Today's Date: _____ Patient Name: _____

CONFIDENTIAL PATIENT HEALTH RECORD

Welcome and thank you for choosing **Crain Chiropractic & Wellness**. We will use the information you provide, along with a consultation and a thorough spinal exam to determine how we can best help you. Please answer the best you can.

PERSONAL INFORMATION

First Name: _____Middle:_____ Last: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

Date of Birth (M/D/Y): _____ Sex: **M F** Marital Status: **S M W D**

Social Security Number: _____

Email Address: _____

Preferred method of communication for patient reminders: **Email Phone Text Mail**

Preferred Language: _____ Ethnicity: **Hispanic/Latino Not Hispanic/Latino I Decline to Answer**

Race: **American Indian/Alaska Native Asian Black/African American White (Caucasian)**

Native Hawaiian/Pacific Islander I Decline to Answer

Your Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

Name of Significant Other: _____ Number of Children: _____

Name of Family Doctor: _____

Whom may we thank for referring you to our office? _____

☐ I choose to decline receipt of my EHR clinical summary after every visit.
(These summaries are often blank as a result of the nature and frequency of chiropractic care.)

IN CASE OF AN EMERGENCY, PLEASE CONTACT

Name: _____ Relationship: _____

Phone: _____

GUARANTOR INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Today's Date: _____ Patient Name: _____

CURRENT HEALTH CONCERN

☐ I do not have a current concern but would like to be evaluated for wellness care. (Skip to Past Health History.)

Describe the primary reason for today's visit: _____

When did this start? _____

What do you feel caused this problem? _____

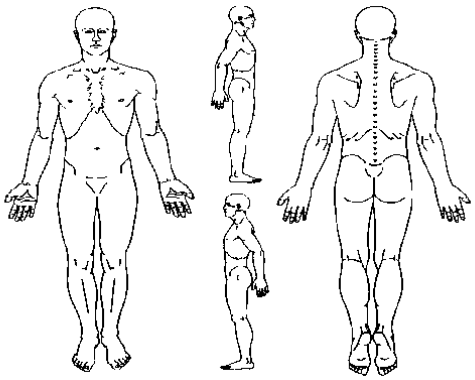
Pains are: **Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness**

Other: _____

On a scale of 0-10 please circle the number that represents your current pain level:

NORMAL	**0**		
LOW PAIN	**1**	**2**	**3**
MODERATE PAIN	**4**	**5**	**6**
INTENSE PAIN	**7**	**8**	**9**
EMERGENCY	**10**		

Please indicate where your pain is located:



Is your condition due to an accident? **Yes No**

Date of accident: _____ Type of accident? **Auto Work Home Other:** _____

Explain Accident: _____

What activities make your condition/pain worse? _____

What activities make your condition/pain better? _____

Is this condition interfering with **Work Sleep Routine Other:** _____

Is this condition getting progressively worse? **Yes No**

Have you seen anyone else for this? **Yes No** Who? _____

PAST HEALTH HISTORY

Previous Surgeries: _____

Previous fractures or broken bones? **Yes No** Explain: _____

Previous falls or accidents? **Yes No** Explain: _____

Previous car accidents? **Yes No** Explain: _____

Have you ever received chiropractic care? **Yes No** Approx. Date of last visit: _____

Chiropractor: _____

Today's Date: _____ Patient Name: _____

REVIEW OF SYSTEMS

Below is a list of conditions that may seem unrelated to the purpose of your appointment. However, these may affect the overall course of your chiropractic care, so please mark any of the following that apply to you.

Please circle O for previously had or Δ for currently have.

General

O Δ Cancer	O Δ Chemical Dependency	O Δ STD
O Δ Multiple Sclerosis	O Δ Parkinson's	O Δ Tuberculosis
O Δ Polio	O Δ Chicken Pox	O Δ Epilepsy

Musculoskeletal

O Δ Osteoarthritis	O Δ Osteoporosis	O Δ Joint Replacement
O Δ Neck Pain	O Δ Low Back Pain	O Δ Shoulder Pain
O Δ Wrist/elbow Pain	O Δ Knee Pain	O Δ Foot/ankle Pain
O Δ TMJ Disorder	O Δ Poor Posture	O Δ Scoliosis

Neurological

O Δ Headaches/Migraines	O Δ Dizziness	O Δ Pins and Needles
O Δ Anxiety	O Δ Depression	O Δ Herniated Disc

Cardiovascular

O Δ Irregular Heart Beat	O Δ Stroke	O Δ Pacemaker
O Δ High Blood Pressure	O Δ High Cholesterol	O Δ Heart Attack
O Δ Short Breath with Exertion	O Δ Heart Disease	O Δ Excessive Bruising

Respiratory

O Δ Allergies	O Δ Asthma	O Δ Sinus Troubles
O Δ Chronic Cough	O Δ Emphysema	O Δ Pneumonia

Gastrointestinal

O Δ Food Sensitivities	O Δ Heartburn	O Δ Eating Disorder
O Δ Frequent Indigestion	O Δ Hernia	O Δ Ulcer
O Δ Unusual Weight Change	O Δ Constipation	O Δ Diarrhea

Eyes, Ears, Nose, Throat

O Δ Loss of Smell	O Δ Ringing in Ears	O Δ Blurred Vision
O Δ Loss of Taste	O Δ Hearing Loss	O Δ Cataracts

Endocrine/Immunological

O Δ Catch Colds Easily	O Δ Autoimmune Disease	O Δ AIDS/HIV
O Δ Frequent Infections	O Δ Hypoglycemia/Diabetes	O Δ Thyroid Disorder
O Δ Swollen Glands	O Δ Low Energy/Fatigue	O Δ Hormone Therapy

Genitourinary

TO BE COMPLETED BY WOMEN ONLY

Could you be pregnant? **Yes** **No** Date last period started: _____

O Δ Premenstrual Symptoms	O Δ Irregular Periods	O Δ Painful Periods
O Δ Headaches with Periods	O Δ Menstrual Cramps	O Δ Infertility
O Δ Hot Flashes	O Δ Hysterectomy	O Δ Miscarriage

Approx. Date of last pelvic exam: _____

TO BE COMPLETED BY MEN ONLY

O Δ Painful Urination	O Δ Prostate Problems	O Δ Erectile Dysfunction

If over age 40, approx. date of last prostate exam: _____

Today's Date: _____ Patient Name: _____

FAMILY HEALTH HISTORY

Is there a known family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other: _____
Father's Side	☐	☐	☐	☐	☐
Mother's Side	☐	☐	☐	☐	☐

Any other hereditary health issues/conditions: _____

HEALTH HABITS & SOCIAL HISTORY

Are you currently taking any medications? *(Include regularly used over the counter medications)*

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

How would you rate your eating habits? **Poor Fair Good Excellent**

Special diet? **Low Carb Dairy Free Gluten Free Vegetarian Paleo**

Do you supplement your diet? **Yes No**

☐ Multivitamin	☐ Essential Fatty Acids (Fish Oil)
☐ Probiotic	☐ Vitamin D
☐	☐

How often are you currently exercising? **Never Daily 1X/week 2X/week 3X/week 4 or moreX/week**

What type of exercise program is it? _____

Do you drink alcohol? **Yes No** If yes, how much? _____

Do you drink coffee, tea or soda? **Yes No** If yes, how much? _____

Smoking Status (Circle one): **Every Day Smoker Occasional Smoker Former Smoker Never Smoked**

Approximately how many ounces of water do you drink per day? _____

What are the major stresses in your life currently? _____

How would you rate the level of stress? **High Moderate Low**

What is your preferred sleeping position: **Side Stomach Back**

What are your hobbies? How do you spend your free time? _____

Today's Date: _____ Patient Name: _____

INFORMED CONSENT & AUTHORIZATION FOR CARE

The practice of chiropractic includes many standard examination and testing procedures, as well as, therapeutic procedures. These include physical examination, orthopedic and neurological testing, specialized chiropractic examinations, radiological (x-ray) examination, and laboratory testing (when clinically indicated). Procedures performed by chiropractors include various physical therapy and rehabilitation procedures and the procedure unique to the chiropractic profession – the chiropractic adjustment. Chiropractic adjustments are delivered to patients by chiropractors to correct spinal or extremity (ankle, knee, wrists, etc.) joint dysfunction. Within the chiropractic profession these dysfunctions are called subluxations. A subluxation is a condition that exists when one or more bones of the spine (called vertebrae) or extremities are misaligned sufficiently to cause a lack of motion in these joints, as well as, interference and/or irritation of the nervous system. The primary goal in chiropractic health care is the removal of subluxations and the restoration of normal joint motion and nervous system function.

It is not enough that you understand the benefits of chiropractic care in restoring normal joint motion and nervous system health, you must also be aware of the existence of the inherent risks and limitations of chiropractic care. Every type of treatment (medical, chiropractic, or otherwise) carries some form of potential risk associated with it. Risks associated with some forms of chiropractic care include muscular sprain/strain, neurological deficit, osseous fracture, and vertebral artery dissection (stroke). While the incidence of injury from chiropractic care is extremely low, and only seldom are the risks great enough to contraindicate care, these facts should be considered in making the decision to receive chiropractic care.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the potential risks of chiropractic care; including the risk that care I receive in this office may not accomplish the intended clinical objective. I have been advised of reasonable alternative treatments including known risks, consequences, and probable effectiveness of each, and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been provided to me concerning the results of the care I will receive.

Patient/Guardian Signature: _____ Date: _____

CONSENT TO TREATMENT OF MINOR CHILD (if applicable)

As parent and/or legal guardian, I have the authority to authorize, and do hereby grant permission to Dr. Crain at Crain Chiropractic & Wellness to administer chiropractic care as she deems necessary to my son/daughter/ward.

Patient/Guardian Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your Personal Health Information (PHI) will never be given to any entity besides what is required for your treatment, payment, and health care operations. Disclosure of your PHI without authorization is strictly limited to defined situations that include other healthcare providers for the benefit of your health and well-being, with applicable insurance companies to justify the necessity of services rendered or to obtain payment for such services, with applicable attorneys to aid in case settlement or litigation, and with law enforcement officials to aid in legal or criminal investigations. You have the right to review your records or request copies of them at any time. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. You may request restrictions on your disclosures.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient/Guardian Signature: _____ Date: _____

FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

Chiropractic care in this office deals with vertebral subluxation, and will therefore be billed under the S8990 adjustment code. While we will provide an itemized receipt upon your request, we anticipate that care will not be reimbursed by a third-party carrier. (This does not apply to PI or Medicare.) I understand that I am financially responsible for ALL costs incurred in this office, whether my insurance pays or not. HSA and FLEX spending accounts may be utilized. If you need to make special arrangements, please ask. We will do everything possible to meet your financial needs.

In the event of a PI claim, I authorize the direct payment to Crain Chiropractic & Wellness of any sum I now or hereafter owed by my attorney out of settlement of my case, and by any insurance company obligated to make payment to me or Crain Chiropractic & Wellness based in whole or in part upon the charges made for services received. I hereby appoint Crain Chiropractic & Wellness authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic or payments due for services rendered.

Advanced Beneficiary Notice of NON-Coverage (ABN). Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions, please ask our staff. Signing below means that you have received and understand this notice.

Patient/Guardian Signature: _____ Date: _____