age _____ Living _____ Deceased _____ Still Living/Current Age _____

Cause of death and age of death (if deceased): _____ Cause of death and age of death (if deceased): _____

FAMILY DISEASES

(Check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother)

- | | | | | | |
|---------------------|---------|-----------------------|---------|-----------------------|---------|
| Tuberculosis: _____ | F M S B | Cancer: _____ | F M S B | Mental Illness: _____ | F M S B |
| Diabetes: _____ | F M S B | Asthma: _____ | F M S B | Heart Disease: _____ | F M S B |
| Stroke: _____ | F M S B | Kidney Disease: _____ | F M S B | Lung Disease: _____ | F M S B |
| Arthritis: _____ | F M S B | Liver Disease: _____ | F M S B | | |

Other: _____

PATIENT HISTORY

Childhood Diseases: Measles _____ Mumps _____ Chiken Pox _____ Others _____

Unusual Childhood Diseases: _____

Adult Illnesses or Conditions: _____

Women: Are you Pregnant? _____

Have you ever had or do you now have any of the following symptoms which are or have been of significant distress to you? (Please indicate with the letter **N** if you have these conditions now, or **P** if you have had these conditions previously.)

N= NOW P= PREVIOUSLY

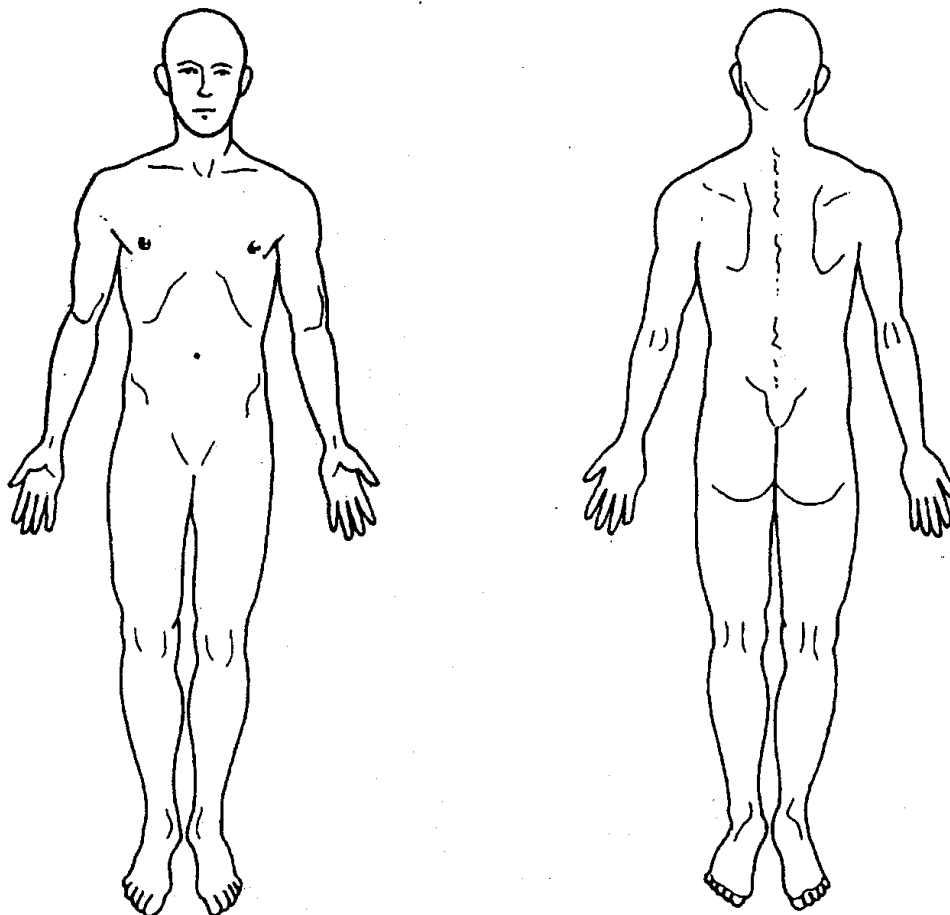
Headaches: _____ Frequency: _____

- | | | | |
|-------------------------------|----------------------------|---------------------|--------------------|
| Shoulder/Neck/Arm Pain _____ | Sleeping Problems _____ | Unusual Bowel _____ | Back Pain _____ |
| Weakness in Extremities _____ | Lights Bother Eyes _____ | Loss of Taste _____ | Stiff Neck _____ |
| Chest Pains/Tightness _____ | Numbness in Toes _____ | Nervousness _____ | Irritability _____ |
| Indigestion Problems _____ | Difficulty Urinating _____ | Loss of Smell _____ | Diabetes _____ |
| Numbness in Fingers _____ | Weight Loss/Gain _____ | Hands Cold _____ | Tension _____ |
| Menstrual Difficulties _____ | Loss of Balance _____ | Depression _____ | Fatigue _____ |
| High Blood Pressure _____ | Loss of Memory _____ | Feet Cold _____ | Fainting _____ |
| Buzzing in the Ears _____ | Muscle Spasms _____ | Ears Ring _____ | Patterns _____ |
| Joint Pain/Swelling _____ | Frequent Colds _____ | Neck Pain _____ | Arthritis _____ |
| Breathing Problems _____ | Sinus Problems _____ | Dizziness _____ | Fever _____ |

PAIN DRAWING

TELL US WHERE YOU HURT.

Mark the areas on your body where you feel your pain with an **X** symbol. Include all affected areas. Describe the type of pain you are feeling as an Ache, Numbness, Pins & Needles, Burning, Stabbing, or Throbbing.



PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. (1) The patient understands and agrees to allow 360 chiropractic Wellness to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow our office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that our office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment. (2) The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions. (3) A patient's written consent need only be obtained one time for all subsequent care given the patient in this office. (4) The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented. (5) For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them. (6) Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures. (7) If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

PATIENT SIGNATURE: _____ DATE: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to our office, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Doctor. The Doctor provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime. I understand that if I am accepted as a patient by a physician at 360 Chiropractic Wellness, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

PATIENT SIGNATURE: _____ DATE: _____

MISSED APPOINTMENT POLICY

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding missed and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least **24 hours notice** in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time. Since our office does not charge for missed or cancelled appointments, please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

PATIENT SIGNATURE: _____ DATE: _____

PREGNANCY WAIVER

I hereby acknowledge that Dr. Jared L Hanson of 360 Chiropractic Wellness has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own violation that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

PATIENT SIGNATURE: _____ DATE: _____