NEW PATIENT INFORMATION

Date ________________

Name____ **Age**________ **Date of Birth**_______________

Name by which you prefer to be addressed (if different from above) ________________________________

Phone number (Home) ____________________________ **(Cell)** ___________________________

Address___________________________________ **City** _________________ **State** _____ **Zip** __________

Social Security # __________________ **Gender**______ **Email**_____________________________________

Employer ____ **Work number** _______________________

Marital Status (circle one) Single | Married | Widowed | Divorced | Legally Separated | Other

Spouse's Name_______________________ **Occupation/Employer**________________________________

Number of children________

EMERGENCY CONTACT INFORMATION

Name ____ **Relation to patient** ____________________

Address___________________________________ **City** _________________ **State** _____ **Zip** __________

Phone number (Home) _______________________ **(Cell)** ______________________

How were you referred to our office? ____

Family Medical Doctor ____

When doctors work together it benefits you. Should a situation arise, do we have your permission to update your medical doctor regarding your care at Milford Chiropractic? (circle one) Y N

Insurance coverage (please check all that apply)

- ☐ **BCBS**
- ☐ **Midlands Choice**
- ☐ **Medicare**
  Supplement (if applicable) ____
- ☐ **Other** ____
- ☐ **No insurance**

Please note that we only file claims with BCBS, Midlands Choice, and Medicare. If you do not have insurance or are covered under a different provider, you will be considered a "Cash Patient". If you wish to file claims with your insurance, please provide the front desk staff with a copy of your insurance provider's claim form and we will provide you with the necessary information to file claims with your insurance.

I understand and agree that the above is true and correct to the best of my knowledge. Milford Chiropractic has my permission to use my Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care.

____ ____________________

Patient Signature (or Legal Guardian if applicable) Date

IMPORTANT Please see the reverse side for important information regarding your health information rights

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 HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office 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 this chiropractic 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 this 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 has 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, the chiropractic physician 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.

____ ____________________

Name of Patient (or Legal Guardian if applicable) Date

Chiropractic Case History

Name____ Date________________________________

1. **PrimaryComplaint:**____

   Secondary Complaint:____

Complaint began when and how?____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _______

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?______________________________

Do you have any numbness or tingling in your body? Where? ____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? ______________________________________

Is the complaint due to injury or sickness arising out of employment?_____________________________________

Is the complaint due to injury or sickness arising out of an auto or other accident?___________________________

Days lost from work?_________________ If due to an accident what was the date of the accident?___________________

Have you seen any other doctors for this condition?____

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:** ___________________

____

____

3. **Medications:**

Drugs You Now Take:

☐ Muscle Relaxers	☐ Tranquilizers	☐ Birth Control
☐ Blood Pressure	☐ Insulin	☐ Thyroid
☐ Blood Thinners	☐ Anxiety	☐ Decongestants
☐ Cholesterol	☐ Pain Killers	☐ Antidepressants
☐ Steroids(allergy/asthma meds)		☐ Other__________________________

4. **Surgeries:**

Date	Type of Surgery
________________________	________________________________
________________________	________________________________
________________________	________________________________

5. Please Check the appropriate box for any of the following symptoms you now have or have had previously:
N = Now P = Previously

General

N P
- ☐☐ Allergy
- ☐☐ Diabetes
- ☐☐ Dizziness
- ☐☐ Depression
- ☐☐ Fainting
- ☐☐ Fatigue
- ☐☐ Fever
- ☐☐ Headache
- ☐☐ Irritability
- ☐☐ Memory Loss
- ☐☐ Numbness
- ☐☐ Nervousness
- ☐☐ Sweats
- ☐☐ Tension
- ☐☐ Tremors

Cardio- Vascular:

N P
- ☐☐ Heart problems
- ☐☐ Stroke
- ☐☐ Pain over heart
- ☐☐ Poor circulation
- ☐☐ Rapid heart beat
- ☐☐ Slow heart beat
- ☐☐ Swelling of ankles
- ☐☐ Hands cold
- ☐☐ Feet cold

For Women Only:

N P
- ☐☐ Pregnant
- ☐☐ Painful menstruation
- ☐☐ Cramps or Backache
- ☐☐ Menopausal
- ☐☐ Irregular cycle
- ☐☐ Hot flashes
- ☐☐ Menstrual problems/PMS
- ☐☐ Excessive menstrual flow

Gastro-Intestinal

N P
- ☐☐ Colitis
- ☐☐ Colon trouble
- ☐☐ Difficult digestion
- ☐☐ Excessive hunger
- ☐☐ Gall bladder trouble
- ☐☐ Hemorrhoids
- ☐☐ Liver trouble
- ☐☐ Nausea
- ☐☐ Pain over stomach
- ☐☐ Poor appetite
- ☐☐ Difficulty urinating
- ☐☐ Unusual bowl problems
- ☐☐ Ingestion problem
- ☐☐ Kidney infection/stones

Muscle & Joint:

N P
- ☐☐ Arthritis
- ☐☐ Bursitis
- ☐☐ Foot trouble
- ☐☐ Back pain
- ☐☐ Neck pain
- ☐☐ Stiff neck
- ☐☐ Pain between shoulders
- ☐☐ Joint pain/swelling
- ☐☐ Gout
- ☐☐ Painful tail bone
- ☐☐ Poor posture
- ☐☐ Sciatica
- ☐☐ Spinal curvature

Pain or numbness in:

N P
- ☐☐ Shoulders
- ☐☐ Arms
- ☐☐ Elbows
- ☐☐ Hands
- ☐☐ Feet
- ☐☐ Hips
- ☐☐ Legs
- ☐☐ Knees

Skin:

N P
- ☐☐ Eczema
- ☐☐ Shingles
- ☐☐ Psoriasis
- ☐☐ Skin rash/hives

Respiratory:

N P
- ☐☐ Chest pain/tightness
- ☐☐ Chronic cough
- ☐☐ Breathing problems
- ☐☐ Wheezing

Eyes, Ears, Nose & Throat:

N P
- ☐☐ Asthma
- ☐☐ Frequent Colds
- ☐☐ Crossed eyes
- ☐☐ Earache
- ☐☐ Ears ring
- ☐☐ Enlarged thyroid
- ☐☐ Eye pain
- ☐☐ Light bother eyes
- ☐☐ Hay fever
- ☐☐ Failing vision
- ☐☐ Loss of smell/taste
- ☐☐ Hoarseness
- ☐☐ Nasal obstruction
- ☐☐ Nosebleeds
- ☐☐ Sinus problems
- ☐☐ Sore throat

Place an "X" on the drawing below on areas causing you pain and a letter describing it

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Signature ______________________________ Date ________________